

**The State Surgeon General:
Exploring Innovations in Public Health Leadership**

Report for Michigan's Office of the Surgeon General

October 2010

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Executive Summary

Michigan was the first state to create an Office of the Surgeon General (OSG) in 2003. Established by Governor Jennifer Granholm, a state-level Surgeon General was unique despite initiatives nationwide advocating and implementing a strengthened public health leadership and infrastructure. The Michigan Public Health Training Center and the Center for Law, Ethics, and Health at the University of Michigan collaborated with the OSG to investigate its inception, development, and accomplishments, and to assess progress in achieving goals from 2003 to March 2006. This report created for the Michigan Department of Community Health and the OSG provides background and lessons learned highlighting the opportunities and challenges in implementing this new state-level office for public health leadership.

Our findings and conclusions are based on semi-structured interviews, and a focus group with key stakeholders representing persons and groups affected by or involved in the creation of the Office and its implementation, especially state government, media, state and local public health agencies, business, academe and health care systems; as well as interviews with former U.S. Surgeons General. Systematic review of archival records and documentation from the OSG was also conducted. Data collection occurred from Winter 2005 to Spring 2007.

The primary purpose of this report is to help Michigan's OSG to clarify its objectives and improve its ongoing operations. In providing basic information about the structure and accomplishments of the Michigan OSG, it may also be of use to additional stakeholders and states seeking to strengthen public health leadership and infrastructure by similar means.

Key Findings

Creation and Structuring of the OSG

Governor Granholm created the OSG in a challenging political and economic context. Years of budget cuts to health initiatives under the previous administration, which did not give attention to the broad economic and social value of promoting public health objectives, had decimated the state's public health infrastructure.

The development and promotion of programs to address major public health issues established the primary role of the OSG as the leading spokesperson for public health in the state and clarified the chief functions of the OSG in performing this role in five key areas of activity. These key areas include:

- 1) Providing visibility and being a vocal public advocate for issues of public health and health prevention;
- 2) Communicating a clear, consistent, and persistent public health message to the public;
- 3) Leading the initiation and development of partnerships between different social sectors in Michigan crucial to building a strong public health infrastructure;
- 4) Helping to rebuild and strengthen the state's public health infrastructure; and
- 5) Participating as a team member with the MDCH and legislature in public health program and policy development.

While the OSG was successful in addressing each of these roles to varying degrees, the primary focus during the first years was on being a voice for public health in the state of Michigan.

Operational Aspects of the OSG

The OSG has tried to raise public awareness through building connections with a variety of organizations and community leaders from the multiple sectors that need to be engaged in promoting the public's health. While the OSG has been able to utilize limited resources to promote several public health programs, no system of measurement has been used to demonstrate whether the efforts of the OSG have had a clear impact on public perceptions and health behavior. In certain areas, however, it is clear from the perceptions of our respondents, that the OSG has had a positive impact.

The OSG has implemented a variety of programs, reports, and initiatives focusing on certain major public health issues affecting Michigan residents. *Healthy Michigan 2010*, and *Prescription for a Healthier Michigan*, helped lay the primary framework for later initiatives such as *Talk Early Talk Often*, and *Walk by Faith*. The *Steps Up* program is an example of an OSG program that has engaged multiple stakeholders and used a variety of media forms to reach out to and engage the public, raising awareness about health issues.

Respondents generally agreed that the OSG's ability to take the lead on new program initiatives and to work on bridging gaps between sectors has contributed to the effectiveness of the OSG. But they also noted that lack of funding and the need to often share scarce resources with the MDCH has hindered its effectiveness. These funding strains have impacted both the ability to develop effective relationships with partnering organizations as well as the potential success of the OSG's programs.

It is difficult to say whether the OSG has been effective at improving the health of Michigan residents because of the absence of program impact measurements. Several respondents noted that the *Steps Up* program does measure use of its health assessment tool, and that only 1000 people or so had so far utilized this tool. This evidence was cited as an example to support the argument that the OSG needs to do more work to publicize its programmatic materials and products, since the mere creation of such materials, including web-based products such as the *Steps Up* tools does not ensure that they will be used. In addition, some of the OSG's programs, such as the business component of the *Steps Up* program, were not well received because they overlapped with existing health promotion programs.

Respondents perceived Dr. Wisdom to have great personal ability to develop relationships and dialogues with community members and partnering organizations. The SG has been effective at connecting with people and listening to their needs at events, and is perceived to have a genuine concern for the health of Michigan's residents. Even with limited resources, the OSG has been able to produce programs that have increased public awareness of specific health issues. But although respondents found value in the materials and tools created by the OSG, they recognized that lack of publicity regarding these resources has limited their use.

Recommendations

Based on the data collected, our researchers compiled the following list of recommendations for the OSG and other states considering appointment of a State Surgeon General, which are offered in no particular order.

- Establish clear criteria for selecting a Surgeon General, including an appointment process that engages multiple stakeholders from all key sectors relevant to the work of an OSG.

- Create a clear “job description” for the Surgeon General, and publicize this as part of the public relationship-building work for an OSG.
- Formalize and institutionalize the position through legislation or Executive Order.
- Institutionalize an OSG with careful attention to insuring adequate funding and staffing for it to accomplish its core mission
- Since building multisectoral relationships and partnerships are key to the success of an OSG’s mission, this Office should be institutionalized (either within or outside of government) in a way that most effectively positions it to do this partnership-building work.
- The form of this institutionalization should be clearly defined and publicized to all stakeholders and the larger public, so that an OSG can be held accountable by its stakeholders and the public it serves.
- An OSG should establish and implement performance measures and other assessment tools (e.g., critical health indicators) that allow it and the public to gauge its levels of success.
- An OSG should develop criteria that allow it to identify strategic priorities for its programmatic and public outreach work.
- An OSG should issue regular (at least annual) reports to the public and the legislature
- An OSG should develop proactive means and multiple two-way channels of public outreach that extend the SG’s visibility as “The People’s Doctor.”

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Introduction

In February 2003, Michigan's new Governor Jennifer Granholm appointed Dr. Kimberly Dawn Wisdom as Michigan's first Surgeon General, and thereby established the first state-level Surgeon General's Office in the United States. Although public health leaders had recognized the need to strengthen public health leadership and infrastructure across the nation, no state had yet created such a position. In her campaign for Governor Granholm suggested this office would help to emphasize the linkage between the health of Michigan's economy and people. The new leadership position was established to champion public health and to provide the state a spokesperson for issues related to health, wellness, and prevention.

Since 2003, according to Dr. Wisdom, the Office of the Surgeon General (OSG) has provided non-partisan advice to the governor to help focus state efforts on strengthening its public health system in accord with the multi-sectoral vision outlined by the Institute of Medicine (IOM). This vision presents public health as a collaborative enterprise that engages the partnership of government, health care providers, business, the media, academia, and community organizations in working together to "assure the conditions in which people can be healthy" (IOM, 1988).

Purpose

To advance the Michigan OSG's mission of strengthening the state's public health leadership and infrastructure, this report does three things. First, it reviews the reasons the Office was created, the context in which this occurred, and the initial goals for the implementation and funding of the Office. Second, it reviews the actual activities and accomplishments of the OSG since it was created in 2003. Lastly, the report offers recommendations for improving the effectiveness of the Office. These recommendations are derived from an analysis of interviews with key stakeholders in the work of the Office, which provided the core data for this report.

At the request of Michigan's OSG, researchers from the University of Michigan School of Public Health worked with the OSG and other Michigan public health stakeholders to review perceptions of the work and accomplishments of the Office from its inception in 2003 through the end of 2005. The report is intended to identify strengths of, and challenges to, the Office by reviewing its accomplishments. These are viewed in relation to stated goals, public visibility, use and generation of resources, program conception and implementation, and progress in building intersectoral partnerships for strengthening Michigan's public health leadership and infrastructure for the twenty-first century.

The primary purpose is to help Michigan's OSG to clarify its objectives and improve its ongoing operations. By providing basic information about the structure and accomplishments of the Michigan OSG, it may also be of use to additional stakeholders and states seeking to strengthen public health leadership and infrastructure by similar means.

Methodology

Framework for Data Analysis

We used a case study approach to focus our attention on the analysis of two key aspects of the Office: the conceptual development of the OSG's stated goals, and the development of the Office's operations over time. Our approach concentrated on four characteristics: (1) visibility of the office; (2) resources generated and used by the office; (3) implementation of public programs; and (4) the partnerships built and fostered with members of the six social sectors that contribute to the achievement of public health goals (government, community organizations, business, health care providers, academia, and the media).

Figure 1 captures how this framework guided the data collection and analysis of the OSG during the study. We were most interested in understanding: (1) how the Granholm administration first conceptualized the OSG at its inception; (2) how the OSG was implemented and developed during its first three years (2003-2005); and (3) the challenges facing the OSG in the near future and beyond.

Figure 1. Case Study of Michigan's Office of the Surgeon General: Framework for Analysis			
Stated Goals			
Operations in terms of: (Evaluation units) 1) Visibility 2) Resources 3) Programs 4) Partnerships with: <ul style="list-style-type: none"> • Government • Business • Healthcare providers <ul style="list-style-type: none"> • Academia • Media • Community 			
	Past <i>Conceptualization</i>	Present <i>Implementation</i>	Future <i>Development</i>
Time			

Data collection

We collected data from three primary sources: archival records, documentation provided by the OSG, and two phases of interviews with a total of 19 public health stakeholders. Systematic review of the Surgeon General's (SG's) log of speaking events and other activities, along with media reports of statements of the Governor and SG provided valuable background information and context for the study. The bulk of our primary data was gathered from semi-structured

interviews conducted with representative individuals from the six social sectors mentioned above. The primary objectives of the interviews were to collect information on the context in which the Office was conceived, to understand the stated goals and subsequent operations of the OSG. A focus group discussion conducted with the members of the Executive Board of the Michigan Association for Local Public Health (MALPH) allowed us to gain further insight into these areas.

Interviews

We conducted two phases of semi-structured interviews with key informants to understand how the Office was created, its core objectives, the kinds of activities the Office initiated to accomplish these objectives, and perceptions of how successful it had been at achieving these objectives. In particular, our interviews explored perceptions of the OSG's success at bringing greater visibility to public health programs and priorities, and at fostering collaboration across different social sectors to improve public health in Michigan. Additionally, we asked respondents about their perceptions of the OSG's identification and implementation of programs, and its use and generation of resources to support these programs.

We selected respondents based on referrals and independent identification of those who had ongoing contact with the Surgeon General's Office throughout our period of interest. Dr. Wisdom was involved in the process of helping the research team identify potential respondents, but final interview selection was exclusively the research team's responsibility. Appendix A illustrates the framework employed to ensure that all elements of the project's analytical framework were addressed in selecting interviews for this case study.

Interview Protocol

To ensure overall consistency in the interview process (across both respondents, interview teams, and phases), we developed a semi-structured qualitative interview protocol for all the interviews. The interview questions (see Appendix B) in the protocol were classified and cross-checked with the analytical framework and research questions. Interview questions were designed to explore the respondent's understanding of the context and background for the creation of the Surgeon General position, as well as the respondent's perceptions of the OSG's successes in making public health issues more visible, implementing public health programs, developing resources for public health, and fostering intersectoral partnerships to benefit public health in Michigan. There were also questions regarding the future of the OSG.

The entire interview protocol was used with all first phase respondents, although emphasis varied depending on the respondents' particular experience with, or role in, the OSG. The second phase interviews were more individualized and designed to focus on specific areas of relevance to the particular experience and work of the respondent. Second-phase interviews therefore included a subset of questions selected from the larger protocol. A subset of the protocol questions was also used in conducting the focus group session with the Executive Board of the Michigan Association of Local Public Health (MALPH).

Interview Phases

Interviews were scheduled in two phases, based on the nature of the respondents' involvement with the OSG. The first phase of interviews included Dr. Wisdom along with those who worked closely with Dr. Wisdom at the Michigan Department of Community Health and in the OSG. It also included those who played key roles in the conceptualization of the Office, the appointment

of Dr. Wisdom, and in the development and operations of the OSG. These interviews provided understanding of the contexts in which the Office was created, the goals established for the Office at its inception, the development of those goals over time, and some of the OSG's accomplishments.

In the second phase of interviews, we engaged representative members of the six sectors of public health not covered by the first phase interviews. The purpose of this second phase of interviews was to explore how external actors interacted with, and evaluated the accomplishments of, the OSG. These interviews also shed light on how various sectors of the public view and evaluate the operations, programs, and activities of the OSG, and provided perspective on how well the Office had promoted the visibility of public health issues, and strengthened public health partnerships and collaboration in the state of Michigan.

Conducting the Interviews

The interviews were conducted between October 2005 and August of 2006, and ranged from 30 to 75 minutes in length. Confidentiality was assured to each respondent, and thus no information in this report is attached to particular respondents. Whenever possible, first phase interviews were conducted in person with at least two researchers present, and each of the first phase interviews was tape-recorded and transcribed. The second phase interviews were conducted via phone by one researcher. Written notes were taken on the second phase interviews, which were also recorded in order to insure accuracy of the note-taking. Researchers involved in the interviews documented their observations throughout this project to further strengthen the reliability of the evidence collected.

In total, we interviewed 19 individuals, including at least three Michigan representatives working in government, community-based organizations, healthcare, and academia, one representative each from the media and business, and two former U.S. Surgeons General. All interviews provided valuable information and perspective on the key accomplishments and challenges facing the OSG during its first three years of operation (2002 - 2005). The interviews also provided perspective on some of the key challenges the Office will need to address in the near future if it is to live up to its primary purpose of providing state-wide public health leadership. This perspective is reflected in the set of constructive recommendations provided at the end of this Report.

Data Analysis

Following completion of the first phase interviews, researchers read each interview and developed thematic summaries of the content of the interviews. Each researcher conducted his or her own separate summary of each interview. After completing the summary, the findings were compared for consistency, and were then consolidated into a thematic analysis of the first phase interviews, which is presented in the results section of this report.

A slightly modified version of this process was followed for the second phase interviews. The notes and tapes of the researcher who conducted the second phase interviews were reviewed for consistency by other researchers, and these researchers then independently developed the thematic analysis of the second phase interviews presented in the results section below. This analysis was then reviewed and confirmed by the researcher who conducted the second phase interviews.

Background

Michigan is the eighth largest state in the country. Approximately 85% percent of Michigan’s 9.9 million residents are concentrated in metropolitan areas in the mid and southern regions of the state, with the remainder of residents living in rural regions in the north. The state is 78% white, 14% African-American, 4% Hispanic and 4% other (KFF, 2007). Unemployment is higher in Michigan than in other parts of the country, and has increased over the last decade largely as a result of downsizing within the auto industry and the loss of other industrial-sector jobs.

Many of Michigan’s leading health behavior indicators are equivalent or slightly higher the national average (See Table). As in the rest of the nation, life expectancy in Michigan has risen over the past fifty years, while heart disease and cancer are the leading causes of mortality. Many of the years of life lost in Michigan can be attributed to cigarette smoking, alcohol consumption, and sedentary lifestyles.

Table. Michigan and US Health Statistics			
Health Indicator	Michigan Rate	National Rate	Year
Heart disease death	231 per 100,000	211 per 100,000	2005
Stroke and cerebrovascular death	47 per 100,000	47 per 100,000	2005
Cancer incidence	478 per 100,000	458 per 100,000	2004
Colorectal cancer death	18 per 100,000	18 per 100,000	2004
Diabetes prevalence	9%	8%	2007
Adult smoking	21%	19%	2007
Adult obesity / overweight	62%	60%	2007
Children overweight (ages 10 -17)	14%	15%	2003
Physical activity participation	51%	49%	2007
Teen birth rate	33 per 1000	41 per 1000	2005
Source: Kaiser Family Foundation, State Health Facts.			
http://www.statehealthfacts.kff.org/profileglance.jsp?rqn=24			

Overall, the increasing toll of chronic disease has come to weigh heavily on the state, and on the Michigan Department of Community Health (MDCH), which is the governmental agency charged with the responsibility of overseeing the health of the people of Michigan. The economic and infrastructural constraints on this agency have further limited its effectiveness.

“Organizational problems also existed for state health officials in 1873 just as they do today... ‘We are indeed a small band to man so long a line; and we must call to our assistance by free and cordial correspondence all physicians and all persons throughout the State who are interested in the principles of hygiene.’”

- Michigan Department of Public Health Centennial Report, 1975

The MDCH was created in 1996-1997 when Governor Engler collapsed what were formerly separate departments of Public Health, Mental Health, Medicaid, and several other programs into one mega-agency with the aim of eliminating duplicative services and increasing efficiency. This consolidation created the role of the Director of the Department of Community Health (ERO No.

1996-1, §330.3101 MCL), while still maintaining the Chief Medical Executive to serve the Department in medical decisions (§333.2202 MCL). The budget for this new agency reduced overall funding for health services, and particularly for public health. The significant loss of

public sector health workers that resulted from this reorganization also drained state-level institutional memory and public health experience. Not surprisingly, this reduction of resources created new strains and exacerbated old tensions in the state's health sector, and especially in the MDCH's relationship with, and ability to support the work of, local health departments (Jacobson et al, 2003).

The 2002 Gubernatorial campaign: Public Health is linked to Economic strength

In the 2002 gubernatorial campaign, Democratic candidate Jennifer Granholm raised the need for new public health leadership to public attention by calling for the creation of a state-level Surgeon General, and by tying the state's economic future to the health of its citizens. The campaign's plan for her administration, titled "Securing Michigan's Future," included the appointment of "a state Surgeon General to coordinate Michigan's public health and prevention efforts" as one of its objectives, and introduced the need for such a position with the following words:

Over the last several years, Michigan's public health programs and leadership have been incorporated into a much larger bureaucracy, and, on many occasions, it appears to have lost its ability to advocate on behalf of the health of Michigan's citizens. To effectively organize our public health resources, Jennifer Granholm will appoint a Michigan Surgeon General with the specific responsibility to advocate for effective community-based health and wellness promotion and disease prevention programs, as well as to act as a watchdog ensuring that Michigan's public health infrastructure is able to meet the challenges of the 21st century.¹

After her election, Governor Granholm confirmed her campaign commitment by noting in her first State of the State address in January 2003 that the health of Michigan's people was a primary foundation for the state's economic health:

Just as stronger schools are critical to our strategy to build Michigan's economy, so too are our efforts to create a healthier Michigan. Not only do we need a healthy workforce, but our state's businesses can't soar if they are weighed down by runaway health care costs.

Granholm introduced the concept of a State Surgeon General as a leader who would champion public health to achieve the goal of a healthier Michigan, and outlined five specific issues as focus points for the disease prevention work that this Office would take on in order to rebuild the state's public health: lead poisoning, teen pregnancy, obesity, teen smoking, and HIV/AIDS. Work on these five issues would provide the initial basis for structuring the work of the newly established Michigan OSG. It was in this context that the Michigan OSG was officially established by Governor Granholm in February 2003 with the appointment of Dr. Kimberly Dawn Wisdom as Michigan's first Surgeon General.

¹ This excerpt from *Securing Michigan's Future* was provided by a staff member working in the Granholm for Governor office. Many of our study participants referenced this document, but none had a copy available for verification.

Specific Findings

Creation and Structuring of the OSG (Phase I)

Contexts for Creation of the OSG

Respondents emphasized that the OSG was created by Governor Granholm in a challenging political and economic context. The state's public health infrastructure had been decimated by years of budget cuts to health initiatives under the previous administration, which did not give attention to the broad economic and social value of promoting public health objectives. There was a strong feeling among the respondents that public health issues had been seriously neglected in the state, and that a major challenge for the new administration would be simply to draw public health issues back into public view and to place public health initiatives on the agenda of the state legislature. Because the new Democratic governor came into office during a time when the state legislature remained committed to cutting taxes across the board, the Governor would have to press for her public health initiatives, including the creation of the OSG, in the face of severe budget limitations and political opposition to new initiatives.

Michigan's public health community was, of course, anxious to see significant changes in health policy, strategy, and emphasis from the new administration. They hoped that the new administration would work to make the health challenges of Michigan's citizens more visible, and were committed to supporting the Governor in this work. The advocacy of Michigan's public health community moved the Granholm campaign to make public health one of its primary concerns, and also seeded the initial idea, noted in *Securing Michigan's Future*, for the creation of a position that would provide a state-level leader to be a spokesperson for Michigan's public health needs, and fill the role of being the people's doctor for Michigan's citizens.

Structuring of OSG Position and Scope

From the beginning of deliberations about this position within her campaign and new administration, Granholm was primarily interested in creating a position that would give more visibility to public health by providing an advocate and spokesperson for public health goals and initiatives. Because the U.S. Surgeon General played this role on the national level, this federal position provided the primary model for conceptualizing the state-level position. No alternative leadership models seem to have been discussed in the planning stage for the Michigan OSG. The Surgeon General model seemed to be the one best suited for a leadership position designed to provide a spokesperson and public advocate, rather than an administrator, for health initiatives in Michigan. The administrative role for public health initiatives was already covered by existing offices within the MDCH.

After Granholm's election, advisors provided the Governor with a short list of several candidates for the OSG position, and from this list the Governor then selected and appointed Dr. Kimberly Dawn Wisdom. Although no specific job description or executive order was developed to define the specific responsibilities of the new OSG position taken up by Dr. Wisdom, the overarching purpose and goals of this position, as noted above, were provided by the words from *Securing Michigan's Future* and Granholm's first State of the State message that provided

the initial conceptualization of this position. These words emphasized the broad need for a public health spokesperson and “watchdog” in Michigan, as well as the more specific need for someone to advocate for, and assist Michigan’s public health community in developing preventive health initiatives to address key issues such as lead poisoning, teen pregnancy, obesity, teen smoking, and HIV/AIDS.

Because the initial framework for this position was fairly open, Dr. Wisdom had considerable freedom to develop the specific characteristics of her role and position in accord with her interests and those of the Governor in promoting the health of the state’s residents. One of the particular areas of responsibility that needed to be clarified early on in the development of the OSG was the potential for overlap between the duties of the OSG and those of the state’s Chief Medical Officer within MDCH. These issues were resolved by clarifying that the OSG would be defined as a non-administrative role outside the administrative structure and responsibilities of the MDCH, while the position of Chief Medical Officer remained an administrative role within the MDCH. Thus the OSG was established as a position with direct (cabinet-level) access to the Governor, rather than as a position subordinate to the administrative direction of the MDCH. While the head of MDCH would eventually need to provide some coordinating administrative oversight to program-level initiatives of the OSG, this public health spokesperson position was created primarily to serve as an “external” complement to the head of the MDCH and its Chief Medical Officer.

Development of Chief Functions/Roles of OSG

Within these political and institutional constraints, Dr. Wisdom played a major role in defining and clarifying the specific duties of the OSG over time, as she worked with colleagues within MDCH and the OSG on the first reports that would provide a framework and agenda for the work of the Michigan OSG. The OSG’s *Prescription for a Healthier Michigan* (2004) which was informed by both the “Surgeon General Rounds” and the *Michigan 2010* report (2004), established the primary framework for the development of the OSG’s chief functions and roles.

To implement the *Prescription*, the OSG pursued the development of core programs, such as *Steps Up*, that were pivotal to crystallizing the operational goals and functions of the OSG. In line with *Prescription for a Healthier Michigan*, the main programmatic objectives taken up by the OSG were related to promoting healthy lifestyles (*Steps Up, Walk by Faith*), lead poisoning abatement, fighting obesity, the state employees Red Cross blood drive efforts, and encouraging and supporting the parental role in sex education through the *Talk Early, Talk Often* program.

Through the development and deployment of these programs, the primary role of the OSG as the leading spokesperson for public health in the state was established, and the chief functions of the OSG in performing this role were clarified in five key areas of activity. These key areas include:

- Providing visibility and being a vocal public advocate for issues of public health and health prevention;
- Communicating a clear, consistent, and persistent public health message to the public;
- Leading the initiation and development of partnerships between different social sectors in Michigan crucial to building a strong public health infrastructure;
- Helping to rebuild and strengthen the state's public health infrastructure; and

- Participating as a team member with the MDCH and legislature in public health program and policy development.

Additionally, these activities may be understood and assessed in terms of the three key spokesperson themes of *visibility*, *message*, and *linkage*:

On the theme of *visibility*, the idea that the primary role of the OSG would be to provide the state a spokesperson and a bully pulpit for increasing the public visibility of issues of prevention and public health by being the people's doctor, and presenting the face of public health, was emphasized by most respondents. Respondents emphasized that the OSG was meant to be a strategic focal point for putting key public health issues, and Public Health generally, back on the public agenda. The creation of greater visibility for public health issues and themes would provide a necessary foundation for promoting legislative and intersectoral action to improve the infrastructure of public health in Michigan.

On the theme of *message*, in her role as public health spokesperson, the OSG would be responsible for communicating a clear and consistent public health message, and for using the authority of the Office's bully pulpit in a strategic way to promote public health programs and initiatives throughout the state.

On the theme of *linkage*, the OSG would be responsible for initiating and nurturing new relationships and partnerships between the social sectors essential to supporting and strengthening the public health infrastructure of the state and the health of its citizens.

Taken altogether, performing these spokesperson functions in terms of these primary themes came to be viewed as the primary responsibilities of the OSG by 2005. But first phase respondents recognized that in order to be successful as a spokesperson and champion for rebuilding state public health infrastructure, the OSG would also need to play a significant role as a team leader and member of the state's public health community. This would require that the OSG also participate as a team member in state public health policy and program development.

Several respondents noted that along these lines the OSG participated in policy discussions within the MDCH Strategy/Executive Leadership committee, but does not lead policy development, which is the role of the head of MDCH. So, for example, by participating as a team member in the development of the *Healthy Michigan 2010* report near the beginning of her term, Dr. Wisdom helped the MDCH to restore the science of critical health indicators as a frame to guide the development of public health programs in Michigan. This report, along with the OSG's *Prescription*, have thus helped to reconnect health policy with health science in the state.

There was general consensus among respondents that the OSG should *not* be held directly responsible for rebuilding the public health infrastructure--lest this responsibility overwhelm the primary role of the OSG to play a role as spokesperson. It is enough to recognize that if the OSG plays its spokesperson role well, and succeeds in promoting stronger intersectoral public health partnerships in the state, the OSG would in effect help to strengthen the state's public health infrastructure over time.

In line with this conceptualization of the core responsibilities and limits of the OSG, first phase respondents expressed their perceptions that the OSG had been successful at establishing public visibility for the OSG and some of the basic disease prevention goals of public health

through the *Steps Up* and Lead Abatement programs. In addition, there was clear recognition among respondents that the OSG had been fairly successful at initiating cross-network relationships between consortia of business, faith, community, and hospital/nursing groups. There was agreement that the OSG had been particularly successful at establishing relationships with business and faith communities, and beyond the state with the National Governor's Association.

Challenges to Sustainability of the OSG Position

Finally, there was broad recognition of the need for the OSG to give more public visibility to public health in a broad sense, beyond specific prevention programs. This involves the need to educate the public and the legislature, which is tremendously demanding on time and resources, and pushes against the limitations of what one person with a small staff can accomplish in the area of public health education.

The OSG, with its emphasis on being an effective spokesperson for the goals and values of public health, requires that the office holder possess a significant degree of charisma. As an Office charged with putting a public face on the work of public health, a lot depends on the effectiveness with which the person holding the OSG position can develop and sustain the public persona of the SG over time. This suggests that one of the key challenges the OSG will face may be finding a series of appropriately charismatic persons to continue to fill this position over time.

A fundamental challenge to the sustainability of the Office is, of course, funding. Existing budgetary constraints within the state budget for health often puts the OSG in the position of competing for limited resources of staff-time and money with other programs and departments within MDCH. This situation has the potential to create severe tensions between MDCH and the OSG over who gets resources for which aspects of health promotion and prevention.

There was general recognition of the need for the OSG to work more closely with local public health departments and local communities. This is a major challenge for the OSG, however, because of the inability of the OSG, as currently staffed, to address the great number of requests for participation in local events and projects. It is therefore important for the OSG to clarify and prioritize the most strategic means for meeting public demand for OSG participation in local programs and networks meetings.

Generally, there is the overarching challenge of making sure that the OSG is not overburdened with too many responsibilities that make it difficult for the OSG to be successful in any of its primary areas of work. In order to avoid this threat, the OSG needs to remain focused on its primary responsibilities and roles as defined above, and work to build and exploit collaborative synergies with MDCH departments and other core organizational public health sector stakeholders throughout the state.

Beyond the funding issues, the other primary challenges to sustaining the OSG have to do with the nature of its institutional positioning within state government. Ideally, the position would become much more secure if it were to be established as an independent position by legislative enactment. Recognizing that this is a large challenge under current state budgetary constraints, these interviews suggested the potential value of developing a public advocacy network within the state public health community on behalf of the OSG. Such a public health advocacy network could help to build public support for legislative action on behalf of institutionalizing the

OSG as an independent nonpartisan position within state government. Respondents also recognized that the publication of the present Report might assist this effort by helping to publicize information about the value and accomplishments of the OSG.

Measures for Judging Success of the OSG

Particular ways of measuring the accomplishments of the OSG were discussed by several first phase respondents, and included the particular measures that are part of the *Steps Up* program; levels of media coverage; measures of increases in public awareness of particular public health issues; successful changes in the policies of external organizations; and evidence of mobilization of organizational actors in the six different sectors that are part of building a strong intersectoral public health infrastructure. It was also recognized that measurements of success should look not only at outcomes, but at measures of the *process* by which the OSG was working to achieve its goals, since many public health goals are by nature longer-term goals that may not be measurable in terms of immediate outcomes.

Operational Aspects of the OSG (Phase II)

Second phase interviews focused much more on evaluating several key aspects of the development of OSG operations over time. We report below on respondent perspectives relating to: various dimensions of OSG effectiveness; the ways in which the OSG clarified its particular roles and objectives; the character of the relationships established between the OSG and the larger public health community, including its accessibility and communications strategies; and considerations relating to OSG sustainability.

Effectiveness of the OSG

A primary role of the OSG is to raise public awareness about public health issues affecting Michigan residents. The OSG has tried to achieve this role through building connections with a variety of organizations and community leaders from the multiple sectors that need to be engaged in promoting the public's health. While the OSG has been able to utilize limited resources to promote several public health programs, no system of measurement has been used to demonstrate whether the efforts of the OSG have had a clear impact on public perceptions and health behavior. In certain areas, however, it is clear from the perceptions of our respondents, that the OSG has had an impact.

Visibility

Respondents from the non-profit, private, and public sectors indicated that there was clear public awareness of the OSG since its creation, and that public appearances of the SG at local events have clearly helped to promote public awareness of the work of the OSG. The OSG has also generally increased its visibility over time through its engagement with health promotion programs, the media, the legislature, and the internet. Most respondents agreed that the OSG's visibility has led to increased visibility of public health programs in Michigan. Some respondents noted that although they were aware of the OSG's general purpose as spokesperson near the beginning of their relationship with the OSG, it was not until later that they understood the more specific roles of the OSG related to public health promotion and programs. Some respondents

also noted perceptions that the OSG's visibility had decreased near the end of the period of our study, which could be due to a lack of resources or political considerations.

Programs

The OSG has focused on certain major public health issues affecting Michigan residents by developing and promoting particular programs to address these issues. The *Steps Up* program is an example of an OSG program that has used multiple media forms to reach out to, and engage, the public to raise awareness about health issues. The *Steps Up* program has used the internet to distribute information and engage individuals and groups in using *Steps Up* tools to conduct their own health assessments. One respondent praised this program's use of the internet in this way because it made health assessment accessible, and allowed the *Steps Up* program to become a regular part of people's lives. The *Steps Up* program also received high marks from respondents because it provided multiple modes of engagement.

When MI Steps Up came along, it made sense to coordinate school efforts that had been going on under MI Action for Healthy Kids with the new Steps Up Program, to build more relationships, under the principle of "working smarter and not harder," which the creation of the OSG has helped us to do.

- *A representative of a Michigan Community-Based Organization involved with Steps Up*

The *Steps Up* program promotes healthier lifestyles among Michigan residents. The five key issues addressed by the *Steps Up* program include physical activity, nutrition, smoking cessation, weight reduction, and motivational tools for increasing healthy behaviors. The program has actively reached out to, and collaborated with community groups, Michigan's school system, local businesses, families, and the healthcare sector to implement this program, which offers particular versions of the program shaped to the needs of these particular groups. The web-based program tools, for example, provide separate pages tailored to the needs of families, businesses, and schools. The *Steps Up* program therefore exemplifies the successful ways in which the OSG has been able to use a specific health promotion program to reach out to, and build connections with, different sectors of the community.

Most respondents felt the OSG had been at least partially successful at bridging significant gaps between the work of public health and public perceptions of health through its implementation of programs like *Steps Up*. The OSG has been successful at reaching its goals, in one respondent's opinion, because it "has been aggressive, creative, innovative, and inclusive in reaching out to the general public." Other respondents felt that the OSG had been successful at raising public awareness about health because the SG has made "a clear and concise case for why certain public health issues are important." Thus, overall, respondents agreed that the OSG's ability to take the lead on new program initiatives and to work on bridging gaps between sectors has contributed to the effectiveness of the OSG. But they also noted that the effectiveness of the OSG has been hindered by the lack of funding and the need to often share scarce resources with the MDCH.

These funding strains have impacted both the ability of the OSG to develop effective relationships with partnering organizations as well as the success of the OSG's programs.

The OSG was an "historical breakthrough" for Michigan, and provided an innovative approach on the state level to integrate and coordinate public health promotion from the micro to the macro level. It is a great mechanism for integration.

It is difficult to say whether the OSG has been effective at improving the health of Michigan residents because of the absence of program impact measurements. However, several respondents noted that the *Steps Up* program does measure use of its health assessment tool, and that only 1000 people or so had so far utilized this tool. This evidence was cited as an example to support the argument that the OSG needs to do more work to publicize its programmatic materials and products, since the mere creation of such materials, including web-based products such as the *Steps Up* tools, “does not ensure that they will be used.” In addition some of the OSG’s programs, such as the business component of the *Steps Up* program, were not well received because they overlapped with existing health promotion programs.

Respondents perceived Dr. Wisdom to have great personal ability to develop relationships and dialogues with community members and partnering organizations. The SG has been effective at connecting with people and listening to their needs at events, and is perceived to have a genuine concern for the health of Michigan’s residents. Even with limited resources, the OSG has been able to produce programs that have increased public awareness of specific health issues. But although respondents found value in the materials and tools created by the OSG, they recognized that lack of publicity regarding these resources has limited their use.

Clarification of OSG Roles and Objectives

Most second phase respondents agreed that the OSG had been successful in developing its role as Michigan’s chief spokesperson and advocate for public health, and at beginning to build collaborative intersectoral partnerships for public health. However, in spite of the initial high-level political attention given the creation of the Office of Surgeon General by Governor Granholm, respondents suggested that the OSG had not done as much as it might to clarify the roles and objectives of the OSG for the public at large.

The Surgeon General has done good work as chief public health advocate, but could do more as “chief physician advocating for public health initiatives” to bring credibility and leverage to the state’s public health message.

In public health advocacy and health promotion, the OSG clearly focused on promoting programs of disease prevention directed at the specific problems of obesity, diabetes, unintended pregnancy, smoking, and alcohol consumption. The OSG helped to bridge gaps in health programs by bringing together different groups of stakeholders, such as families, businesses, and schools, to work on common health problems. Furthermore, the OSG was active in advocating issues that had “gotten lost” in the administrative structure of the MDCH.

However, while respondents agreed that the OSG had been successful in all these areas, most respondents provided additional perspectives on how the OSG might clarify and strengthen perceptions of its roles and objectives in the eyes of the broader public. Respondents suggested, for example, that the OSG should reach out to more community groups, increase follow-up, and improve publicity for health education materials created by the OSG. Most importantly, respondents emphasized the need for the OSG to give more effort to publicizing the role of the OSG as the Office of the “people’s doctor,” in order to popularize the overall concept and particulars of public health. Popularization and clarification of the role of the OSG as the people’s doctor may be the most potent means by which the OSG could accomplish its core mission of advocating the goals of public health within the state. Publicity work along these lines

might work to build partnerships with advertisers and the media, who could help the OSG to accomplish the objective of clarifying the OSG's role as the "people's doctor."

There were also some significant inconsistencies across the range of respondents regarding their own perspectives on the proper roles and objectives of the OSG, especially in relation to policy. This may be because the OSG has not dedicated much overt effort to coordinating and shaping stakeholder perspectives about the OSG's roles and functions, both broadly and in specific relation to policy. Some of these inconsistencies in stakeholder perception of the OSG may be interfering with the creation of more coordinated intersectoral action around public health objectives within the state of Michigan.

Many respondents noted that the OSG had not been particularly active in promoting legislation that might work to improve Michigan's public health system. The OSG's main involvement in the policy arena to this point, according to the perceptions of respondents, has been to improve public health services currently being offered, such as the unintended pregnancy programs. For the most part the OSG has simply acted as a spokesperson on health-specific issues within the state, though some commented that the SG's role as advocate has helped to inform the public and to bring attention to public health policy at both the state and federal levels. But on the particular issue of perceptions of the role of the OSG in shaping public health policy, respondents generally agreed that the OSG should play a nonpartisan role politically, in order to work as much as possible to build bipartisan consensus and collaboration on behalf of advocating public health policy objectives.

Relationships between the OSG & Public

During the period under study, the OSG worked with health professionals throughout the state on a day-to-day basis. The ability of the OSG to create and maintain relationships with state health and public health professionals, as well as with the larger public, is part of the OSG's role as the "People's Doctor." OSG accessibility and communication strategies are therefore central to the successful day-to-day operations of the OSG.

OSG Accessibility and Communication Strategies

Respondent perspectives on overall OSG accessibility and communication were positive. Most respondents indicated that they were readily able to establish contact with the OSG when they wished to initiate collaboration with the OSG on certain projects or request public appearances from the OSG. Respondents also indicated that correspondence from the OSG was usually timely, and that the OSG kept them informed about various events and programs. The OSG has been very active in reaching out to the public through appearances at public events including, for example, those organized to present awards to examples of public health leadership in the state. Respondents also indicated that the current Surgeon General was accessible, responsive, and a good listener.

A few respondents noted, however, that as state resources for the OSG began to be cut near the end of our period of study, they began to experience more problems in accessing and communicating with the OSG. One respondent stated that contact with the OSG diminished considerably after budget cuts to health promotion and prevention programming were announced in fall 2005. Some respondents also noted that the OSG's communication was not always as proactive as it might have been, and that there was sometimes a lack of follow-up and continuity in communication with OSG stakeholders. Some respondents working closely

with the OSG on particular programs suggested they did not always receive adequate press releases or updates relating to program implementation and impact. Several respondents noted that while the OSG has created a website to communicate news of its activities to the public, the OSG could be more proactive in using this website to communicate with the public. Overall, most of the shortcomings in OSG communication and accessibility were perceived to be due largely to the substantial limitations of OSG staffing and resources.

Support for Strengthening the OSG's Ability to Build Relationships with the Public

Beyond issues of communication and access, many respondents had mixed perspectives on the ability of the OSG, as currently constituted, to build effective relationships with the public on behalf of improving its health. The OSG was perceived to be strong in certain kinds of relationship-building, such as those created among diverse stakeholders in the *Steps Up* initiative, but limited in moving beyond OSG-centered initiatives. And while most respondents perceived the overall work of the OSG to be successful as far as it went, respondents also suggested that there was significant need for strengthening OSG's abilities to build effective and sustainable relationships. There was overall agreement on the need to further strengthen the OSG as a valuable asset for the improvement of the health of Michigan's residents.

Some respondents suggested, for example, that the OSG was not always effective at updating public partners and maintaining strong relationships over time. Respondents felt that relationships with the OSG therefore often started out strong but diminished with time. One respondent noted that public interest in working with the OSG on projects would "eventually fade" if the OSG regularly promoted projects that were not adequately leveraged and "planned through to the final goal." Another respondent similarly worried that the lack of follow through and collaboration with partnering organizations may lead to reluctance to work with the OSG in the future.

Many respondents recognized the lack of staffing and financial resources was a primary reason for the OSG's inability to maintain contacts and relationships, and some were also concerned that the failure of the OSG to realize the full potential of building collaborative relationships was a major weakness of the office.

Overall, respondents felt the OSG had developed supportive relationships with them. The OSG was viewed as a valuable resource to many respondents' organizations. While it's clear that limited resources have kept the OSG from developing and maintaining more effective working relationships with its partners, there is a general consensus that the OSG provided invaluable services and increased awareness of public health in Michigan.

OSG Structure and Sustainability

Respondents unanimously supported the value of continuing the OSG because of the considerable advantages it brings to public health promotion in Michigan, in the ways highlighted above. One respondent suggested that the OSG should be maintained because it can take the state to a new level of public health promotion at a very minimal expense. Respondents also noted a concern that if the OSG is not maintained, restarting the office at some later date would be difficult because it would require rebuilding lost public trust. Public perceptions of the OSG as temporary would be a problem because public health problems and programs require long-term institutional and partnership investments.

While resource limitations impact many aspects of the functioning of the OSG, they are by no means the primary problem that needs to be addressed in order to sustain the Office. Respondents understood that if the OSG is to have an existence beyond the governorship of Jennifer Granholm, the

“The key shortcoming is: why doesn’t the legislature think the OSG is a great thing and want to put more money into it?”

funding problem is only one aspect of a set of larger issues that need to be addressed regarding how the OSG is positioned and institutionalized in relation to state government. Those respondents who believed that the OSG’s current funding mechanism was neither sustainable nor sufficient, for example, understood that this problem could be resolved only by reconsidering the way the OSG is institutionally positioned in relation to the executive and legislative branches, and also in relation to the MDCH and private public health funders in the State.

Respondents generally recognized that resolving these structural problems is also a necessary step in addressing some of the key institutional barriers keeping the OSG from becoming a more effective advocate for the health of Michigan’s residents. And since respondents were interested not only in seeing the work of the OSG continue, but also in seeing it become more effective, they offered a variety of suggestions for dealing with problems of institutional structuring and sustainability.

Many respondents believed that the sustainability of the office depended on obtaining more direct support from the legislature, especially through the House and Senate health committees. Respondents also stressed the need to build bi-partisan support for the OSG. And a majority, though not all, of the respondents believed that the OSG should be more formally defined by law, either through legislative enactment or executive order. There were doubts, however, about whether this could be done in the current political environment.

The majority of respondents also believed that the OSG should be more directly engaged with the state legislature. There should certainly be open and strong lines of communication between the OSG and the legislature, and especially with the House and Senate health committees. Some respondents suggested that the legislature should play some kind of oversight role for the OSG, which would make the OSG accountable to the legislature. In the absence of a formal oversight role, many of the respondents suggested that the OSG should at minimum provide some kind of regular reporting to the legislature, and half of the second phase respondents suggested that this reporting might take the form of an annual report to the legislature.

Creating a funding structure that would allow the OSG to employ staffing appropriate to its responsibilities would enhance the ability of the OSG to play its role as effective spokesperson and advocate for the health of Michigan’s residents. Staffing should be sufficient to allow the OSG to provide ongoing and proactive project support and follow-through for all OSG-initiated programs. Resources in this area would also allow the OSG to maintain and develop more effective collaborative relationships and networking with more health-related organizations in Michigan.

Beyond public funding sources, some respondents suggested the OSG might also be supported through private funding mechanisms rooted in Michigan’s philanthropic and foundation communities. In one respondent’s opinion, funding through private sources would be an advantage, since it would help to lessen the burdens, both political and financial, of public sector support. From this perspective, public funding for the OSG should merely supplement primary funding obtained through private sources.

Finally, all respondents agreed that any efforts directed toward clarifying and documenting how the OSG has contributed to strengthening the public health infrastructure of Michigan, and to improving the health of Michigan's residents, would help to build support for sustaining the OSG. This suggests the need to establish OSG assessment and performance measures that would allow the public to gauge the impact of OSG programs and operations on public health in Michigan. Many respondents felt such measures would help to justify sustained public financial support for the OSG.

Recommendations and Conclusion

In conclusion, we have compiled the following list of recommendations for the OSG and other states considering the appointment of a State Surgeon General, which are offered in no particular order. These recommendations for creating, sustaining, and strengthening an OSG stem from our review of data from our interviews, in line with our sense of the overarching mission and objectives of the Michigan OSG, as well as our understanding of the challenges that public health promotion faces in the present political and economic environment of Michigan and the nation.

- Establish clear criteria for selecting Surgeons General, including an appointment process that engages multiple stakeholders from all key sectors relevant to the work of an OSG.
- Create a clear "job description" for the Surgeon General, and publicize this as part of the public relationship-building work for an OSG.
- Formalize and institutionalize the position through legislation or Executive Order.
- Institutionalize an OSG with careful attention to insuring adequate funding and staffing for it to accomplish its core mission
- Since building multisectoral relationships and partnerships are key to the success of an OSG's mission, this Office should be institutionalized (either within or outside of government) in a way that most effectively positions it to do this partnership-building work.
- The form of this institutionalization should be clearly defined and publicized to all stakeholders and the larger public, so that an OSG can be held accountable by its stakeholders and the public it serves.
- An OSG should establish and implement performance measures and other assessment tools (e.g., critical health indicators) that allow it and the public to gauge its levels of success.
- An OSG should develop criteria that allow it to identify strategic priorities for its programmatic and public outreach work.
- An OSG should issue regular (at least annual) reports to the public and the legislature
- An OSG should develop proactive means and multiple two-way channels of public outreach that extend the SG's visibility as "The People's Doctor."

These recommendations are offered in no particular order or priority, and in the same spirit of ambition and hope for the future of the Office shared by all the respondents who contributed to this study and made it possible. As one respondent so eloquently noted, the OSG was an "historical breakthrough for Michigan, and provided an innovative approach on the state level to integrating and coordinating public health promotion from the micro to the macro level. The OSG provides a great mechanism for public health integration." The researchers as well as many of the participants in this study would, we suspect, heartily agree.

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Addendum

Alternative models for a state-level Surgeon General: Comparing experiences in California, Arkansas, and the federal government

There is no evidence that any specific blueprint of a state Surgeon General office was used as a basis for creating Michigan's Office of the Surgeon General. But during this same period, the state of Arkansas established its own version of a state Surgeon General, and the state of California proposed its version of a state-level Surgeon General. There also exists, of course, the model of the U.S. Surgeon General. Each of these alternative models provides insight into issues and strategies for strengthening Michigan's OSG.

California

In the years immediately following the attacks of September 11, 2001, and the anthrax cases shortly thereafter, public health received an influx of attention. What had been clear to public health workers for quite some time came to the forefront of national politics: the public health infrastructure is weak and ill prepared for its duty as a first responder. In California, the Milton Marks "Little Hoover" Commission on California State Government Organization and Economy identified the public health system as the "weakest link in California's homeland defense." Based on this finding, the Little Hoover Commission, an independent oversight agency, convened a special investigation of the public health system in California to discover how it works and how it could be improved.

In its report, "To Protect and Prevent: Rebuilding California's Public Health System" (2003) the Commission recommends creating a new public health department, separate from Medicaid and other state insurance programs, and led by a California Surgeon General. This person would be a "physician selected [by the governor] from a pool of nominees recommended by the new public health board and the California Conference of Local Health Officers based on strict scientific, medical, public health, leadership and management criteria" (page 30). The position is envisioned as reporting directly to the Governor within a structure comparable to the Centers for Disease Control and Prevention's parallel management model; further guidance and expertise in public health would come from a volunteer board of health and public health officials in the state of California (e.g., deans of schools of medicine, nursing, and public health, local health departments, etc.).

California and Michigan both identified the need for a state Surgeon General based on the need to rebuild or at least re-conceive the public health system and build strong relationships within and outside of the system to create a more seamless, efficient and effective approach to improving health. Both models share the vision of science-based, non-partisan approach to public health. The California approach, however, assures stakeholder support for a Surgeon General candidate prior to taking the position, highlights the need for public health infrastructure supportive of position suggesting changes to assure the authority and organizational structure of the position.

Arkansas

In Arkansas, settlements from the tobacco companies led to investments and renewed attention to their public health system. In 2000, the state legislature decided to dedicate these monies to creating a new College of Public Health at the University of Arkansas for Medical Sciences (<http://www.uams.edu/coph/>) where new initiatives and the political will for change led to the reorganization of the state public health system. Led by then Governor Mike Huckabee and the legislature, the separate State Departments of Human Services and Health were moved into one Department of Health and Human Services (HHS) in Spring 2005. Under this new structure, the Director of the Division of Health became an administrative position reporting to the Director of DHHS who reports directly to the governor on behalf of the thirteen divisions within DHHS. To maintain the cabinet-level health advisory role, the reorganization created a new position, "Chief Health Officer," independent of the Director of DHHS. This Chief Health Officer is appointed by the Governor, and has no budget or official position within the administrative structure of DHHS. Early in the development of this position, the suggestion was made to change the title from "Chief Health Officer" to "Surgeon General," in order to avoid confusion of roles with the Director of the Division of Health, who has title of "State Health Officer."

The initial primary emphasis of the Arkansas Surgeon General/ Chief Health Officer was on health policy. Specific responsibilities of the SG as identified in our interviews were to:

- 1) Develop health policy initiatives that bridge departments of state government, and that focus attention on interdepartmental relationships;
- 2) Develop partnerships between state government and the private sector; and
- 3) Think about policy in terms of "global design," as outlined in the Healthy America initiative of Governor Huckabee.

In contrast to the Michigan model, Arkansas's Surgeon General focused almost exclusively on promoting state health through policy. This initial priority stemmed from two main sources. First, the expertise and interest of Arkansas' Surgeon General was in policy. Even before his appointment, Dr. Thompson had been serving as a leading advisor to the Governor and Legislature, and was therefore well-known by both. He pursued a nonpartisan approach before taking up the SG position, continues to maintain this neutral position, and is seen as a trusted, non-partisan policy spokesperson and advisor, even though he now has an official appointment from a Republican Governor. The SG sees himself as speaking for good policy, and not as pushing the Governor's agenda. Second, the governor of Arkansas, Mike Huckabee was active in assuming the bully-pulpit role and the State Health Officer was already responsible for communicating to the public on behalf of Arkansas nationally at public health functions. For policy related issues, the SG might play a highly visible role, but only as needed and often in coordination with the State Health Officer.

It was only recently (2007) that the position of Chief Health Officer was re-named Surgeon General through statute to better differentiate between Chief Health Officer and State Health Officer. Dr. Thompson was named to this position by the current governor, Mike Beebe, a Democrat.

The U.S. Surgeon General

While the stories of State Surgeon Generals reflect some optimism in making serious attempts at improving the public health system, the story of the U.S. Surgeon General is marked by

steady decline. Over its 137 year history, the role of the SG has been whittled to two main responsibilities: First, oversight of the U.S. Public Health Service Commissioned Corps. The vast majority of the 6000 – 7000 members of the Commissioned Corps report to agencies to which they are assigned (e.g. CDC, IHS, etc.) In the case of a national public health emergency, the Surgeon General can deploy the Public Health Service as first responders. Clearly, the state Surgeon General model does not have this resource though both of the Surgeons General interviewed for this report suggested that a close tie to fifty state Surgeon Generals could be of great assistance to the U.S. SG, if these were adequately empowered, funded, and competent.

This corps of state Surgeons General would also be helpful in meeting the second, and most well recognized responsibility of the Office, which is to communicate with the American public as “chief health educator” (surgeongeneral.gov) or the “Doctor of the Nation.” This is accomplished through publishing evidence-based reports on current public health issues. The ties between science and politics were amply clear and tense in interviews with former and current U.S. and state Surgeons General. At the federal level, the goal of the Surgeon General is to use science to drive the creation, publication and dissemination of reports. When reports were effective, science trumped the influence of politics, which did not necessarily support the findings of science. In cases where politics (and in some cases religion) swayed the conveyance of science, or where the science was not strong enough to counter political influences, a Surgeon General might be asked to resign, or the authority of the Surgeon General severely undermined. The State Surgeons General also strive to strike this balance between politics and science, by staking a fair amount of authority on the scientific strength of their work. At all levels, this independence from the political system was perceived as one of the biggest strengths of a Surgeon General. By the same token, it is also one of the greatest challenges to maintain this separation.

In all cases except Michigan additional credibility and support come from the appointment process. At the federal level, the Surgeon General is nominated by the president and approved by the Senate. In Arkansas, the Surgeon General is a cabinet position nominated by the governor and approved by the Board of Health. The California recommendation is for Surgeon General candidates to be nominated by local health departments, and then selected and appointed by the governor.

None of the models articulate specific measures of an effective Surgeon General; however, our interviewees suggested the following as possible metrics:

Reports

1. How many reports are issued by the OSG?

Influence

2. What is the impact of these reports?
3. How much is the Surgeon General utilized in informing prudent health policy?

Recognition

1. How much does the public recognize the Surgeon General?
2. How much does the legislature call upon the Surgeon General to testify?
3. What kind of acceptance as a leader the person has attained by professional and practice organizations (e.g. state health departments, medical associations, etc.)?
4. How often is the Surgeon General in the media speaking to issues of health?

In the future evolution of the office of Michigan's Surgeon General, and state public health leadership generally, the experience to date of Surgeons General provides valuable insights. For example, articulation of the scope and powers of the Surgeon General (state or federal), formal and informal relationships with the existing public health infrastructure, and balancing scientific and political demands have mounted challenges and opportunities to Surgeons General. While states may not require major overhauls of their public health systems in order to accommodate a Surgeon General, addressing these operational and organizational issues is requisite.

Appendix A – Analytical Framework

Table 1 (below) is a more detailed version of the analytical framework previously discussed.

Table 1. Case Study of Michigan's Office of the Surgeon General: Interviews			
Stated Goals			
Operations (Visibility of the office)			
Operations (Resources)			
Operations (Programs)			
Operations (Partnerships) Government			
Operations (Partnerships) Community			
Operations (Partnerships) Media			
Operations (Partnerships) Academia/ Education			
Operations (Partnerships) Business/ Employers			
Operations (Partnerships) Health Care Providers			
	Past (Conceptualization)	Present (Implementation)	Future (Development)
	Time		

Appendix B – Interview Questions

Category	Question
Interviewee characteristics	<ol style="list-style-type: none"> 1. What type of organization do you work for? (Select one – this question will be helpful in understanding how to guide the questions below) <ol style="list-style-type: none"> a. Government <ol style="list-style-type: none"> i. Local ii. State iii. Federal b. Community c. Private Sector <ol style="list-style-type: none"> iv. Business v. Health care provider d. Academia e. Media
Context Background of position	<ol style="list-style-type: none"> 2. What were the circumstances that gave rise to the position of Surgeon General in Michigan? 3. What do you think made the creation of this position politically feasible? How was/is the position framed to encourage acceptability by the public? 4. How does the Office of the Surgeon General fit together with other initiatives of the Governor? 5. What is the authority of the Surgeon General? 6. Were other leadership models considered (e.g., a state Board of Health. Were other titles considered?)? 7. How was the current Surgeon General appointed to her position? (Selection process, other candidates, etc.) 8. What was the purpose of appointing a Surgeon General? What were the short-term and long-term goals, in your mind, of having a state-level Surgeon General?
Evaluation of position - general, partnerships	<ol style="list-style-type: none"> 9. <ol style="list-style-type: none"> a. Have you contracted the OSG for assistance on developing programs? If so, which ones? b. (Media only) Have you contacted the OSG for assistance in media stories? Have you been contacted by the OSG? Please describe. 10. Were the projects you have worked on with the OSG successful? In what ways? In what ways could these have been improved? 11. Has the relationship between your organization and state public health efforts developed and/or changed since the inception of the Office of the Surgeon General? In what ways has it changed/developed? <ol style="list-style-type: none"> a. Describe an example of a successful step in your development of a relationship with the Surgeon General. b. Have there been challenges in developing your relationship with the Office of the Surgeon General? Please explain. 12. In your experience, how has Michigan benefited from having a Surgeon General? <i>(Probe for advocacy role, specific example unique to participant's organization or target audience (i.e., "story of impact")</i> 13. In your experience, what have been the limitations of the Office of the Surgeon General? 14. Do you feel the role of the Surgeon General is well defined in Michigan? Please explain. <ol style="list-style-type: none"> a. If you feel the role has not been well defined, should it be, and if so, how?
Evaluation of position - general, partnerships (Continued)	<ol style="list-style-type: none"> 15. To your understanding, what are the primary goals of the Office of the Surgeon General? 16. Please comment on the effectiveness of the OSG in meeting the goals you mentioned. 17. The Office of the Surgeon General states that the following are the goals of the

	<ul style="list-style-type: none"> a. Act as the state's chief public health advocate b. Rebuild the public health system c. Develop public health policy d. Build collaborative relationships <p>18. [-if applicable~ You have already mentioned the role(s) of ____. Insofar as the others are concerned,) Please comment on the effectiveness of the OSG in meeting its goal to:</p> <ul style="list-style-type: none"> a. Act as the state's chief public health advocate b. Rebuild the public health system c. Develop public health policy d. Build collaborative relationships <p>19. Are there additional roles the Surgeon General ought to assume? Are there duties that are performed by the OSG that would be better performed by a different division or agency?</p>
Evaluation of position – visibility	<p>20. Have you noticed that public health issues have become more visible since the inception of the Office of the Surgeon General? Why or why not? How do you think they can become more visible through the OSG?</p> <p>21. How often do you hear about the activities of the Surgeon General's Office? (Very frequently, Frequently, Sometimes, Almost never, Never/ or --- times per month)</p> <p>22. How do you usually hear about the activities or programs of the Office of the Surgeon General? (e.g., PSA, newspaper, work meetings, etc.)</p> <p>23. How has your awareness of the position changed over time (since 2003)?</p>
Evaluation of position – resources	<p>24. What are the measures of a good state-level Surgeon General?</p> <p>25. Currently, funding for the Office is negotiated annually and is currently provided in the Michigan Department of Community Health budget, and by funds generated by the Office itself. Do you think this is sustainable?</p> <p>26. How would you change this funding structure to increase the likelihood of sustainability? (For example, permanent funding from MDCH, Office of the governor, taxes, donations, etc.)</p>
Evaluation of position - programs	<p>27. Have you worked with the OSG in any of the development or implementation of any of the office's programs (For example: Michigan Steps Up, Task Force to Eliminate Childhood Lead Poisoning, Walk by Faith, etc.)? Please describe.</p> <p>For each of the programs mentioned:</p> <p>28. Do you feel that this program (i - above) has been successful in meeting its stated goals? In what ways?</p> <p>29. What changes would you suggest (e.g. expansion/contraction)? (To initial program, to the future of the program, or of other, related programs)</p>
Future of the OSG	<p>30. Currently the OSG is not proscribed in state law or by Executive Order. Should it be?</p> <p>31. How could the position be leveraged to ensure continuation?</p> <p>32. What, if any, relationship should there be between the state legislature and the Office of the Surgeon General? (Examples: <i>statutory authority of position, regular reporting to both houses, relationship to both health committees, etc.</i>)</p> <p>33. Do you think the Office of the Surgeon General ought to be maintained? Why or why not? How do you envision the role of the Surgeon General evolving with the future of public health in Michigan?</p>

Appendix C - Role of Surgeon General during Governor Granholm's second term

Beginning April 2, 2007, the Michigan Surgeon General began a dual role between Henry Ford Health System and the State of Michigan, Michigan Department of Community Health. As a private-public sector executive, Dr. Wisdom's time is allocated between both agencies. She serves as vice president of Community Health, Education and Wellness for Henry Ford Health System, and continues her role as Michigan Surgeon General for the state of Michigan. "This partnership will allow Dr. Wisdom to continue the critical work she is doing to promote healthy lifestyles across Michigan while saving taxpayer dollars," stated Governor Jennifer Granholm. The W.K. Kellogg Foundation was interested in testing the sustainability of a private-public partnership, and agreed to fully fund Dr. Wisdom's continued state role.

As the vice president of Community Health, Education and Wellness at Henry Ford Health System, Dr. Wisdom will lead quality initiatives to address health care equity and health disparities; and provide clinical leadership to community, health literacy and diversity initiatives.

Dr. Wisdom continues to lead Michigan Steps Up, the statewide healthy-lifestyles campaign she launched in 2004 with the Michigan Department of Community Health and hundreds of community organizations. Her ongoing state work will also include related initiatives such as the W.K. Kellogg-funded middle school project "Generation With Promise," the National Governor's Association Health Workplaces program, as well as continuing to support Governor Granholm's initiatives for health care access and the Governor's Blueprint for Preventing Unintended Pregnancies.