Partnering for the Public's Health: The Role of Public Health Institutes as Fiscal Agents and Intermediaries

By the National Network of Public Health Institutes
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Executive Summary

Dr. Thomas Frieden, Director of the Centers for Disease Control and Prevention, encouraged local health officials at the National Association of County and City Health Officials annual conference in July 2009 to work with fiscal intermediaries to expedite the delivery of services and processes administered by public health agencies. Following his statement, NNPHI was approached by the Procurement and Grants Office at CDC as well as by the CDC Foundation; both of which were seeking additional understanding of the extent to which public health agencies have worked with fiscal intermediaries. The CDC Foundation supported NNPHI to conduct a study on the mechanisms, benefits and challenges regarding the collaborative endeavors and partnerships between public health institutes and governmental public health. This report and the supporting documentation describe the methods, findings, and recommendations of the study.

Public/Private Partnership Model

NNPHI and its members have long standing relationships with government on the local, state, and national levels. NNPHI was formed with the support from CDC and the Robert Wood Johnson Foundation. The organization has partnered with divisions across CDC to complete multiple, multi-state projects through a cooperative agreement. Public health institutes across the country were created to add capacity to the state's population health agenda, and public health agency representatives often sit on the boards of the institutes.

The institutes have a long track record of performing rapid, high quality public health projects, as well as providing technical assistance, training and evaluation. Institutes are grounded in a multi-sector approach, bringing together government, academia, community organizations, and businesses, among others, to build innovative partnerships. Institutes have robust business practices with sound financial accountability. These partnerships provide an innovative mechanism for government to overcome the many administrative, human resources and political challenges that state and local governments face.

Methodology

NNPHI gathered data from public health institutes through an email survey to gain a snapshot of the current and past collaborations between institutes and local, state and federal governmental public health entities. The data collected prompted NNPHI to identify 13 institutes to participate in key informant interviews. The interviews were conducted in October 2009. As the data were analyzed, NNPHI engaged a number of institutes in the development of brief case studies that further illustrate the work and structure of their organizations.

Findings

This study identified proven mechanisms through which public health institutes serve as partners with governmental public health agencies. These mechanisms include:

designation as a bona fide agent, contracts, and direct grants that enable institutes to serve as fiscal intermediaries. The institutes also offer a host of competencies that add value to public health infrastructure, including policy information and formulation, education and training, and research and evaluation. Use of these mechanisms allows public health agencies to preserve their authority and responsibilities while accomplishing work in an efficient and effective manner.

Recommendations

NNPHI suggests that governmental public health agencies continue to partner with public health institutes and intermediaries. There are several opportunities for CDC to foster and support the collaboration between state and local health agencies and public health institutes. These include supporting the use of intermediaries as either bona fide agents, direct recipients of program funds, or as sub recipients of program dollars. CDC can clarify guidance to agencies in regards to the mechanisms through which they can work with intermediary organizations. Finally, CDC can invest in the development of institutes as key partners within the public health system.

The study also yielded recommendations for local and state health agencies on how to enhance the use of intermediaries. Agencies can further their knowledge of the use of intermediaries and the benefits to government through these partnerships. Additionally, local and state agencies should examine state policies and procedures that limit or enable the use of intermediaries.

Partnering for the Public's Health:
The Role of Public Health Institutes as Fiscal Agents and Intermediaries

"Although governmental actions and agencies constitute the backbone of all efforts to assure the health of the public, government cannot assure population health alone; other sectors and parties have an interest and a civic role to help create the conditions that make health possible." Institute of Medicine, The Future of the Public's Health in the 21st Century (2002), p.22.

1. Introduction

Improving the public's health is a shared responsibility that requires a multi-sector approach. The governmental public health system shares a large portion of that responsibility and is tasked with providing the essential services of public health. Government faces many challenges in meeting those responsibilities. These include bureaucratic and political limitations, human resource scarcity, and chronic funding shortages, among many others. In addition, some important public health activities, such as policy analysis and research, are not ideally implemented within a governmental setting. To respond to the challenges and limitations that government often faces, innovative public health leaders have created and worked with intermediaries from other sectors to meet the needs for speedy action, solid results and accountability.

One type of intermediary used is the public health institutes. Institutes across the nation were developed with the open or tacit support and direction of governmental public health officials. They have a population health mission, support multi-sector collaboration, are independent and have a commitment to providing quality, timely products and services. They are perceived as neutral parties to convene broad partnerships and stakeholders to deal with difficult topics or negotiations. They work in partnership with government, academia, community organizations, foundations and private interests to accomplish public health goals.

CDC Director Dr. Thomas Frieden requested a further exploration of successful intermediary models in September 2009. To support that exploration, the CDC Foundation funded the Association of State and Territorial Health Officials (ASTHO) and the National Network of Public Health Institutes (NNPHI) to conduct studies that would explore the current use of intermediaries, learn more about these complex relationships and describe successful models. The ASTHO report will outline these relationships from the state government perspective. This report will outline the findings from key informant interviews with several public health institute leaders. It is an in-depth look at the mechanisms, roles, attributes of success, challenges and recommendations for the use of intermediaries to improve the public's health.

2. Background

NNPHI and Public Health Institutes

The National Network of Public Health Institutes was established in 2001 to enhance the capacity of the nation's public health institutes and promote multi-sector activities resulting in measurable improvements to public health structures, systems and outcomes. The Network was formed with support from CDC and RWJF, primarily as a forum for institute leaders to learn from one another and work together as well as to foster the development of emerging institutes. NNPHI is an active network, fostering opportunities for multi-institute projects and serving as a national program office for initiatives conducted with local, state and national partners. CDC has been a partner and supporter of NNPHI from its inception; through a cooperative agreement, NNPHI and its members have completed projects on behalf of and in collaboration with divisions across CDC (See Attachment 1 for a complete listing of CDC/NNPHI projects).

In 2001, when the National Network of Public Health Institutes was formed, there were 11 public health institutes identified as members. In 2009, there are 25 institutes in NNPHI. Twenty one of these are established as independent, nonprofit 501 © 3 organizations. In addition, four are affiliated with universities, often operating as unique and independent centers in the academic setting. NNPHI also has nine additional members that are considered provisional institutes or affiliate members of NNPHI. The institutes range in size from very large to quite modest (See Attachment 2 for a complete listing of NNPHI members). They also have variations in their longevity. One of the oldest, the Public Health Institute located in California, was started over 40 years ago and manages a broad range of programs, both domestically and internationally. There are also 8 emerging institutes with minimal history and modest budgets, but comparable vision.

One of the requirements of membership with NNPHI is a demonstrated relationship with state and local government. Most institutes have a governmental public health entity as part of their governance structure. The institutes often have missions that closely mimic that of the governmental public health agencies related to improving the health of the population. They were created to complement the work of governmental public health and create additional capacity for public health initiatives. (See Attachment 3 for a letter from a state government leader describing their relationship with their institute).

The Government Public Health Landscape

Government is stymied by both bureaucratic hurdles and political limitations. The response to HIV/AIDS, for example, showed a limitation to how quickly government could respond to the wise use of new resources, staffing up to meet the challenges, and, often, having to wait for delays in legislative approval to spend resources that were available. The same problems have plagued public health agencies with funding for emergency preparedness and response, as well as H1N1. In some cases, equipment

purchases have taken far too long as the prescribed bidding processes are followed. The classified services and unions also have made it more difficult to hire staff for short term projects for research proposals and other short term initiatives. Managers sometimes do not take advantage of opportunities because of the problems that would be created when short term projects end. At times, the salary scales for highly skilled and hard to recruit positions have also left government unable to respond to population needs. Some states and local governments have capped the number of employees or FTE, and imposed hiring freezes. Some states and localities have statutory or constitutional limitations on budgets, including funds coming from outside their jurisdiction, such as federal or foundation funding.

The political pressures associated with data gathering and reporting, such as hospital information and policy recommendations, such as in tobacco, have shown that government is not always a friendly place for objective analysis of policies and information. Evaluating programs is also best performed by independent third parties, a role that institutes often play.

An Innovative Solution

There has been much exploration of the importance of multi-sector partnerships to tackle the challenges that government faces and improve health in the past decade. The best public health thinking, including that evidenced in the Institute of Medicine's 2002 study of the Future of Public Health, noted that public health is more than governmental work. The work of authors like David Osborne and Ted Gaebler, whose 1992 best seller, Reinventing Government, (Osborne, David and Ted Gaebler, Reinventing Government, How the Entrepreneurial Spirit is Transforming the Public Sector, Addison Wesley Publishing House, 1992) introduced the concept that "government should be steering and not rowing" (p. 25). They quoted Governor Mario Cuomo who said, "It is not government's obligation to provide services, but to see that they're provided." (p.30). As one institute noted, "Government needs to deal with philosophical issues while the institutes, as private organizations, need only deal with getting the work done."

With an understanding of the value of partnerships and in search of creative ways to avoid the challenges and pitfalls of government, many state health leaders have turned to public health institutes as an intermediary. Institutes provide a range of services to support government in their work and to leverage new resources for health in their states. Examples of this intermediary role include funneling money to others in a pass-though arrangement, hiring staff that sit next to governmental staff on particular projects, managing such programs as EPSDT, WIC, and Cancer Registries, performing research, convening groups for consensus and bringing in private foundation funding to address the needs of the state. The range is broad and varied. The tasks are primarily determined by the particular need in that state and for that agency (or in some cases, foundations).

3. The Study Purpose and Methods

NNPHI was asked to learn more about the wide range of roles that institutes play to support government as an intermediary. This study was designed to gather more detail about the specific financial mechanisms that institutes provide but also to explore the broader roles they play to add value to the state. To gather that information, NNPHI worked with institutes via three mechanisms:

1. Informal email survey: NNPHI staff gathered information from all its members on their collaborative efforts with CDC. The information was organized by the following characteristics: financial mechanism (bona fide agent, contract, direct grant), relationship with state/local governmental entities, project focus, funding amount.
2. Phone interviews with key informants: Following the email survey, NNPHI interviewed leaders from 13 institutes. The phone interviews sought to expand the understanding of the mechanisms through which institutes are working to support both CDC and state and local governmental public health as fiscal intermediaries. Numerous questions were posed about the mechanisms through which they receive funding and serve as a support to the governmental entity; as well as lessons to be learned from these established relationships, such as: enabling factors, barriers/challenges, and recommendations for enhancing the functionality of partnerships between government and intermediaries.
3. Case Studies: During the interviews, NNPHI asked several institutes to submit case studies and additional documentation supporting the research questions for inclusion in the report.

This paper describes the findings from the informal survey and phone interviews. Throughout the study, NNPHI has maintained close contact with CDC PGO, the CDC Foundation and ASTHO to coordinate the research and findings.

4. Findings

Collaborations between governmental agencies and public health institutes as fiscal intermediaries or agents operate at several levels ranging from large scale implementation of projects to basic procurement services and management functions. Each level of partnership between governmental entities and institutes preserve the governmental roles and functions that cannot and should not be delegated to non-public entities. In each level, the governmental entity retains responsibility for ultimate accountability and oversight of public funds and services. The range of functions provided via these partnerships is broad and includes combinations of the following:

Functions and Roles Institutes Play as Fiscal Intermediaries

1. Management of a project or program for the governmental unit (or other

organizations such as foundations). This model includes full responsibility for the outcomes of the work and independent decision-making within the scope of the project.

2. Re-granting of funds to local public health agencies, private organizations or non-profits with fewer restrictions than governmental procurement allows. This is an important role played by the Louisiana Public Health Institute after the devastation of Katrina in 2005.

3. Acting as an employer, handling the payroll, maintaining personnel records, and managing all taxes, benefits, etc. but leaving the staff supervision to the public health agency.

4. Performing certain activities in an out-sourcing model, such as development of information technology for a governmental unit.

5. Financial support by accepting revenues and paying expenses for a program or project. For example, institutes often handle the funds for training courses or conferences.

Financial Mechanisms to Support Partnerships

Governmental agencies and legislatures have used a range of mechanisms to pass funds to institutes. These include sole source designation which eliminates the need to bid work that is intended for the institute. In other cases, the institutes have been earmarked in legislation. All of these mechanisms designate the institute as fiscally responsible with the expectation of full accountability, transparency, and the use of sound audit principles.

1. Designation to Serve as Bona fide Agent or Agent of the State

Bona fide (good faith) agent status requires a letter from the Governor, health officer or a mayor designating an institute or other intermediary organization to apply for a particular grant program in partnership with a state government agency (See Attachment 4 for an example of such a letter). Bona fide agents then manage and implement the program for the state. In the states where this arrangement has been accomplished, state leadership has had familiarity with the mechanism or has worked with the institute to create the arrangement. It was apparent from the interviews with institute leaders that this is an underutilized mechanism; many states lack familiarity with this process. In addition, state policy and procedure may not support these relationships, and state government may be concerned about lack of control.

Successful examples include: Louisiana Public Health Institute, Public Health Solutions (New York City) and the Michigan Public Health Institute. The Louisiana Public Health Institute was recently designated the bona fide agent for

the state on the ARRA project *Communities Putting Prevention to Work.* (See Attachment 5 for a descriptive case study on this arrangement).

2. Subcontracts from a Governmental Agency

A. Master / Sole Source Agreements

A master contract or sole source agreement is a designation to receive contracts without the use of the bidding process. These agreements have been established in various ways either at the time of the creation of the institute or as a result of successful partnership with the governmental agency. In some cases the agreement is recognized in legislation. The arrangement creates a simple process to work on projects and request new work (including short term training, technical assistance, and small evaluation requests) between the state and institute and avoids the administrative hurdles of the bidding process. Often the state will designate the institute for a sole source arrangement if they feel the institute is the only qualified organization to do the work or they recognize that the institute has a special capacity to accomplish the task. From the interviews, it appears that this mechanism is much more common and supported in states where leadership recognizes the value added and special capacity of the institute.

Successful examples include: Georgia has a master contract with the Georgia Health Policy Center that by-passes the usual bidding process. In Texas, the vehicle used is a Memorandum of Understanding. The Michigan Public Health Institute receives state funding to manage many projects including the Michigan public health accreditation program for local health departments.

B. Contracts through Competitive Bidding Processes

Institutes may also have to bid for the work that they perform. Funding may go through contracts, memoranda of agreement, purchase orders, or any other typical fiscal vehicle. Institutes are often requested to bid on certain projects; they also create innovative partnerships and bring multi-sector leaders together to create a successful proposal.

Successful examples include: Public Health Solutions in New York City is one of six contractors providing services for the state health department in the Nurse Family Partnership program.

3. Public Funding through Legislative Authorization

Some public health institutes were created through authorizing legislation. Other institutes have been recognized through resolutions passed by state legislature.

For many, this legislation was driven by government agencies. Due to this relationship, some institutes are written into state appropriations. This mechanism is rare among public health institutes.

Successful examples include: The North Carolina Institute for Public Health is cited in the Appropriations Bill for North Carolina to receive certain funds for such activities as workforce development and accreditation.

4. *Direct Grantees of Federal Funds (without need for Bona fide Designation)*

Institutes also apply directly to federal agencies, such as CDC, HRSA, SAMSHA, NIH, HHS, etc., for projects and programs that complement the state's population health agenda. In recent years, CDC has specifically identified public health institutes in outlining eligible organizations to apply for funding opportunities. This is a common mechanism in which institutes support their state by bringing new resources and project opportunities that the state may not have the capacity to attain.

Successful examples include: The Georgia Health Policy Center provides technical assistance for rural health policy networks through a HRSA funded project. The Texas Health Institute has a Mental Health Transformation grant for a community collaborative demonstration project through SAMSHA.

In addition to partnering with governmental entities to execute programs and services with public funds, institutes also leverage private funding in the form of grants from foundations and private donations to support public health activities. The ability to attract these private funds augments the overall investment in public health in a state or community. In many instances, it has been easier for an institute to receive private funding from foundations and corporations because they are a neutral entity and institutes provide a level of efficiency and accountability without the administrative hurdles that many states face. Government leaders have encouraged foundations to directly fund the institutes to do work that is desired for the public health community. This funding can be significant. The Michigan Public Health Institute brought over $50,000,000 to public health activities in Michigan from non-state sources during the period 1992-2004. Health Research, Inc. assisted New York State in attracting over $6 billion in external funding. Such arrangements lead to partnerships that allow government to enjoy the results of work done by others and funded by others.

In addition to serving as a fiscal intermediary – institutes also partner with government to add capacity and support via numerous additional competencies. These competencies are built through project work with government as well as federal and private foundation partnerships. These core competencies can be applied to any critical or emerging public health topic and include:

1. Policy Information and Formulation: Institutes view policy as an important mechanism for improving health. Policy development is incorporated in program implementation. Many institutes also function as advocates for policy change. Policy efforts conducted by institutes also involve providing neutral information. For example, the Kansas Public Health Institute has a news service geared towards informing policy makers, and they conduct a legislative education program which assists policy makers with a more in-depth understanding of critical health issues in Kansas.
2. Education, training and workforce development: Institutes provide extensive educational and training opportunities for their state government colleagues. These activities range from offering educational webinars on critical health topics to extensive personnel training in state systems. For example, the Michigan Public Health Institute facilitates ongoing training in the latest systems and issues in service provision for all WIC agency staff for the state of Michigan.
3. Research and Evaluation: Several institutes have extensive capacity to conduct research and evaluation for the state. Several institutes have been approached to provide evaluation services for state run projects and programs as well as complete independent research on critical public health issues. For example, the University of Wisconsin Population Health Institute partners with the state to complete an evaluation of chronic disease services coordination across the state.
4. Communications: Several institutes have sophisticated communications teams that have expertise in social marketing, media outreach and public health communications campaigns. Institutes have assisted their states in targeting high risk populations for public health messaging, conducting social marketing campaigns in promoting physical activity, nutrition, and smoke-free environments, and many other activities. For example, The Louisiana Public Health Institute has supported the state with Stay Healthy Louisiana, a toll-free hotline, website and mass media campaign that brings important public health news to Louisiana residents.
5. Neutral Convener: Perhaps one of the most important roles that institutes serve to add capacity for their state is that of a neutral convener. Through partnerships with academia, community organizations, foundations and private interests, institutes are able to convene the most innovative leadership in a neutral space to work collaboratively to address public health issues. For example, the New Hampshire Community Health Institute, through a community participatory process, organized five workgroups consisting of individuals from 45 organizations representing businesses, local communities, schools, the health care industry, and the food and recreation industries to identify and prioritize proven practices for promoting healthy eating and active living.

Attributes of Success as Intermediaries

This study revealed several key characteristics that are exemplified by successful intermediaries, whether serving at the minimal fiscal flow-through role or full implementation of programs on behalf of government or others.

These include:

1. Partnerships and relationships with governmental public health agencies
2. Multi-sector approach
3. Capacity and accountability
4. Responsiveness and flexibility
5. Public health mission, knowledge and approach

1. Partnerships and Relationships with Governmental Public Health Agencies

Relationships between multiple levels of leadership at both the institute and the state or local public health agency are critical to making the partnership between the agency and the institute work. Successful institute leaders have used positive communication strategies, reaching out with every change of leadership at the agency level and cultivating existing relationships. Several institutes have government represented on their boards. Some of the institutes have staff and/or leadership with experience at the state agency level. This experience can be a plus in knowing how to connect with the decision-makers as well as understanding the culture and practices of the agency. Top leadership at the state level frequently changes, requiring that the institute put forth continuous effort to maintain relationships with the agency. In some cases, institutes provide a level of "institutional memory," as staff and leadership at the institute do not turn over as frequently as top level governmental directors. Often they are a long term partner on specific projects that may see multiple state health department employees assigned. It was suggested that development of relationships with staff that may have longer tenure within the health department is critical to maintaining continuity and productive relationships on joint projects.

An important aspect of the successful partnerships when institutes function as intermediaries on behalf of government is that they often are operating behind the scenes, providing back office support that goes unheralded. This "humility" of not needing to receive credit is necessary for a strong partnership to flourish. As one institute noted, "Institutes are about execution, not talk and pomp. Institutes don't mind making others look good without taking the credit."

2. Multi-Sector Approach

A strength of many institutes is their ability to convene or moderate different perspectives

and approaches and to engage multi-sector partners, including academia, elected officials, related governmental agencies, private sector/business, media, etc. These partnerships position the institutes as neutral conveners to navigate multi-sectored approaches to difficult policy issues, such as tobacco, and with bringing new partners together for planning, such as for preparedness and H1N1 planning.

3. Capacity and Accountability

Development of core operational infrastructure and capacity is a requirement for any successful intermediary or agent role. This includes sound financial systems, computer/information systems, communication capability, insurance, legal support, and solid personnel structures including performance reviews, proper classifications and salary levels. Sound management is a requirement for showing results and creating trust.

Accountability requires solid financial management and disclosure, an active board with strong oversight, and transparency in actions and methods. Accountability cannot be achieved without the capacity and the strong board cited above. Overhead must be reasonable and defensible.

4. Responsiveness and Flexibility

One of the values that institutes offer is to move public money quickly to accomplish public good. The institutes must have processes that move with deliberation and do not reflect the bureaucratic barriers that are seen in government. Bills must be paid quickly, reports must be timely, and hiring must go smoothly. In addition, institutes often have a reservoir of talent that can be accessed for quick and competent work. Consultants can be hired easily and at appropriate rates through institutes. In addition, institutes must be ready to change direction if that is indicated, either through their work or at the direction of the governmental agency. For example, directions from CDC may change due to new scientific information.

5. Public Health Mission, Knowledge and Approach

For a successful partnership with government or foundations in a public health initiative, the institute must operate from a foundation that is mission-driven towards improving the public's health. Institutes, by their nature, are often "strategically opportunistic", but that does not imply a lack of mission or goals. Some institutes have a broader mission that embraces a role with health care and health care providers, but the mission also supports and promotes population health. If the agent and the governmental agency have conflicting values or mission, the partnership cannot flourish.

Institutes are committed to a population health perspective in the work that they do. It is this depth of capacity and knowledge base in public health practice that makes partnering with institutes a productive relationship. Public health work done by sound public health practitioners with solid credentials is a great asset to governmental public health

agencies. Institutes have the freedom to recruit widely and offer competitive salaries.

Challenges for Public Health Institutes in the Role of Fiscal Intermediary

The partnership between governmental public health agencies and institutes that act as a financial intermediary can help governmental agencies increase productivity, achieve results and act quickly. However, there are challenges, both perceived and structural, that impede the extent to which these partnerships are employed.
Some of these include:

1. Lack of knowledge or precedence for establishing a designation as a bona fide agent. Many state government leaders are unfamiliar with, have never used, or do not understand the mechanisms for working with a bona fide agent.

2. Legislative and/or agency rules that prohibit the establishment of sole source or bona fide designations. There are often direct administrative barriers or policy/procedural language in state statute that prohibits agencies from working with an intermediary.

3. Changes in leadership at either institution can create a need for renewed relationship building if the relationships have not been institutionalized. State health department employees, especially at the leadership level, change frequently. Their openness to partnering, previous experience in public health, and leadership style affect the quality of relationships with multi-sector partners.

4. Relationships ebb and flow. Agency leadership may have concerns about loss of authority, loss of control, or loss of recognition when using an intermediary. There may be a sense of competition if the relationships have not been solidified.

5. States may not have a strong intermediary organization such as a public health institute that can partner with state government to accomplish its mission. Some states may have organizations that are not robust enough to provide the breadth and depth of capacity needed to support state government.

Recommendations

Below are key recommendations that interviewees suggested regarding what the CDC, as well as state and local agencies, can do to help support the adoption and implementation of successful intermediary partnerships with the institutes:

CDC

1. Support the use of fiscal intermediaries when appropriate to produce timely and high quality public health work that can add capacity to the limits of government.
2. Encourage intermediaries to be utilized as sub-recipients in the application and

development phases of a project, including designating a particular institute in the budget and award.

3. Provide guidance to state and local agencies regarding how and what types of intermediary relationships they can have with their institutes.
4. Recognize the challenges currently facing the public health system and support the development of these nonprofit and academic institutes to ensure that their capacities are sufficient to meet high standards.

State and Local Agencies

5. Public health agencies can enhance their knowledge of the use of intermediaries and the benefits to government through these partnerships. Consideration of and piloting of the use of intermediaries will demonstrate the viability of these partnerships to improve services.
6. Public health agencies can examine state policies and procedures in order to enable and support a more effective use of intermediaries or fiscal agents, including the use of master contracts or cooperative agreements that allow sole source designation. Procedures exist to alter state purchasing rules and regulation and can be used to make the processes more friendly to partnerships.

Conclusions

Public health institutes and public health agencies can partner successfully to improve the public's health. There are numerous examples of the mechanisms and the roles that public health institutes play as intermediaries that support partnerships with public health agencies. Both creative and pragmatic approaches which range from using a bona fide agent model to providing value added as a partner without the exchange of dollars. The model has been proven, but success can only be assured when there is sufficient capacity in the institutes, trust among all the partners, and accountability for the roles that each partner plays.

Government can improve its services and retain accountability while sharing activities with fiscal intermediaries. Institutes have the capacity to help advance the population health agenda in accordance with the mission and purpose of public health agencies and other public health systems partners. One model is not the answer, rather states and their partners will choose varying approaches. There is great opportunity for improved services if the needs of all parties are met.

Appendices

1. Highlighted Listing of NNPHI / PHI Projects with CDC

2. Listing of NNPHI Members

3. Letter of Support for the NNPHI / CDC Cooperative Agreement from Janet Olszewski, State Health Officer, Michigan Department of Community Health

4. Sample Letter Declaring Bona Fide Agent Designation

5. Public Health Institute Case Studies

Appendix 1. Highlighted Listing of NNPHI / PHI Projects with CDC

Highlighted Listing of NNPHI / PHI Projects with CDC

Current Projects:

Project Name	Participating Institutes	CDC Sponsors
Advancing the Development of Public Health Institutes (since 2002)	Overarching support for all institutes	Office of Strategy and Innovation, previously supported by the National Center for Health Marketing and Public Health Practice Program Office
Public Health Leadership Society (since 2002)	Strategic partnership with North Carolina Institute for Public Health and Public Health Institute in California	Office of Workforce and Career Development
National Public Health Performance Standards Program (since 2004)		Office of the Chief of Public Health Practice
Community Benefit	Public Health Institute – California (Lead)	Office of Strategy and Innovation
Health Impact Assessment – Climate Change and Transportation	Community Health Partnership – Oregon's Public Health Institute	Office of Strategy and Innovation, National Center for Environmental Health
Base Realignment and Closure	Georgia Health Policy Center	Office of Strategy and Innovation, Coordinating Center for Infectious Diseases, Coordinating Center for Environmental Health and Injury Prevention
Mobilizing Action Toward Community Health	University of Wisconsin Population Health Institute and up to 30 additional institutes	Office of Strategy and Innovation

Previous Projects:

Project Name	Participating Institutes	CDC Sponsors
CDC Leaders to Leaders Conference (2008)	Georgia Health Policy Center	Office of Strategy and Innovation
Public Health Institute Assessment Project	Georgia Health Policy Center	Office of Strategy and Innovation
Public Health Systems Research (2007-2008)	North Carolina Institute for Public Health, Michigan Public Health Institute	Office of the Chief of Public Health Practice
Health Transformation (2007)	Georgia Health Policy Center	Office of Strategy and Innovation
National Public Health Leadership Institute Curricula Development (2007)	Public Health Institute	Office of Strategy and Innovation
Preparedness Computer Modeling Project (2007)	Florida Public Health Institute, New Hampshire Community Health Institute, Michigan Public Health Institute	National Center for Environmental Health
Jail Health Project (2007)	Texas Health Institute	Office of Strategy and Innovation
Advancing Public Health Through Non-Traditional State Partners (2007)	Arkansas Center for Health Improvement	Office of Strategy and Innovation

Appendix 2. Listing of NNPHI Members

State	Organization Name	Year Formed	Health Issue Expertise	Website
AR	Arkansas Center for Health Improvement (ACHI)	1998	Tobacco, Childhood Obesity, Health Care Finance, Coordinated Student Health	www.achi.net
CA	Center for Health Improvement (CHI)	1997	Children's Health, Infectious Disease Prevention, Worksite Wellness, Health Care Quality, Chronic Disease Management, Healthy Aging	www.chipolicy.org
MS	Center for Mississippi Health Policy	2005	Childhood Obesity; Children's Health Coverage in Mississippi; Children's Health Insurance Program; Trauma Care System in Mississippi	www.mshealthpolicy.com
WI	Center for Urban Population Health (CUPH)	2001	Cancer, HIV/AIDS, Infant Mortality, Health Disparities, Teen Pregnancy, Health Systems, Academic-Practice Partnerships	www.cuph.org/public
CO	Colorado Foundation for Public Health and the Environment (CFPHE)	1993	Injury Prevention, Antibiotic Resistence, Diabetes, Cancer, Dental Health, Food Safety, Heart Disease, Women's Health	www.cfphe.org
CO	Colorado Health Institute (CHI)	2002	Health Care Workforce; Health Information Technology; Health Insurance; Long-Term Care; Medicaid; Public Health; Quality of Care; Rural Health; Safety Net	www.coloradohealthinstitute.org
OR	Community Health Partnership, Oregon's Public Health Institute (CHP)	1999	Prevention of childhood obesity (which includes physical activity, nutrition, breastfeeding, reducing screen time, school nutrition, menu labeling, healthy planning, active living by design, etc); food stamps and child care, HAI	www.communityhealthpartnership.org
FL	Florida Public Health Institute (FPHI)	2006	Healthcare Finance; Oral Health; Environmental Health; School Health; Workforce; Bio-Preparedness; FQHC Expansion; Health Policy; Community Benefit	www.flphi.org
GA	Georgia Health Policy Center	1995	Cancer, Child Health and Well-Being, Community and Public Health, Community Health System Development, Long-Term Care, Private Policy and Grants Management, Public and Private Insurance Coverage	www2.gsu.edu/~wwwghp
OH	Health Policy Institute of Ohio (HPIO)	2004	Health Policy, Health Information Technology, Mental Health, Tobacco, Violence Prevention, Public and Private Insurance Coverage	www.healthpolicyohio.org
NY	Health Research, Inc (HRI)	1953	HIV/AIDS, Emergency Preparedness, Cancer, Biotechnology research	www.hrinet.org
VA	Healthy Appalachia Institute	2008	Tobacco; Telehealth; Rural Strategic Planning for Health Delivery; Diabetes Prevention and Treatment; : Cancer Screening and Treatment in Rural and Tobacco-Friendly Environments	www.healthyappalachia.org

IL	Illinois Public Health Institute (IPHI)	1997	Public policy development/physical activity & nutrition; Health Information Exchange; Health data dissemination/development of web-based data query system; Training and technical assistance to LHDs to support collaborative community health assessment, planning and implementation; Accreditation and Quality Improvement	www.iphionline.org
WI	Institute for Wisconsin's Health (IWHI)	2006	Accreditation and Quality Improvement	www.instituteforwihealth.org
KS	Kansas Health Institute (KHI)	1995	Informing Policy Makers, Health Indicators, Childhood Immunizations, Racial and Ethnic Minority Health Disparities, Obesity, Oral Health, Tobacco, Public Health Systems, Health Care, Insurance Coverage, Health Informatics, Early Childhood Development	www.khi.org
LA	Louisiana Public Health Institute (LPHI)	1997	Health Systems Development; Tobacco Prevention; Stay Healthy Louisiana; HIV/AIDS; School Health; Health Informatics; Communications	http://lphi.org
ME	Maine Center for Public Health (MCPH)	1996	Violence Prevention, Public Health Information Systems, Cancer Control, Community Health Planning, Obesity, Oral Health	www.mcph.org
MA	Massachusetts Health Policy Forum (MHPF)	1998	Health Policy & Research/Evaluation	http://masshealthpolicyforum.brandeis.edu
MI	Michigan Public Health Institute (MPHI)	1990	Cancer Control, Tobacco, Health Promotion and Disease Prevention, Child and Adolescent Health, Health Informatics, Health Systems	www.mphi.org
MN	Minnesota Institute of Public Health (MIPH)	1972	Alcohol and Drug Education, Substance Abuse, Safe Schools, Mental Health, Gambling, Health Promotion, Tobacco	www.miph.org
MO	Missouri Institute for Community Health (MICH)	2003	Accreditation and Quality Improvement	www.michweb.org
DC	National Health Policy Forum (NHPF)	1971	Aging & Disability; Medicaid & CHIP; Medicare; Pharmaceuticals; Private Markets; Public Health; Quality; Safety-Net	www.nhpf.org
NV	Nevada Public Health Foundation (NPHF)	1996	Access to Care, Emergency Preparedness, Teen Health, Tobacco	www.nphf.org
NH	New Hampshire Community Health Institute (NHCHI)	1995	Accreditation and Quality Improvement, Emergency Preparedness, Teen Health, Tobacco, Aging, Public Health Systems, Rural Health, Community Health Planning, Healthy Eating/Active Living	www.nhchi.org
NC	North Carolina Institute of Public Health (NCIPH)	1999	Workforce Development including management/leadership training, All-hazards Preparedness and Preparedness Systems Research; Healthy Lifestyles Community Support; Public/Private Legal Preparedness; various issues on the broadcast, Public Health Grand Rounds	www.sph.unc.edu/nciph

CA	Public Health Institute CA (PHI)	1964	Alcohol/Tobacco/Substance Abuse; Chronic Diseases: Asthma, Cancer, Diabetes, Cardiovascular, Tuberculosis; Communicable/Infectious Disease including HIV/AIDS; Disability; Environmental Health; Family Planning/Reproductive Health; Health Policy Research; International Health; Leadership Development; Maternal & Child Health; Media Advocacy; Nutrition/Physical Activity/Obesity Prevention	www.phi.org
IL	Public Health Institute of Metropolitan Chicago	1999	Community health planning, Faith and Community Health, Chronic Disease, Obesity	phone: 312-566-0285
OK	Public Health Institute of Oklahoma (PHIO)	2003	Worksite wellness, Public Health Systems	www.publichealthok.org
PA	Public Health Management Corporation (PHMC)	1972	Behavioral Health Services; Emergency Assistance; Environmental Health: Asthma, Lead, Asbestos; Family Services; Health Promotion: HIV/AIDS Prevention, HIV Care Outreach, Injury Prevention, Pennsylvania Injury Reporting and Intervention System (PIRIS); Intermediary Services; Health Care Centers; Services to Special Populations: African American Community, Asian Community, Children with Special Needs, Homeless, People with HIV/AIDS, Latino Community, LGBT Community, Adults with Mental Retardation, People Seeking Housing Assistance, Welfare Recipients, Youth	www.phmc.org
NYC	Public Health Solutions	1957	Women's Health/Reproductive Health; Nutrition; HIV/STD care and Prevention; Training and Technical Assistance; Child Health and Development; Emergency Preparedness	www.healthsolutions.org
SC	South Carolina Public Health Institute (SCPHI)	2007	Uninsured/Underinsured in South Carolina; Long-term Care; Childhood obesity; Latino Maternal and Child; Health HIV/AIDS prevention; Public Health Preparedness	www.scphi.org
TN	Tennessee Institute of Public Health (TNIPH)	2005	Health education/advocacy; Tobacco; Health Risk data county reports; Neutral convener of state public health academic units, not-for-profits, for-profits, and public health professional organization for focused dialogues	www.state.tn.us/tniph
TX	Texas Health Institute (THI)	1964	Healthcare Access, Mental Health, Obesity, Jail Health, Long Term Care, Genetics/Genomics, Disaster Preparedness, Health data	www.TexasHealthInstitute.org
WI	University of Wisconsin Population Health Institute (UWPHI)	2001	Population Health Assessment; Substance Abuse; Health Care Policy; Social Determinants of Health; Program Evaluation	www.pophealth.wisc.edu/uwphi

Appendix 3. Letter of Support for the NNPHI / CDC Cooperative Agreement from Janet Olszewski, State Health Officer, Michigan Department of Community Health

STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

JENNIFER M. GRANHOLM
GOVERNOR

JANET OLSZEWSKI
DIRECTOR

March 14, 2008

Mr. Joseph Kimbrell, CEO
National Network of Public Health Institutes
1515 Poydras Street, Suite 1200
New Orleans, Louisiana 70112

Dear Mr. Kimbrell:

Since its inception in 1990, the Michigan Public Health Institute (MPHI) has been a key ally to all of the departments of the state of Michigan that share the responsibility for the health and well-being of Michigan's citizens. No short summary can do justice to the breadth and scope of MPHI's involvement in this crucial endeavor, so I will simply highlight MPHI's contributions in the key areas of forming partnerships with state agencies, leveraging resources, building community capacity, extending the capabilities of the state, and communicating knowledge and outcomes.

The most extensive of MPHI's partnerships has been with the Michigan Department of Community Health (MDCH). MPHI performs an impressive variety of tasks for MDCH, including designing and implementing information and surveillance systems, providing data to inform and improve policies, conducting program evaluations, conducting federally mandated trainings for program staff, writing grant proposals, designing and conducting demonstration projects, and providing coordination for direct service and pilot projects. In addition, MPHI staff members work closely with MDCH staff and the staff of other state departments to enhance the capacity of the state and communities in a wide range of community health activities and services.

Another key contribution of MPHI has come in the area of leveraging resources. The state works with MPHI to apply for funds that support new projects, pilot projects, and demonstration projects that meet our overlapping missions of maximizing positive health conditions in populations and communities throughout Michigan. In some cases, foundation funds are available to 501(c)(3) corporations, but not to units of government. In other cases, MPHI builds a consortium, including the state, to apply for federal or foundation funds that are available only to statewide consortia.

MPHI's efforts have been responsible for bringing in over $50,000,000 in non-state resources from a variety of private and public sources at the state and national level. Examples of specific awards in the last five years alone include: over $5,250,000 from the W. K. Kellogg Foundation for efforts such as community health improvement and nurse-managed primary care networks; more than $800,000 from the Robert Wood Johnson Foundation for the "Covering Michigan

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Kids Project"; $70,000 from Harvard University for work on the National Violent Injury Surveillance System; over $1,000,000 from the Department of Health and Human Services Health Resources and Services Administration for the National Child Death Review Resource Center and related efforts; approximately $1,000,000 from the Centers for Disease Control and Prevention for research on traumatic brain injuries, planning related to bio-monitoring, and surveillance of child maltreatment. In addition to this vital infusion of funding, MPHI has been able to bring in essential in-kind resources to support such vital state activities as the Detroit Wayne County Health Initiative and the Michigan Cancer Consortium.

MPHI has also been an indispensable ally to the state's efforts to build and improve the capacities of the healthcare systems serving its communities. Community-level projects supported by MPHI have provided capacity building, training, continuous quality improvement, surveillance data and technical support to organizations and communities throughout Michigan. Some of the beneficiaries have included: five primary care providers working to increase cancer early detection and follow-up; five African-American communities working to increase cancer awareness and early detection; three counties with colorectal cancer mortality rates higher than the state average; five counties with cervical cancer mortality rates higher than the state average, and all of the counties participating in Michigan's BCCCP recruitment and CQI efforts and activities.

In addition, MPHI's expertise in health information and surveillance systems has been indispensable in providing the data and data analyses that enable communities to effectively target the needs of their residents. Specific examples include: trainings for more than 500 health education professionals to enhance local capacity to effectively promote nutrition and physical activity behavior change; development of a unique community nutrition environment assessment tool and strategic planning toolkit to implement community changes to make healthier eating easy; community-based demonstration grant funding and technical assistance to develop, implement and share effective, innovative healthy eating and physical activity initiatives; the Traumatic Brain Injury Project, which brings together central and local front-line and supervisory staff from Community Mental Health, Department of Human Services, Area Agencies on Aging, public schools, as well as advocacy and private provider groups to offer services to individual Michigan citizens and to plan for service improvements; and the Muskegon Coalition for Appropriate Antibiotic Therapy, an extraordinary cooperative initiative that involves two competing provider networks and health systems, the public health department, insurers, a pharmaceutical company, community foundations, and a community service organization.

MPHI also is responsible for a local public health accreditation program that works with the Michigan Departments of Community Health, Agriculture, and Environmental Quality to ensure that the needs of all communities are being met by their local public health departments. It also facilitates community forums and surveys on key topics in order to encourage two-way

information exchange and guide agency decision-making. Other specific services provided to these local public health departments include the coordination of review schedules and procedures, technical assistance, trainings, and evaluation capacity.

Another crucial function played by MPHI has been its ability to extend the capabilities of state agencies. A variety of state of Michigan agencies contract with MPHI to meet the requirements associated with federal funding of programs and projects. MPHI's experience with information systems projects related to federal funding of Medicaid and the requirements of HIPAA have helped the state meet federal requirements in a timely and efficient manner, thereby avoiding penalties or interruptions in federal funding. The expertise of MPHI staff members has enabled state agencies to call on it to meet tight deadlines for projects in highly specialized fields such as bioterrorism, cancer research, and behavioral risk factor special surveys. Access to this resource permits the state to comply with federal regulations and guidelines, meet deadlines, and draw additional federal dollars.

Finally, MPHI has enhanced the availability of high-quality healthcare information by means of publications, including books, brochures, calendars, websites, articles, and training sessions. Examples include educational programs for physicians, patients, and schoolchildren on appropriate antibiotic use that have been developed in conjunction with the Michigan Antibiotic Resistance Reduction Coalition and the multi-media "Keeping Kids Alive" campaign that is part of the Michigan Child Death Review Program. MPHI has also been at the forefront of projects that enable state employees to improve their access to electronic knowledge in their fields of expertise.

Additional details on all of the specific projects that I've mentioned can be found in "Michigan Public Health Institute: A 15 Year Retrospective." Yet even that document only scratches the surfaces of the contributions that MPHI has made. In short, MPHI has become a mainstay of the state of Michigan's commitment to providing exemplary public health support services to all of the citizens of Michigan, permitting us to extend our reach, capacities, and resources. It is difficult to imagine where we would be today without the assistance of MPHI. Fortunately, we do not have to do so!

Sincerely,

Janet Olszewski

Janet Olszewski
Director

Appendix 4. Sample Letter Declaring Bona Fide Agent Designation

BOBBY JINDAL
Governor

State of Louisiana
Office of the Governor

October 16, 2009

Tracey Sims, Grants Management Specialist
Procurement and Grants Office
Centers for Disease Control and Prevention
2920 Brandywine Road, MS E-09
Atlanta, GA 30341
Phone Number: 770-488-2739
Fax Number: 770-488-2677
E- mail: atu9@cdc.gov

RE: Funding Opportunity Number: CDC-RFA-DP09-912ARRA09
Designation of the Louisiana Public Health Institute as the bona fide agent of the State of Louisiana for Communities Putting Prevention to Work (CPPW)

Dear Ms. Sims,

The State of Louisiana designates the Louisiana Public Health Institute (LPHI) as its bona fide agent applying for FOA CDC-RFA-DP09-912ARRA09 under the state coordinated Small City and Rural Area category. LPHI will serve as the lead/fiduciary agency in partnership with the State of Louisiana Department of Health and Hospitals (LA DHH) should the grant be awarded.

The contact person at LPHI for the purposes of this grant opportunity is:

Joseph Kimbrell, MA, LCSW
Chief Executive Officer, Louisiana Public Health Institute
1515 Poydras Street, 1200
New Orleans, LA 70112
504.301.9807; jkimbrell@lphi.org

The contact person at LA DHH for the purposes of this grant opportunity is:

Courtney Phillips
Executive Management Officer
Office of the Secretary
Louisiana Department of Health & Hospitals
225-342-3581 (Office)
Courtney.Phillips@LA.GOV

Sincerely,

Bobby Jindal,
Governor of Louisiana

Post Office Box 94004, Baton Rouge, Louisiana 70804-9004 • (225) 342-7015 • Fax (225) 342-7099
www.gov.state.la.us

Appendix 5. Public Health Institute Case Studies

1. **Georgia Health Policy Center:** GHPC is a university affiliated public health institute with a long standing relationship with the Georgia Department of Community Health. GHPC strongly supports the state with evidence based policy guidance through research, analysis and legislative education.
2. **Kansas Health Institute:** KHI is an independent, non-profit health policy and research organization supported by substantial core funding from an innovative local funder.
3. **Louisiana Public Health Institute:** Recently granted Bona Fide Agent status for the ARRA project, *Communities Putting Prevention to Work,* this document outlines the qualifications and capacities of LPHI to provide support for the state.
4. **Michigan Public Health Institute:** Formed by legislation, MPHI was created to directly support the Michigan Department of Community Health. A comprehensive paper on the impetus, evolution and value add for the state of Michigan is included as well as a two page document used to orient state government staff to the role of MPHI as an intermediary organization.
5. **Public Health Institute:** PHI provides extensive leveraging of private foundation funding to accomplish health goals in the state of California. This paper explores that work from the private foundation perspective.
6. **Public Health Management Corporation:** An excerpt from The Birth of a Fourth Sector by Richard Cohen and Tine Hansen-Turton, October 2009, PHMC's case study outlines PHMC as part of a growing movement of independent, nonprofit organizations whose efficient business practices and high performing, effective capacities support government in accomplishing its mission.
7. **University of Wisconsin Population Health Institute:** Also housed within a university, UWPHI has a long history of partnership with state agencies to conduct program evaluation and policy projects. UWPHI has managed several federal programs for the state.

A Case Study of the Georgia Health Policy Center

Background and History

Georgia Health Policy Center (GHPC), established in 1995, provides evidence-based research, program development and policy guidance locally, statewide and nationally to improve health status at the community level. The center was originally housed in the College of Health and Human Services, but relocated in 1998 to the newly-created Andrew Young School of Policy Studies at Georgia State University (Coburn, Hurley, & Ricketts 2007).

GHPC conducts, analyzes and disseminates qualitative and quantitative findings to connect decision makers with the objective research and guidance needed to make informed decisions about health policy and programs. The center is a catalyst for collaboration and innovation that builds trust and relationships among local, state, national, public, and private agencies interested in improving health.

Growth and Development

Since its founding, the center's project portfolio and external funding have grown steadily and represents over 40% of the school's external funding. Over the last five years, the center has received an average of $4 million in newly-awarded contracts each year and an average of $436,000 in annual state and university support.

As the only public university-based health policy center in Georgia, the center has become a premier source of policy analysis, applied research, evaluation, and technical assistance for local communities, governmental agencies, the legislature, state health care provider organizations, and national organizations. Building on its work in Georgia, the center has become nationally recognized and funded for its work on rural health systems development (Coburn, Hurley, & Ricketts 2007).

Institute Capacity and Areas of Specialty

The Georgia Health Policy Center is at work today throughout Georgia and in more than 200 communities and in 48 additional states, helping communities achieve health improvement. The center's work addresses tough, complex issues in health and healthcare. Listed below are recent key projects:

- Cancer – *Revision of Georgia's Comprehensive Cancer Control Plan; Cervical and Breast Cancer Analysis*
- Child Health and Well-Being –*Katie Beckett Waiver Study; Building Strong Families*
- Community and Public Health – *Urban Safety Net Study; Legislative Education Initiative; Policy Impact Council; the Georgia Rural Health Project; Southern Regional Health Consortium*
- Community Health System Development – *HRSA National Technical Assistance; Delta Health Alliance; Northern Sierra Rural Health Network Strategic Planning*
- Long-term Care – *Evaluation of the Aging and Disability Resource Center program; Policy Analysis and Guidance to the Alzheimer's Association – Georgia Chapter; State Plan on Aging; Peer Support for the Elderly*
- Private Policy and Grants Management – Administrative home and research arm of *The Philanthropic Collaborative for a Healthy Georgia*
- Public and Private Insurance Coverage – *2008 Georgia Population Survey; State Planning Grant for 3-Share Plan Development; Medicaid Study; State Children's Health Insurance Program Evaluation*

Partners include state and national foundations such as the Annie E. Casey Foundation; Robert Wood Johnson Foundation; The Commonwealth Fund; federal and state agencies including the U.S. Department of Health and Human Services, U.S. Centers for Disease Control and Prevention, Georgia General Assembly, Georgia Governor's Office, Georgia Department of Community Health; Georgia Department of Human Resources; as well as local, state, and national health agencies and community-based health organizations.

Institute's Unique Role
As the only health policy center in the Georgia university system, GHPC is already the "go-to" source in the state for objective, non-partisan, and credible health policy analysis and assistance.

The Georgia Health Policy Center's work is well known, highly regarded, and highly valued by community and state leaders throughout Georgia and by a growing number of national health policy leaders in government, foundations, and elsewhere. The center is becoming well known nationally for its applied research and rural community and health system technical assistance. Center publications have appeared in *Health Services Research, Health Care Financing Review, Health Economics, Maternal and Child Health Journal, American Journal of Public Health, Journal of Public Health Management and Practice, Journal of Policy Analysis and Management, Community Mental Health Journal, and American Journal of Preventive Medicine.*

The center has established an impressive array of very solid relationships with key sectors and organizations representing its primary audiences, users, and funders. These include state policymakers in the legislature and executive agencies, philanthropic organizations, health care provider associations and organizations, community health organizations, among others (Coburn, Hurley, & Ricketts 2007).

Stories from Georgia
The Georgia Health Policy Center was awarded a grant of $540,000 from the Robert W. Woodruff Foundation to enhance, over three years, its efforts to educate legislators about issues of health policy. Known as the Legislative Education Initiative, GHPC has created a Legislative Health Policy Certificate Program. This eight-part educational initiative helps inform legislators about the pressing issues related to health.
Conducted over the course of nine months, the program provides legislators and their staff with core competencies in the areas of health financing, coverage, access to care and the impact of poor health on our state. Participants in the program also chose the areas of mental health, childhood obesity and trauma care as subjects that they wanted to explore in more depth. The Georgia Health Policy Center's Legislative Health Policy Certificate Program is designed to prepare elected officials for the challenging health issues that come before them during the session. "Our goal is to help state policy leaders think about health from a broader policy perspective as they wrestle with complex issues like health care financing, access to care, the uninsured and Medicaid," says Karen Minyard, Executive Director of the center.
Now in its second year, the program has awarded 11 officials and four staff members certificates. This year's program currently has 25 officials enrolled.

References

Coburn, Andrew, Hurley, Robert, Ricketts, Thomas (2007). External Program Review Report: Georgia Health Policy Center, Andrew Young School of Policy Studies, Georgia State University.

A Case Study of the Kansas Health Institute

Background and History

The Kansas Health Institute is an independent, non-profit health policy and research organization based in Topeka, Kansas. The Kansas Health Foundation (KHF) founded the Kansas Health Institute (KHI) in 1995 and has provided multi-year core grants to support KHI in its mission, "*To conduct research and policy analysis on issues that affect the health of Kansans and to communicate that information so that informed decisions can be made which optimize our health.*" KHI was created in response to a perceived lack of objective, relevant public health and health policy data in the state, and after considering models of policy institutes from other states. KHI is not university-based, but is free-standing and has an independently elected board of directors. The perpetual core funding for KHI allows its work to focus on health issues in Kansas and to remain mission-oriented, freed from the need to chase available funding.

KHI has built a portfolio of policy-relevant work that reflects a broad understanding of health and the factors that influence health, including not only medical care, but also public health and social, behavioral and community factors. Our work is targeted to high-level policy makers in the state and is built on close working relationships with elected officials and senior staff of state and local agencies.

Growth and Development

Since inception, KHI has been supported by core operating grants from KHF. The foundation has encouraged KHI to not seek other funding sources that could divert it from its mission. The objective has not been growth, but rather strategic deployment of resources. In general, the foundation provides core funding for about two-thirds of the operating budget, and the remainder comes from grants and contracts from other foundations and state and federal agencies. In 2008, the level of core funding from the Kansas Health Foundation was increased substantially to support the development of communication strategies and additional analytic capacity. Our current total annual operating expenses are near $3.5 million.

Institute Capacity and Areas of Specialty

The Kansas Health Institute is organized into four units (Health Policy, Public Health, Public Affairs and Administration), which collectively support eight KHI-wide strategies: legislative engagement, community engagement, public health services and systems, health reform, KHI news service, coverage and access, health information exchange and technology, and operations (including communications, financial management, human resources and technology applications).

A strong knowledge management core connects and supports these eight strategies. KHI's knowledge management core consists of engagement, dissemination of actionable information and knowledge transfer. Through engagement of policymakers and communities, dissemination of actionable information to target audiences, and using best practices in the science of knowledge transfer, KHI works to improve health policy development in Kansas.

Institute's Unique Roles and Attributes

1. **Grants management and fiscal intermediary experience:** KHI manages multi-million dollar grants and has a federally negotiated indirect cost rate. KHI has managed pass-through grants for state agencies and foundations, as well as for national foundations and federal agencies. A recent example is the role played by KHI after being designated by Governor Sebelius as the designated entity to administer a federal grant addressing privacy and security of electronic health data. KHI has supported this state-wide partnership, and distributed funding from the grant to several partners, for the last four years.

2. **Substantial core funding to support our work.** The availability of core funding has made it possible to sustain an organization with the capacity of KHI even in a small state with relatively

limited dollars to support the kind of work we do, while maintaining our focus on the health of people in our state. Simply put, we could not retain the quality of staff that we have doing work exclusively in the state without substantial core support. We would be forced to seek funding for projects that would draw our focus away from the population we were created to benefit.

3. **Reputation for independence and objectivity.** KHI's national affiliations and its partnership with state philanthropic and advocacy organizations give it access to multiple perspectives and a wealth of pertinent information. Its reputation for independence and objectivity means that policymakers – legislators and others –turn to KHI to convene meetings, write analyses of critical issues and provide news coverage of the unfolding health policy discussion. KHI regularly produces educational material for policy makers in partnership with the research department of the legislature as well as executive branch agencies.

4. **Direct work with legislators.** KHI has a long history of working directly with legislators and other high-level policy makers in the state. An example is the recently launched Legislative Health Academy developed in response to legislative interest.

5. **Leader in improving the public health system.** KHI has been active for years with state and local health department partners actively promoting a more effective structure for the state public health system and planning for national accreditation.

6. **Excellence in communication, commitment to knowledge transfer.** KHI is the go-to organization for relevant research on and timely analysis and accurate, in-depth coverage of critical health policy issues. KHI uses creative and collaborative approaches to strategic communications of our analytic work including reports, issue briefs, meetings/forums and individual meetings with policy makers. In addition, KHI has made a significant investment in the development of the KHI News Service.

7. **Highly talented and diverse staff:** KHI employs 25 highly trained staff with expertise in public health, health services, public policy, health care economics, social work, biostatistics, health policy, epidemiology, behavioral science, journalism, communications, media relations, maternal child health, sociology, poverty and health, trauma and violence, program planning and evaluation, Medicare and Medicaid, health care financing, insurance coverage and access to care.

Stories from Kansas

While KHI was not created by the state health agency, we have a close working relationship. For example, twice in the last few years KHI has signed an agreement with the state health agency to provide the state with access to the services of a public health physician when the state agency did not currently have anyone in that capacity.

KHI has recently launched a Legislative Health Academy. With input from legislative leadership, 12 legislators holding key positions on health and budget committees, and broadly representative of the legislature as a whole, are engaged in a year-long process led by KHI staff and our partners to become better prepared to address difficult public health and health policy issues through the lens of values frameworks, system dynamics and adaptive leadership.

Three years ago KHI launched the KHI News Service in response to the retrenchment of the media, particularly the newspaper industry, in providing substantial coverage of important health policy issues. We employ highly qualified journalists that constitute the largest statehouse newsroom in the Kansas. We cover issues related to public health and health policy that are not covered effectively by newspapers. The quality of the work of our journalists is enhanced by their access to and interaction with content experts on our research and policy staff. We view the News Service as another option on the palate of information vehicles that we offer policy makers, subject to the same standards of rigor, objectivity and relevance that exists in all of our work. The growth in readership of the News Service and anecdotal

evidence of its impact on the health policy discussion in the state have been remarkable. Other states and a national foundation have studied our model when launching other health news services.

The Kansas Health Foundation recently created the Kansas Leadership Center to cultivate civic leadership across Kansas with the goal of making Kansas a healthier place to live. This Center also receives core funding from the foundation and works strategically with both KHI and the foundation on selected initiatives. For example, the Leadership Center is providing the leadership component of the Legislative Health Academy, and also working collaboratively with KHI on community-specific interest in responding to the County Health Rankings released in 2009.

Louisiana Public Health Institute (LPHI) as LA DHH's Bona Fide Agent for the ARRA / CDC *Communities Putting Prevention to Work* Grant Opportunity

September 23, 2009

Introduction

The purpose of this document is to briefly describe how LPHI is uniquely qualified to most effectively serve as the Bona Fide Agent of the Louisiana Department of Health and Hospitals applying for the competitive ARRA grant opportunity administered through the CDC called *Communities Putting Prevention to Work*. As documented below, LPHI brings the infrastructure, competence, relationships, and experience necessary to 1) design and manage a collaborative process resulting in timely submission of a competitive federal grant proposal rooted in evidence-based public health practice; and 2) implement program activities as required by the eventual Notice of Award in concert with LA DHH and program partners. This can be done by LPHI without some of the administrative barriers (procurement, contracting, hiring) that can often compete with government's ability to carry out grant requirements in a timely and efficient way. In addition, LPHI brings the proven ability to leverage private funding in support of grant goals.

LPHI Overview and Federal Grants Management Experience

Founded in 1997, LPHI is a 501(c)3 not-for-profit organization with a mission to promote and improve the health and quality of life in Louisiana through public-private partnering. LPHI's portfolio includes local, state and federal grants and contracts as well as private foundation awards totaling $37,315,000 for FY 2009-10. LPHI has steadily built a record of accomplishment in effectively managing federal health grants and cooperative agreement programs—both as a direct grantee and through partnerships with governmental agencies. See Table 1 below.

Table 1. LPHI Federal Grants Administration Experience

Project Name	Amount	Funding Source
Primary Care Access and Stabilization Grant (PCASG)	$99,500,000	HHS/CMS via LA DHH
Community Access Program	2,429,065	HRSA directly to LPHI
Community Capacity Enhancement	193,500	HRSA directly to LPHI
Social Services Block Grant Supplemental, Primary Care Recovery and Expansion	13,500,418	SSBG via DHH
Healthy Communities Access Program	1,619,857	HRSA via Catholic Charities Archdiocese of New Orleans
STEPS to a Healthier LA - New Orleans	7,695,000	CDC via City of New Orleans
NNPHI Program Management	1,562,160	CDC via NNPHI
Louisiana Health and Population Survey	600,000	CDC via National Network of Public Health Institutes
Unity for the Homeless	582,000	SSA via Unity for the Homeless

Core competencies beyond administration include program design and implementation; research and evaluation; facilitation and health planning; information systems development; and communications. LPHI enhances its capacity by engaging local and national expert advisors and vendors to work in coordination with LPHI staff and partners. LPHI employs a staff of 55 at its headquarters in New Orleans, and an additional 18 employees located throughout the state.

LPHI's Prevention Programming Experience and Relationships

LPHI brings rich experience in prevention programming, primarily stemming from management of the following two initiatives:

Steps to a Healthier Louisiana, New Orleans, September 22, 2003 - September 21, 2008
Funded by the Centers for Disease Control and Prevention, LPHI was the implementing partner of this multi-million dollar Cooperative Agreement Program in partnership with the City of New Orleans Health Department. The purpose was to implement and evaluate integrated chronic disease prevention and health promotion efforts focused on reducing the burden of obesity, diabetes, and asthma, as well as addressing physical inactivity, poor nutrition, and tobacco use in New Orleans.

Louisiana Campaign for Tobacco Free Living (TFL), July 1, 2003 to present
The Louisiana Campaign for Tobacco-Free Living (TFL) is a statewide tobacco control program funded by a state excise tax on tobacco passed in 2002 with an annual budget of approximately $7 million. TFL envisions a healthier Louisiana through 100% tobacco-free living. The mission is to implement and evaluate comprehensive tobacco control initiatives that prevent and reduce tobacco use and exposure to secondhand smoke.

Table two below provides examples of LPHI's obesity, physical activity and nutrition programming experience in terms of the programming requirements listed in the ARRA *Communities Putting Prevention to Work* RFP (see page 10 of the Funding Announcement).

Table 2. Snapshot of LPHI's Prevention Programming Experience Relevant to *Communities Putting Prevention to Work*: Obesity, Physical Activity and Nutrition

	Nutrition	**Physical Activity**
Media	• 2006 *Eat Better* Campaign • 2007 Corner Store campaign-newspaper/bus and streetcar ads/in store marketing • "Junk" food campaign- television and radio ads) • Stay Healthy Louisiana blog promotes healthy food choices.	• 2006 *Walk More* Campaign • Three-year contract with the Regional Planning commission, to promote awareness of bike and pedestrian safety laws in the New Orleans area
Access	• Corner Store Initiative offered monetary incentive to stores who selected at least two healthier food options • Created School lunch RFP to assist schools in selecting and requesting healthier options from their vendors • Provided technical assistance translating the 2002 Vending Machine Act • Partnered with the LA Obesity Council regarding education, policy/advocacy and outreach to schools • Partner of the New Orleans Food and Farm Network	• LPHI employs an engineer on loan to the Regional Planning Commission to include the provision of sidewalks, mixed use, parks • Partnered with and funded multiple organizations to make physical activity more accessible (aerobics, afterschool, dance, etc.)
Point of Purchase/ Promotion	• Corner Store Initiative had point of purchase signage for healthy food choices	• Signage for neighborhood destinations in walkable/mixed-use areas • Signage for bike lanes/boulevards • Bike racks in public places for cycling promotion
Price		• Reduced price for park/facility use • Incentives for active transit • Subsidized memberships to recreational facilities
Social Support & Services	• LPHI has recently begun working with MCH Coalition to support several policy initiatives including breastfeeding.	• Implemented Safe Routes to School

LPHI maintains strong partnerships and other involvements throughout that further strengthen LPHI's position as a capable bona fide agent of the state for the *Communities Putting Prevention to Work* program. For example LPHI is a member of the **Steering Committee of the Food Policy Advisory Committee**, the **Healthy Retail Food Study Group, the Prevention Research Center Advisory Committee,** and the **Complete Streets Work Group** and others**.**

LPHI's Evaluation Division supports evidence-based decisions, designs decision-making tools, and synthesizes and interprets data. Data collection expertise includes needs assessments, formative research, quantitative surveys, surveillance, and data management. Of particular relevance to this opportunity, LPHI collaborates with CDC and their survey contractors in the design and implementation of all Behavioral Risk Factor Surveillance System (BRFSS) and Youth Risk Behavior Surveys (YRBS) in Louisiana.

LPHI Personnel

Over half of LPHI's staff are master's prepared in public health or related field, and LPHI is provides life-long learning opportunities to ensure skills and knowledge stay current. LPHI' most senior and experienced staff will be closely involved in management and oversight of *Communities Putting Prevention to Work*.

The Michigan Public Health Institute

Kevin Piggott, MD

Preventive Medicine Resident

June, 2009

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.[1] 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.[2,3] 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 1.[3]

Table 1. 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. 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.[4] Indeed, some of them did (California, Maine, Massachusetts, New York, Ohio, and Texas responded affirmatively).

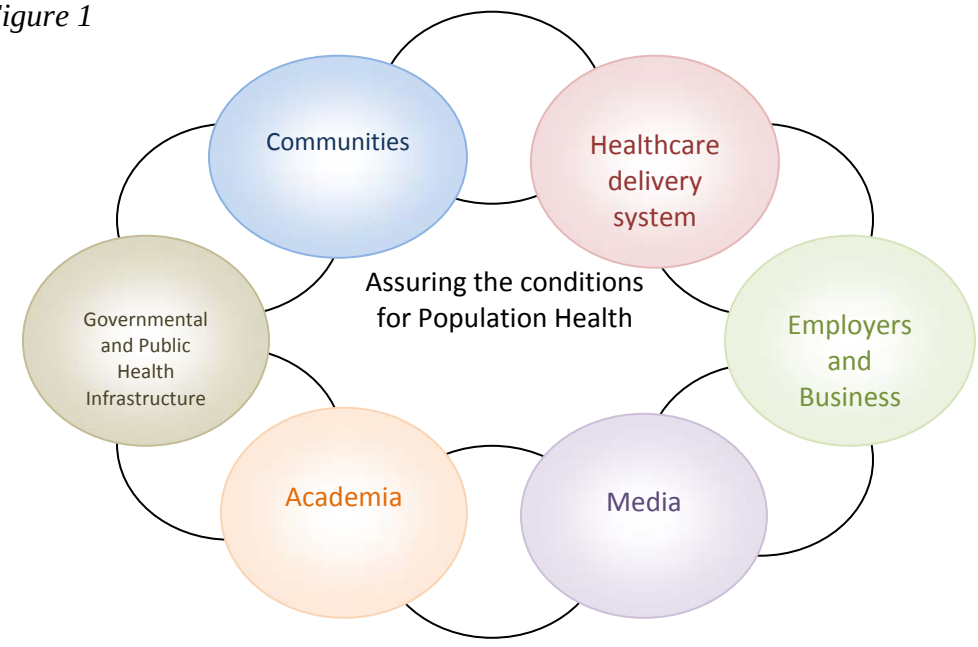
The MDPH staff then further researched and studied these "first wave" institutes as the model might apply in the State of Michigan. By January of 1987, a draft paper on policy options had been developed and released.[13] This was followed by Acting State Health Director Raj Wiener initiating a planning 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 18th, 1989 which was unanimously passed by the House and Senate. It was signed into law December 24th, 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.

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 21st Century*, and its multi-sectoral approach to public health as illustrated in Figure 1.[5]

Figure 1



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

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."*

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. MPHI has grown considerably since its fledgling days, having built strong partnerships and a credible reputation. In 2008, MPHI had 37 funding sources, 251employees, ~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; [6]

- 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

The core competencies at MPHI offer benefits to its partners. 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

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.

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 .[8] 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).[9] 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). [10]

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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MPHI AS AN "INTERMEDIARY SUPPORT ORGANIZATION"

In today's world, lines are blurring between private, public, and voluntary sectors. Rapid changes in communications technology, science, and other technical fields are difficult and expensive to assimilate. Issues facing communities are complex and involve a wide variety of stakeholders. And philanthropy is seeking to make its impact more relevant. Yesterday's methods don't work, and there is little time or resource to master new methods. "Intermediary Support Organizations" are emerging as a means to building capacity in today's environment. And capacity enables progress.

Only an organization with a credible, strong reputation for technical excellence, neutrality, mission, and partnership can serve as an intermediary. As such, most consulting firms, associations, political and academic organizations cannot be effective. Nor can many older local institutions– too much history. There are three hallmarks the Michigan Public Health Institute embraces as our essence as an intermediary organization: mission, means, and impact. These, in addition to our technical depth and breadth, uniquely qualify MPHI to serve in the important role of intermediary.

MPHI is a mission-based non-profit organization created to maximize positive health conditions in populations and communities. A complex network of variables and systems impacts the health of people and communities. While our work is through many means and at many levels within this network, all our projects are based on our mission and all increase capacity to maximize the public's health in some way. And all of our interactions with systems and people are based on this mission. MPHI's mission focus pushes us to do more than just a project's work, but also to synthesize messages about community health from our wide and varied projects, and to carry and deliver these messages to policy and decision makers.

INTERMEDIARY ROLES

Initiative development: Conceptual development and brainstorming with funders, to explore commonalties in mission and develop goals and methods.
Convenor: Draws stakeholders together from a variety of sectors, in a neutral setting. Facilitates process and tends to relationships, builds trust among parties around common goals.
Technical Assistance: Makes resources and expertise available to parties where needed, provides work engine through staff functions, maintains momentum.
Re-grantor: Makes foundation funding available to small and emerging non-profits.
Builds links between stakeholders: Facilitates linkages between participating stakeholders. Brokers communication; "shuttle diplomacy" among the parties, especially where power is unequal. Continuous improvement is inherent, goal is to *improve* rather than prove.
Evaluation and dissemination: Conducts evaluation and assists group to apply the findings in on-going activities. Builds bridges from a single multi-stakeholder initiative to larger stakeholder groups of interests, disseminates experience to others.

MPHI's means of interacting with systems, funders, communities, and clients is deliberately designed to enable the flow of information among parties concerned with the public's health. Key features of our means are neutrality, credibility, and a commitment to "leaving light footprints." A track record of high-quality and effective work in complex and politically charged environments has earned MPHI the role of "shuttle diplomat," trusted mediator, and neutral facilitator. MPHI's

philosophy is to make a difference without taking credit, to enable rather than own. Only a non-profit organization that shares a common mission with community health partners can earn and credibly assume this intermediary role.

The impact of MPHI's work builds capacity. In our intermediary role, MPHI's work accumulates to advance the capacity of the sectors in which we operate. In communities, the capacity of local non-profit organizations to evaluate their services, and work collaboratively has increased, and our mission is to continue to advance the capacity of this vital sector. Local government organizations are strengthened by the role of a reliable intermediary to their state partners, and vice versa. The cumulative effect of our many interactions is the ability to credibly carry the voice of any sector to any other sector in ways that are highly effective in bringing about change and building capacity.

The intermediary role is vital in inducing and sustaining an environment in which parties can work together toward a common goal. In this case, the goal is healthy people and communities, and the intermediary is the Michigan Public Health Institute.

Examples of MPHI as an intermediary
Cardiovascular Disease Reduction Projects in Minority Communities
Local Public Health Accreditation
Graduate Nursing Education Project
Michigan Cancer Consortium
Comprehensive Community Health Models in Michigan

The mission of MPHI is to maximize positive health conditions in populations and communities through collaboration, scientific inquiry, and the application of scientific health practices. MPHI will carry the voice of communities to health policy makers, scientists, purchasers, and funders. MPHI activities will advance community capacity to improve health and reduce disparities among populations groups and geographic areas.

The Public Health Institute
Working as an Intermediary Organization

Foundations are uniquely positioned to set a new standard for creativity, authenticity and generosity in their partnerships with intermediaries and funding peers in their spheres of interest…for the long-term benefit of the entire sector.

- Tom David, *Partnering with Intermediaries*, 2007

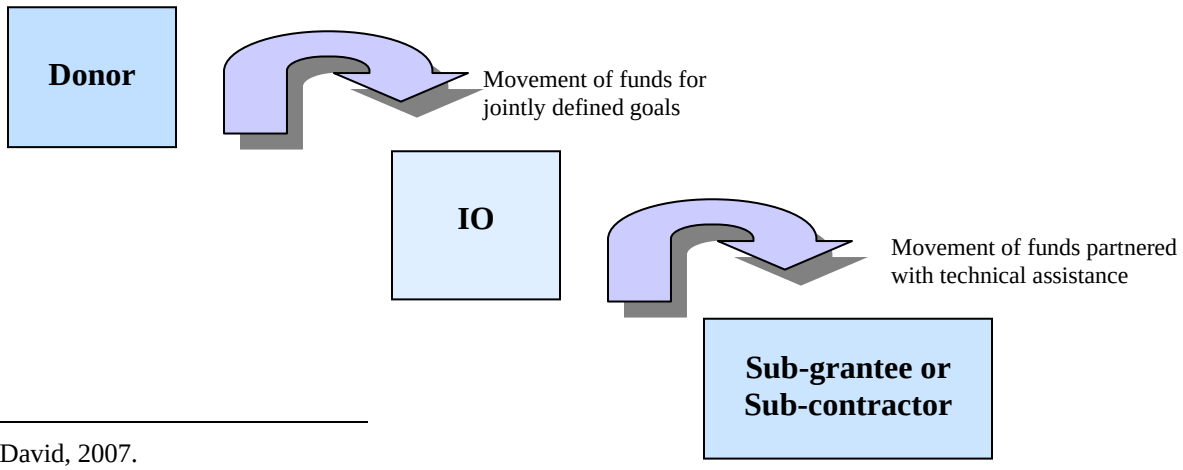
I. Introduction

1.1 The need for Intermediaries

Internationally, donors working in health and development are growing in size and scope of work. In particular, many large foundations are increasing the amount and depth of international work they seek to fund. In order to adapt to their expanded missions, it is predicted that foundations will partner with intermediary organizations (IO) more frequently.[1] Working with an IO allows these donors to support programs in new technical and geographic areas without having to invest in extensive internal operations and administrative support. This strategy is both financially and legally advantageous for a donor and can result in better program outcomes for beneficiaries.

1.2 What is an Intermediary Organization?

An IO can be defined as, "a grantee or contractor that performs important functions in support of a foundation's mission that it otherwise might handle itself."[2] In this role, the scope of work of an IO varies significantly depending on the nature of the project at hand and the relationships among the funding agency, IO and any sub-grantees. Responsibilities of an IO usually involve managing foundation funds through sub-grants and sub-contracts as well as providing a certain level of technical assistance to grant recipients. Working with an IO adds technical and administrative capacity to donors without increasing their operations costs. Donors also benefit from the IO role as a mid-level manager and, as such, a broker and buffer for all involved parties.



[1] David, 2007.
[2] Ibid.

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IO responsibilities may include, but are not limited to:

1. **Financial**: re-granting, advising in resource allocation, and financial management
2. **Program Design and Management**: serving as a program office to manage a foundation initiative, overseeing a grant portfolio in a technical or geographic area, grant monitoring and due diligence, and serving as a coordinating mechanism
3. **Capacity Building**: conducting assessments of sub-grantee capacity, providing technical assistance to sub-grantee, designing strategic communications, guiding leadership development, and providing general organizational development (e.g. expanding capacity in information technology)
4. **Reach**: extending the foundation network and connection to populations where it lacks contacts, and crossing cultural or language boundaries on behalf of a foundation
5. **Knowledge**: providing subject matter expertise, providing research capacity to quickly acquire new knowledge, providing reports, synthesizing information, developing knowledge management strategies, and conducting program evaluation
6. **Public Policy**: conducting policy analysis, convening and educating decision makers, designing and managing public education campaigns

Both the capacity of the IO and the nature of the donor-IO relationship determine the potential for program success. IOs must have the necessary content knowledge and technical expertise in the programmatic areas relevant to project deliverables. A successful donor- IO relationship is based on shared values and on a common understanding of IO strengths and weaknesses in: leadership; internal management; relationships; practical knowledge; convening; grant-making; and learning.

> ***Working with an IO allows a foundation to "make big bets to grow partnerships for the long term that can literally transform their fields of interest."***
>
> - David, 2007

While every experience of an IO is unique, some guidelines have been identified that help assure success for IOs and their donors. It is critical that a foundation or other fiscal sponsor clearly identify its principles and objectives for working with a specific IO. Principles include: clarity of each organization's roles and objectives; effective partnership development based on accountability, control, flexibility, and comfort with risk; building networks; and sharing a long-term vision and commitment. Longer-term investments of time and finances assure that an intermediary can recruit and retain the best staff, support business operations, maintain appropriate flows of capital, and complete necessary capacity building at the individual and organizational levels.

1.3 Partnering with PHI

Launching a new IO or working with an IO that needs extensive structural and organizational support is expensive. Such support generally requires foundations to fund programs in addition to the full operating expenses of a separate organization. In comparison, partnering with an organization such as the Public Health Institute (PHI)

limits this additional investment for foundations and other donors. PHI is a mature organization with: a business model and diversified funding stream, a sound ethical framework, strong leadership, and an extensive network of domestic and international staff. Together, PHI programs provide a multi-tiered network of public health experts from the community to federal level on several continents. This network is continually growing in both breadth and depth.

PHI has the capacity to absorb significant grants without 'tipping,' or violating tax codes as a 501(c)3, due to the organization's current size and budget. This is a unique asset as many smaller non-profits cannot quickly absorb large grants.

PHI is renowned for its capacity as an intermediary in California and internationally. PHI's experience spans the spectrum from developing and supporting a full-service program office to managing a sub-grant on behalf of a foundation or government agency. Concrete examples of PHI's work as an IO are found in the next section. In addition to the functions identified in those profiles, PHI has performed the following roles as an IO:

- Staffing, including hiring foreign nationals
- Funds management and bills management for programs and for sub-grantees
- Setting up business licenses internationally
- Fiscal agent to sub-grantee
- Special projects like facilitating the completion of publications
- Incubate new projects and organizations

II. PHI Experiences as an IO

2.1 International Health Programs (IHP)[3]

IHP has acted as an IO for a variety of foundations (Packard, Compton, and Hewlett) and at three separate levels:

- As a hiring mechanism on behalf of a foundation or organization
- Managing country support offices of a foundation
- Transferring finances to in-country organizations that do not have the capacity or experience to apply for and manage their own grants

By partnering with IHP, foundations benefit from increased agility and speed on the ground. They also have the capacity to take programmatic risks at a lower public profile than a direct grant would imply. Through IO partnerships and programs, IHP has contributed to strengthening in-country infrastructure, NGO efficiency, and public health leadership.

IHP leadership describes its work with the Packard Foundation as exemplary. IHP manages country offices in Ethiopia, India, Nigeria, Pakistan and the Philippines (and previously in Mexico and Sudan) on behalf of the Packard Foundation. This work is longstanding, and has allowed staff at both IHP and Packard to solidify relationships and

[3] From phone interview with Jim Williams and Nicole Lordi. July 14, 2009.

clarify goals. IHP staff is frequently included in Packard team meetings and strategic decision-making processes. Lines of communication are open and candid.

In other roles as an IO, project processes and deliverables have been adversely affected by: poor communication from foundation partners, a lack of clear partnership strategy, and inconsistent decision-making protocol from foundation leadership. Failed projects most commonly fall on the shoulders of IHP, as the IO, rather than on those of the foundation. This is a risk that IO partners take when engaging in intermediary work.

It is worth noting, as well, that work as an IO has not always been financially beneficial for IHP. It is critical to budget for the appropriate amount of staff and operational overhead to support IO work. Otherwise, IO program and office staff can carry a heavy burden of work without commensurate compensation.

2.2 Partnership for the Public's Health (PPH)[4]

PPH is a project sponsored by the California Endowment Fund (the Endowment) with the mission of strengthening California state and local health departments with high community involvement at the county level. The Endowment was in its nascent stages and had only limited capacity for program design, implementation and oversight. For this reason, the Endowment selected PHI as an IO to support the implementation of the project. Since the project's inception, PHI has performed the following activities as an intermediary:

- Program design, strategy and budgets
- Management of project financial and human resources
- Selection of community partners at the county level
- Provide technical assistance to community organizations
- Design and manage the evaluation process

Notably, PPH has undergone three stages of program design. In the first phase, PHI played the largest role and used a considerable staff to perform the full list of functions. PHI handled all program aspects from design and financial management through evaluation. In the second phase, the Endowment had developed internal capacity to more equally share program responsibilities. PHI maintained its role as the project manager and provider of technical assistance; reduced responsibilities required a smaller staff. PPH is now entering the third phase of work in which PHI will continue to design and manage the technical assistance component of implementation. PHI's decreased role reflects project and foundation strengths that PHI helped build. This dynamic reflects how the use of an IO can incubate and support organizational, programmatic and professional development within the field of public health. The Endowment has also worked with PHI as an intermediary for the California Convergence and California Healthy Cities and Communities programs in the state of California.

2.3 Mesoamerican Health Initiative Planning Project (MHI)[5]

[4] From phone interview with Joe Hafey, July 16, 2009.
[5] Language adapted from overview drafted by Rebecca Aced Molina.

In October 2008, PHI received a grant from the Bill & Melinda Gates Foundation (BMGF) to facilitate a planning process that would, "develop and establish the decision-making, financial, operating and evaluation infrastructure supporting the launch in 2010 of a program to protect and significantly improve the health of millions of people in the Mesoamerican Region" (PHI Proposal to BMGF, Sept 2008). Public health leaders and technical experts from within and outside the region collaborate in designing the program using a work-group process to address six specific public health issues: human capacity; immunizations; malaria and dengue; monitoring and evaluation; nutrition; and reproductive, maternal, and neonatal health. PHI is serving as an IO to fulfill the following responsibilities to assure the completion of project tasks:

- **Re-granting Financial Resources**
  - Develop sub-contract scopes of work and monitor deliverable completion
  - Disburse and monitor funds allocated to sub-grantee
  - Manage finances for travel
- **Program Management**
  - Represent BMGF to communicate priorities, expected outcomes, and timelines associated with the MHI sub-contract
  - Coordinate multiple stakeholders as necessary
  - Coordinate travel and in-person meeting logistics
- **Capacity Building**
  - Provide technical assistance to MHI workgroups, including logistical support, research assistance, support for on-line communication and information synthesis, and strategy development
  - Provide support related to process evaluation, including synthesizing lessons learned during the MHI planning phase

The role of PHI in MHI has been altered significantly since the inception of the project. Lessons learned to date include the necessity for both clearly defined roles of program partners and unambiguous modes of communication among said partners. In order to address technical challenges of MHI, project staff have: excelled in adapting to changing roles and resources; proactively developed strategies and concrete tools for providing technical assistance; promoted integrated knowledge sharing within and among contributing parties; and developed internal expertise in web development, process evaluation, leadership strengthening, etc. as necessary.[6]

[6] Written by: Maggie Emmott, Research Associate II, direct: 510 285 5691 email maggie.emmott@phi.org

Public Health Management Corporation: A Case Study
An excerpt from *The Birth of the Fourth Sector* by Richard Cohen and Tine Hansen-Turton
October 2009

Public Health Management Corporation (PHMC) is a 501(c) (3) nonprofit corporation founded in 1972 to address problems in the organization and delivery of health and social services. It was created through a U.S. Department of Health and Human Services Health Services Delivery System demonstration grant with the purpose of developing and testing new forms of state and local organizations designed to consolidate the planning and management of community-wide health services delivery systems. The intent of the demonstration grant was not for agencies to provide direct services, but to partner with local government. Thus, when PHMC began it was believed that it could survive without providing direct services. That has changed over the years. PHMC looks very different today, 37 years later, though its core mission of serving the community's health needs remains constant. PHMC identifies its role as a nonprofit public health institute that builds healthier communities through partnerships with government, foundations, businesses and community-based organizations. It fulfills its mission to improve the health of the community by providing outreach, health promotion, education, research, planning, technical assistance, and direct services. More important, it is a facilitator, developer, intermediary, manager, advocate and innovator in the field of public health. With over 1400 employees, 70 sites and 250 programs spanning behavioral health / recovery, community-based and culturally-based health promotion, smoking cessation, obesity prevention, early intervention, HIV/AIDS, violence intervention, homeless health services, and primary care, policy and association management, and 10 affiliates with programs throughout Pennsylvania, one of which is nationwide, PHMC has become one of the larges public health organizations in the nation serving more than 87,000 clients annually.

Despite the changes, PHMC's initial focus of being a resource to the public sector has shaped its direction and had profound impact on its current structure. In order to support its extensive network of services and programs, PHMC has developed a comprehensive infrastructure that allows program staff to focus on clients while administrative staff concentrate on the ancillary work that is needed to track, report, invoice, fund, staff, manage, communicate, and generally support the service delivery network. Since 1989, PHMC has included a process of affiliation in which another nonprofit that would benefit from PHMC's management expertise, administrative capacities and strategic approach can become a subsidiary organization while maintaining its separate board and 501(c)3 nonprofit status. This strong infrastructure has allowed PHMC to act as the incubator of a family of now 10 affiliated agencies that, along with PHMC's own programs and services, mutually benefit from efficiencies of scale that allow them collectively to provide better services more cost-efficiently and with a combined overhead rate of under 7%, more than 8 points lower than the national average of over 15% among nonprofits.

Organizations approach PHMC to affiliate or are led to PHMC by community leaders with an interest in the agency's success; often they are struggling to survive when they come to PHMC. Affiliation occurs after a period of mutual due diligence, and once finalized PHMC provides business management and strategic guidance as well as the array of back office services noted above. Within 24 months of affiliation, the agencies have become sustainable with budget growth, program expansion and the related staffing increases. For example, one agency that joined PHMC 9 years ago has expanded 8-fold since becoming an affiliate. What's more, the affiliate's employees gain a broader colleague base and opportunities for professional growth.

PHMC understands that it is a business and so must be both bottom line and results oriented. PHMC invested 30 years ago in the establishment of a first class research and evaluation arm,

staffed with PhD researchers and other professionals, which has the capability to conduct both academic evaluation and research. PHMC also invested in its own IT infrastructure to support the data collection needs of all its programs, services and affiliates, as well as professional marketing, PR and internal communications and ongoing training. It is even with these capabilities that, the organization manages $165+ million budget with a combined an administrative cost of under 7%.

PHMC knows the importance of building and maintaining relationships as key to its success. Through the years, PHMC has demonstrated a capacity to foster collaborations and connections among public, private and nonprofit stakeholders. PHMC's role as a participant in, and convener of, effective partnerships and collaborations has helped to keep many organizations strong, focused and serving the needs of the region. PHMC's Board of Directors itself is unique as it includes individuals who together offer a broad perspective on public health in its community by filling designated and at-large roles representing health systems, employers, health insurers, government, labor and foundations. Public Health Management Corporation thus is both a catalyst and a model of stakeholders coming together across the key sectors toward the development of solutions to complex health and human service issues.

A Case Study of the UW Population Health Institute

Background and History

The mission of the University of Wisconsin Population Health Institute (UWPHI) is to "translate research into policy and practice." With this mission, the Institute is a focal point for University faculty, staff, and students interested in using their skills and experience to answer real world questions. The Institute was established in 2001, but has prior roots in the Wisconsin Network for Health Policy Research (established in 1994), the Public Health Initiative (operational from 1998 to 2001) and the Center for Health Policy and Program Evaluation (CHPPE) which was initially chartered in 1984. The merger in July of 2004 of CHPPE with the UWPHI has expanded the scope and reach of the organization. The missions of the two organizations have both included applied research in the arena of health policy and public health. Historically, the Institute emphasized translational work, health policy, epidemiology and surveillance. CHPPE focused largely on evaluation research projects in public health, substance abuse prevention and treatment, maternal and child health, geriatric services and related areas. CHPPE's work, in particular, has emphasized collaborative partnerships with community and governmental organizations in developing and evaluating innovative demonstration programs in public health and human services.

Much of our work involves partnership with state agencies. We conduct program evaluation and policy projects in collaboration with several divisions within the WI Department of Health Services, the Department of Corrections, the Department of Public Instruction, and the Department of Transportation. CDC funded projects are primarily via the DHS, and include an evaluation of chronic disease service integration and a just-completed study of Fetal Alcohol Syndrome Prevention. We make extensive use of CDC-funded surveillance systems, including BRFSS and with DPI the YRBS.

Growth and Development

We have continued to grow over the years, most recently with an infusion of funding from the Robert Wood Johnson Foundation to produce nationwide county level health reporting. This surveillance and assessment project makes extensive use of the CDC generated data (YRBS and BRFSS). The total expenditures for 2009 (difficult to calculate on a snapshot basis due to projects starting and ending throughout the year) are expected to total about $3.5 million; there are about 50 individuals (35-40 FTE) including 12 graduate students on our payroll. Approximately 30 separate projects (ranging from small analysis project to large scale community assessment efforts) plus core efforts such as e-news and issue brief development, are underway at any given time.

Institute's Unique Roles and Attributes

We have a long history of collaboration with state agencies tracing back to the early 1980's. A large portion of our funding derives from federal pass-through dollars from state agencies, in which we support and collaborate on state efforts and demonstration projects. Our organizational setting allows us to marshal academic talent with flexible staffing for these efforts. We combine community public health development, health policy, academic research and scholarship, and applied research and program evaluation in a single academically based center. We are also a significant training resource for graduate students from many departments who work with us to obtain applied experience in population health-related policy and research.

Institute Capacity and Areas of Specialty

We have four areas of operation:

Population Health Assessment Research: monitors and assesses the major components of population health: health outcomes, health determinants and programs and polices in Wisconsin and the U.S. This research is rooted in the principle of public health surveillance, defined as "the ongoing systematic collection, analysis, and interpretation of health data that are essential to the planning, implementation, and evaluation of public health practice" (Thacker and Berkelman 1988). The program includes not only a capacity for data collection and analysis, but also for communication with those who need to know (Remington and Nelson, in press). Thus, population health surveillance combines assessment and policy development—core functions of public health—and requires competency in data collection and analysis, health communication, policy development, and program evaluation.

Health Policy Unit critically examines the evidence base for health policy, focusing especially on health care cost, financing, access, and quality. This research is conducted in close partnership with Wisconsin's leading public and private sector policy makers in health and health care. Evidence and analyses are communicated through Issue Briefs, consultancies, periodic conferences and health policy forums, and direct collaborations. The primary partners interested in the findings from this research include Legislators, executive agency leadership and staff, health care purchasing and payer organizations, and provider associations.

Program Evaluation Unit evaluates programs and policies in public health, substance abuse prevention and treatment, maternal and child health, correctional health, geriatric services and related areas. The evaluation research group also maintains directly funded federal evaluation research projects, evaluating intervention programs with experimental and quasi-experimental designs. The primary partners are community, tribal and state and local governmental organizations. There is also extensive collaboration with other UW researchers to provide program evaluation services for demonstration programs. The topical focus is on substance abuse prevention and treatment, maternal and child health, health services innovation, school health, correctional health and geriatric service.

Education and Training Unit provides service learning and applied public health training programs. The Institute supports two major training and education programs:

> A Public Health Fellowship Program which supports mph trained fellows placed in community organizations and state and county public health settings, and .
>
> The Healthy Wisconsin Leadership Institute, a joint program of the UW SMPH and the Medical College of Wisconsin intended to enhance the skills and leadership capacity of the state's public health workforce. The major program is the Community Teams Program, which is a year long program focused on building skills and knowledge in collaborative leadership for 5-8 community teams.

Stories from Wisconsin

See Remington, PL, Moberg, DP, et al., 2009. "Dissemination research: The University of Wisconsin population health institute." Wisconsin Medical Journal 108(5): 236-239.