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Transformations in public health

In This Issue

Maine Public Health Finds New Resources

Ann Conway

Like many states, Maine confronts painful budget dilemmas. The most rural state east of the Mississippi, Maine faces population loss and rapid change in its economic base, as manufacturing jobs leave for overseas. Our other economic mainstays of logging, farming, and fishing are similarly challenged. Maine has, according to one report, the third-fastest growing rate of poverty in the country. The state is faced with many public health problems and has little formal infrastructure with which to confront them.

But Maine also has many assets, including a strong sense of community, a willingness to act on pressing problems, and a rich spirit of collaboration. There is a shared recognition that we have serious public health problems and that there are effective ways to address them. The successes of the public health community and associated leveraging of funds are attributable to this common sensibility and desire to do more.

Background

In 1999, when we received the first Turning Point planning grant, Maine public health was at a crossroads. Then as now, Maine faced many public health problems: high rates of diabetes, heart disease, chronic obstructive pulmonary disease, cancer, and other disorders. Maine's public health infrastructure consisted of the State Bureau of Health and one urban public health department, located in the large, southern city of Portland. The healthy communities movement was alive and well in the state and had often been successful in mobilizing communities to deal with health problems, but its effectiveness was challenged by lack of funding and capacity.

Much variation existed in the training and educational background of the public health workforce, in part because few training opportunities were available. The closest graduate public health program, for example, was located in Boston. In addition,

(Continued on p. 3)

From the Turning Point National Program Office

A Broader Definition of Leverage

Bobbie Berkowitz, Director

Leverage – noun. (1) The action of a lever, or mechanical edge gained by it. (2) Power, effectiveness. (3) The use of credit to enhance one's speculative capacity.

Leverage – verb. To provide (as a corporation) or supplement (as money) with leverage. Also, to enhance as if by supplying with financial leverage. (Merriam Webster online)

The right level of funding for the right programs is crucial for public health outcomes. In business, companies invest resources strategically to create products that in turn bring the greatest profit. Public health invests resources to bring about the greatest improvement in health. Our goals may be different, but our investment strategy should be similar. Leveraging resources is a strategy aimed at not only making do with the funds we have, but using these funds to accrue more support.

When we think of leveraging resources, we usually think money. Yet money isn't the only thing required for public health improvement. Yes, we need to leverage financial support, but don't we also need to leverage our power to gain the acknowledgment and participation of others? Perhaps most important in our search for greater support for public health is our broadening the definition of *leveraging* to include engaging new partners. Public health has never been alone in this business of improving health, but more than ever before, reaching our goals is dependent on partnering.

Turning Point abounds with examples of successful leveraging, both of funds and supportive partnerships. In terms of funds alone, The Robert Wood Johnson Foundation's investment of over $21 million to state partnerships over the past six years has paid off handsomely. We estimate that, by leveraging these funds, state partnerships have more than quadrupled their original RWJF resources for public health improvement. In the state of Maine alone, they have used an annual investment of $125,000 from Turning Point to expand their public health resources significantly, influencing how tobacco settlement dollars were used for public health system improvements. And this is only one example. In Arizona, a unique partnership with the library system has led to a funded information access project, as well as a continued dialogue with an organization critical for communicating about public health.

Several Turning Point states have developed 501c3 organizations to sustain the work started by Turning Point in the years to come. These organizations are legal and physical manifestations of successful leveraging of power. In true Turning Point form, they represent the sharing of power as well, between the private sector and the public sector and among their members.

[Resources—continued from p. 1]

although Maine health care providers understood the utility of public health in informing clinical practice, few projects brought clinicians and public health providers together to explore common interests. In the health policy arena, a chasm seemed to exist between those advocacy groups interested in health care issues versus those interested in public health. Those in the former group often advocated for the disenfranchised and saw access to health care as the key to health reform. The public health community concurred, but their leaders also noted the importance of prevention and health promotion, so that the chronic diseases did not occur in the first place. Unfortunately, public health messages related to preventing and reducing chronic disease were sometimes viewed as regressive, unfairly targeting lower-income people, who suffered from higher rates of chronic disease.

For years, the Maine Public Health Association had worked hard, entirely through volunteer labor, to promote public health in Maine. Its efforts were sustained largely by donations and good will. There was no central convening organization in Maine that could develop sustainable initiatives in public health research (because of our lack of academic affiliations, public health research programs were difficult to develop), education, policy, and planning. During the 1990s, interest grew in developing such an organization, which would be modeled on similar institutes in Michigan, California, and elsewhere.

Assessing Maine's public health status

During the first two years of our Turning Point process, we focused on assessing our public health concerns and developed a strategic plan to address the issues. The process involved a broad and innovative constituency—almost 200 partners worked together to identify Maine's most pressing public health needs, in areas including infrastructure development, workforce, and the interface between clinical care and public health. We worked hard to include nontraditional partners in our work, such as those in business, local government, religious groups, and the "access" community.

Other critical public health developments also emerged during the first years of the project, which would have been, if not impossible, much more difficult without Turning Point funding, the creation of its constituencies, and its accomplishments. For example, the significant interest that developed in creating a convening public health organization ultimately led to the creation of the Maine Center for Public Health in 1999. After a start-up period and preliminary funding by a range of foundations, nonprofits, insurance providers, and educational and health systems, the Center hired a president in 2000 and assumed leadership of the Maine Turning Point Project in 2001.

Because Maine Turning Point was now headquartered in the emerging organization, its intensive, multisector-planning process quickly gave the Center visibility not only in the public health world, but in the Maine policy arena in general. The Center is now involved in a number of highly visible public health efforts, including the Maine-Harvard Prevention Research Center, public health emergency preparedness, task forces on Maine's innovative health insurance plan, Dirigo Health, and a range of evaluation activities.

The Center has received about $2.9 million in funding since its inception, which we regard as largely attributable to Turning Point activities. These funds have included support for education and training activities, including liaison with the University of New England as it developed a graduate public health certification program (a master's degree program is now in development), educational activities offered in conjunction with

(Continued on p. 4)

[Resources—continued from p. 3]

Harvard School of Public Health, and the coordination (with the Bureau of Health) of the Maine Harvard Prevention Research Center, which now centers its work on childhood obesity, evaluation activities, efforts to create integrated primary care and mental health systems, and many other initiatives.

In a development corollary to the creation of the Center and the implementation of Turning Point, the public health community embarked on one of its most significant advocacy/policy efforts of the past decade. Maine had had many legislative victories in the area of smoking, but as of 1999, the state still led the nation in young adult (aged 18-34) smoking rates. Youth smoking was not far behind. When tobacco settlement moneys became available (totalling $26 million), Maine was able not only to preserve the funds for health promotion and prevention purposes, but to disseminate them to 31 new local coalitions linked to hospital service areas, which originally focused on tobacco prevention and have now expanded to examination of diet and exercise issues.

In our Turning Point discussions, these "Healthy Maine Partnerships" represented the beginning of a public health infrastructure in the state, one closely allied with the community empowerment model pioneered by healthy community coalitions. In subsequent years, the $6.5 million annually earmarked for the "Fund for Healthy Maine" has been aggressively defended by the public health community, which has grown to encompass the many new constituencies included in the Turning Point process. The Healthy Maine Partnerships themselves have become a vocal, new public health constituency. The effectiveness of the Fund has been proven; smoking rates have declined precipitously as the result of the Fund's activities, especially among younger age groups.

In another effort to enhance community partnerships, Turning Point also funds the Maine Network of Healthy Communities (MNHC). In its three years of existence, MNHC has developed organizational capacity and embarked on a variety of educational and mentoring activities.

The future

We are now in the fifth year of the Turning Point project. In January 2003, we released a summary planning document on the project, with an emphasis on development of a regional and local public health system in the state. Because Maine has a very strong tradition of populist local control, achieving consensus that a regional public health system was necessary was a real achievement. We continue to participate in discussions about the development of a regionalized system. We believe that successful implementation of activities associated with the current federal award of $3.6 million annually to Maine for public health emergency preparedness—with its links to the creation of public health infrastructure—has been enhanced by the progress we have made on public health infrastructure development in the state.

This proposed infrastructure, which has the potential to change so many lives, is closely linked to two political developments in Maine. These are the reorganization of the Department of Health and Human Services (incorporating the Bureau of Health, our state public health agency) and the Department of Behavioral and Developmental Services, as well as the creation of Dirigo Health, an innovative health insurance plan designed to make coverage available to every non-elderly, uninsured individual in Maine. The reorganization will proceed over the next two years. We believe that it

(Continued on p. 7)

Turning Point Member Profile

Dave Palm

The single word that best describes Dave Palm is *visionary*. His career in public health has always focused on building partnerships among diverse stakeholders to set the direction for public health in Nebraska. He constantly acts on his belief that if people in the community work together and take ownership of problems, a better quality of life for everyone will follow.

Dave began his career in public health as a health economist with the Nebraska Department of Health, working in the area of health planning. After he became bureau chief, he supervised all facets of the state health planning program including vital statistics, data management, and rural health. He is currently director of the state's Office of Public Health. The Office of Public Health works to strengthen the public health system in Nebraska by improving collaboration and working more effectively with local public health departments and other community-based public health organizations. It also serves as the focal point for coordinating public health policies and activities at the state level. Dave oversees such major functions as the critical access hospital program, the Nebraska health care cash fund grant program, the state planning grant for the uninsured, coordination of the Nebraska 2010 Objectives, and the Nebraska Turning Point Initiative. He also serves on several boards and speaks at numerous public health and rural health meetings within and outside of the state.

Dave was the driving force behind the Nebraska Turning Point Initiative. He wrote the Letter of Intent and application, and organized the site visit by The Robert Wood Johnson Foundation team. Even before the state was notified of its grant award, Dave had started organizing public and private sector partners into a stakeholder group. Under Dave's leadership, and with the help of more than 400 people, the stakeholder group wrote and implemented Nebraska's plan to strengthen and transform public health in the state. As a result of these efforts, for example, Nebraska's public health system has expanded from 16 local health departments covering only 22 of the state's 93 counties in 2001 to almost total health department coverage in 2004.

Because of Dave's vision, Turning Point funds were used to form the local community partnerships ultimately responsible for organizing many of the 16 new multi-county public health departments. The Nebraska plan and the Turning Point Partnership also helped secure $5.7 million dollars of Tobacco Settlement Funds to fund the new multi-county health departments. Nebraska was cited in the February 2004 issue of *Governing Magazine* as a model state because of its efforts to improve its public health infrastructure by organizing and funding the new multi-county health departments in such a short time.

Dave holds a Ph.D. in Economics from the University of Nebraska. In addition to his public health work, he also teaches a health economics class at the university. Dave's work has been recognized twice with the Nebraska Rural Health Association's President's Award.

When he isn't busy improving Nebraska's public health system, Dave enjoys running, watching college football and basketball games, and reading mystery books.

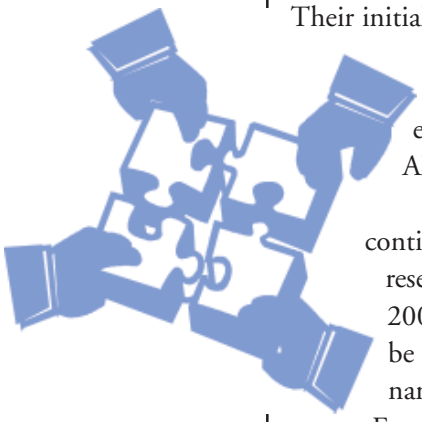
Nominate Turning Point members to be profiled in future issues.

Leveraging Both Funds and Power

Marleyse Borchard

Created in the late 1990s by two visionary change organizations and two innovative foundations, the Turning Point Initiative was meant to make big waves in public health. Six years later, our successes are due to the original innovators and early adopters of the Turning Point collaborative model and also to the ability of Turning Point partnerships to leverage power and funds beyond their original Turning Point grants so they can continue to improve public health.

Traditionally, public health funding has been almost entirely reliant on government dollars, which were usually tied to distinct programs. The question "how can we restructure public health?" was difficult to broach in a siloed and often reactive environment. Lack of consensus on a strong vision for public health plagued many states, and was exacerbated by the lack of resources to engage in proactive planning. In 1998 and 1999 the momentum for change began when twenty-one states and forty-one communities received funding to engage in a collaborative planning process. Their initial planning grants went toward identifying constituents for a broad-based and diverse partnership in each state. A rare tack was taken—finding and inviting *any and all* who had an interest in public health to the table to examine creating a new future for public health. From South Carolina to Alaska, public health partnerships were born.



With a Public Health Improvement Plan in hand, these partnerships continued to meet and work on implementing their plans, bringing those researched and carefully chosen priorities to life. Along the way to the year 2000, partnerships had grown, as they identified other groups that needed to be involved to improve the public health system. Leveraging power was the name of the game, bringing on partners who could help bring about change. Examples of successful leveraging of power can be seen in every Turning Point state.

- In Nebraska, Turning Point director Dave Palm and Mary Munter worked closely with the Nebraska Public Health Association. Through their broad coalition they successfully garnered nearly $13 million to build multi-county public health departments.
- In Louisiana, Michele Jean Pierre and the staff of Louisiana Turning Point have partnered with the Better Health for the Delta/Southern Rural Access Program and have gained expanded staff resources as well as avenues for outreach to the twenty-nine rural parishes that can benefit from the Louisiana Turning Point's Center for Capacity Enhancement training.
- New York's Turning Point partnership with the State University at Albany School of Public Health and others has brought a focused presence to the State Department of Health on the importance of public health workforce capacity building. The voices of partners within and outside of state public health have led the department to invest $650,000 a year in continuing education programs.
- The Turning Point Partnership in Minnesota has also leveraged power inside and outside of traditional public health. Committed to understanding and addressing the effect of social and economic conditions on health and health disparities, the partnership published a report strongly urging that Minnesota's public health community adapt to the growing understanding of the relationship between the

health of individuals and communities and the social and economic environment in which they live. In response to the growing recognition that income, education, living conditions, and other social, cultural, economic, and environmental factors are powerful determinants of health, the Blue Cross/Blue Shield Foundation of Minnesota (the largest grant-making foundation in Minnesota dedicated exclusively to improving community health) is refocusing its annual $2 million-a-year grant program to addressing these "root causes."

- In Colorado, Jill Hunsaker, her partnership, and staff have successfully leveraged nearly $500,000 in funding and other resources from local foundations and governmental agencies such as the Centers for Disease Control and Prevention and the federal Office of Minority Health. These dollars support Colorado's work on racial and ethnic health disparities, including the publishing of reports from health disparities data analysis.
- Turning Point states have also leveraged volunteer time, to the tune of tens of thousands of professional hours, and in-kind resources to support their partnerships' work.

These are just a few examples of how leveraging power through partnership development can bring new life and also greater resources to public health improvement efforts. As Turning Point states continue to work with diverse partners, the investment of the Turning Point Initiative, health departments, and our communities will continue to see payoffs.

[Resources—continued from p. 4.]

may consider regionalization of services in general and, therefore, may offer an enhanced opportunity to develop a regional public health system.

Because the intent of Dirigo Health is to address the soaring health care costs associated with Maine's epidemic of chronic disease, it offers another opportunity to stress the importance of public health infrastructure and public health concerns in general. Although the program is still in its early phases, the public health community has advised that services such as health care and disease management be linked to community-level health promotion and prevention resources. Our Dirigo Policy Development and Rulemaking Task Force, comprised of many longtime Turning Point stakeholders, has been very successful in communicating this approach.

Our Turning Point partnership and its activities proceed on many levels—workforce development and associated education, clinical care and public health, infrastructure development, community empowerment, and other areas. We estimate that Maine Turning Point has been able directly or indirectly to leverage about $32.5 million dollars in funding, attesting to much hard work, a spirit of collaboration, and a fortunate confluence of events. Much more remains to be done, of course, to create a stronger public health system in Maine, one that further stems the tide of preventable death and morbidity that claims so many of our citizens. With the legacy of Turning Point, we believe we will be successful in achieving this goal.

Ann Conway is director of the Maine Turning Point Project.

A rare tack was taken—finding and inviting *any and all* who had an interest in public health to the table to examine creating a new future for public health.

Policy Corner

Public health issues draw contradictory viewpoints and heated debate, sometimes between colleagues and partners who are nevertheless committed to working toward a common goal. Turning Point's focus on building diverse partnerships to improve public health infrastructure gives us an opportunity to engage in dialogue on important topics. We invite readers to send us their thoughts on the policy statement below or go to our online Policy Corner and add their comments to the online discussion.

Policy Statement

With enactment of a new Medicare law in December 2003, progress was made toward addressing one aspect of the current health care crisis in the United States—the lack of prescription drug coverage for Medicare beneficiaries.

Responses

The new Medicare law is an important first step, albeit an imperfect one, toward meeting the prescription drug needs of seniors and disabled adults. Beginning Jan. 1, 2006, Medicare Part D (the drug benefit) will become available. After paying a monthly Part D premium, beneficiaries will have a $250 deductible. Medicare will then pay 75 percent of drug costs up to an initial coverage limit. Thereafter, the plan has a coverage gap (often referred to as a "doughnut hole"), followed by catastrophic coverage—with Medicare paying 95 percent of the beneficiary's drug costs. In addition, the new benefit will provide significant financial assistance to certain Medicare beneficiaries with low incomes, who will have lower, if any, premiums and cost-sharing.

Pam MacEwan, Vice President, Public Affairs and Governance
Group Health Cooperative, Seattle, Washington

In order to stay within the $400 billion budget, the prescription drug benefit is designed with a significant coverage gap. Beneficiaries will be responsible for paying 100 percent of their drug costs if their expenses are between $2,250 and $5,100. It is anticipated that half of all Medicare-eligible seniors will be without drug coverage for part of the year. The coverage gaps, coupled with higher premiums, will be financial hardships for seniors living on fixed incomes and facing multiple health issues. Some low-income seniors as well as those with very high drug costs will be helped by the new law; however, it's estimated that some 6.4 million low-income beneficiaries will end up paying more than they currently pay or losing access to coverage for drugs they need.

The law does nothing to curtail the skyrocketing costs of prescription drugs. In fact, the Medicare program will be prohibited from leveraging its tremendous purchasing power, as the Veteran's Administration currently does, to negotiate for lower drug prices.

Excerpted from the Web site of the Alliance for Retired Americans, www.retiredamericans.org

Add your comments to the discussion of this topic by going to our online Policy Corner at *www.turningpointprogram.org/web_log/weblog_index.html.*

Deadline: June 16, 2004

More responses to the Policy Corner statement in the Winter 2004 issue.

Policy Statement: *The structure of the US economy virtually ensures that economic good times will worsen the already large income gap between the rich and the poor—leading to adverse effects on population health as well as to increased health disparities.*

Two issues are associated with the relationship between income gap and disparities in health status. The first, documented from several jurisdictions, is that the wider the income gap between the top and bottom income categories, the more likely those at the bottom will have worse health outcomes. Although there is little in the way of solid explanation, the easiest is that this means those at the bottom have fewer resources available to ensure food, shelter, clothing, recreation, or medical treatment, all of which are essential to improving health. The second problem is more subtle, but perhaps more meaningful. The wider the gap, it seems to me, the less likely those at the top are to see those at the bottom as "people like me." If that is the case, it could also justify a failure to see those individuals as members of the same community and, thus, as part of a common effort to make things better for all. If those at the top can live in gated, guarded communities, never riding on public transportation or sending their children to public schools, and buying a boutique "personal care physician," they have less and less need to ensure that general services are effective or even meet a minimum level of quality. This neglect of the public good surely leads to a worsening of the health status of those whose only access to support is through public programs.
Kristine Gebbie, DrPH, RN, FAAN
Columbia University, School of Nursing

In order to change the widening income gap between the haves and the have-nots, all public health professionals must become knowledgeable about the social determinants of health—products of society, such as, housing, job security, education, safety, health care, and social justice. Research is proving that these two areas have a huge effect on the health of a community. Social determinants of health must be introduced to the students currently enrolled in the health profession schools and made widely available to all currently working in the public health arena. It is up to us as public health professionals to embrace social justice.
Teresa Wall, MPH
Executive Director, Department of Public Health, Gila River Indian Community, Sacaton, AZ

How do you not have "poor and not poor" in a free capitalistic society? A society where I can work if I want to; educate myself or not. Sometimes bad things happen to rich people and some "poor" person can win the lottery. The most plaguing health issues are within the influence of the choices we make. The enigma: in economic good times, more dollars are available to address disparities than when times are bad.
Stephanie Bailey, MD, MSHSA
Director of Health, Metro Public Health Department, Nashville, TN

The structure of the US economy does not guarantee that economic good times worsen the gap between rich and poor. In good or bad times if the government is owned by those of wealth rather than all the people, and they use that ownership of government to their advantage, then the gap will worsen.
Tom Engle
Project Director, Turning Point Oregon

These comments have been edited for length. To read the full comments, go to the online Policy Corner at www.turningpointprogram.org/web_log/weblog_index.html.

Making the Case for Workforce Diversity In Public Health

Elizabeth M.S. Krause

At the Colorado Turning Point Initiative, we are focused on reducing racial and ethnic health disparities. One of our strategies toward this end is working for increased racial and ethnic diversity at the Colorado Department of Public Health and Environment, our program's home. Like so many states, the racial and ethnic composition of Colorado is growing. People of color make up approximately 25 percent of our state's inhabitants, and in Denver, ethnic minorities now make up the majority (50.1 percent) of the population. In the Health Department, however, only 12.9 percent of health professionals are people of color, and none are in senior staff positions.

Traditionally, the case for diversity has leaned toward the "remedial" argument to correct past inequalities, but our goal was different. We wanted to argue that workforce diversity could help improve health outcomes. After examining strategies from the human resources and business fields, we found the "business case" for diversity appealing, first because it links workforce diversity to outcomes, and second, because it is proving effective in today's economic times.

Colorado Turning Point's diverse staff: Elizabeth Krause, Jill Hunsaker, Judy McCree Carrington, Donald Lim.

In brief, the business model is about using a diverse workforce to improve an organization's bottom line. It holds that diversity, when properly harnessed, improves productivity, innovation, and performance, creating a competitive advantage in a global marketplace. A diversity of perspectives, experiences, and thoughts facilitates a higher level of creative problem solving and decision making, which in turn attracts a wider client base. Diverse employees help an organization recognize new markets and increase its ability to provide more tailored services. A diverse workforce also projects a more positive public image in the community.

Because support from senior management is a critical predictor of a successful diversity initiative, the business model is a useful framework for showing senior management how workforce diversity will contribute to the success of the organization.

Translating the business case for public health

Colorado Turning Point initially wondered how to translate rhetoric from the business case about bottom lines, marketplaces, and competition—not terms used everyday in public health. The recent University of Michigan Supreme Court ruling demonstrated that we simply needed to state the business case in terms that resonate with public health, just as Michigan framed the business case in a way that made sense for higher education. In June 2003, the Supreme Court upheld racial and ethnic diversity as a compelling and constitutional state interest. In presenting its case, Michigan founded its diversity rationale on the educational benefits of a diverse student body. Through its ruling, the Supreme Court recognized the interrelationship between diversity and excellence.

In formulating public health's business case for diversity, we too should see the

value in diversity for the sake of excellence and for ensuring that the U.S. public health system is one of the best in the world. We also need to focus on the functional utility of a diverse workforce in light of the changing demographics and racial and ethnic health disparities that exist. In Colorado, for example, the state has recognized the value of all its inhabitants' equal opportunity to be healthy, regardless of race or ethnicity. The business case can help us demonstrate how a diverse workforce facilitates this goal.

Taking steps toward a diverse workforce

The Colorado Turning Point Initiative is taking action on several fronts to promote workforce diversity. Most importantly, we are leading by example. Director Jill Hunsaker has intentionally hired one of the most diverse staffs in the department. She also co-chairs the Department's Employee Diversity Advisory Committee (EDAC), and all Turning Point staff are active participants. She has made a point of garnering support from senior staff for EDAC's diversity agenda—a fundamental piece of the business model, which was missing in past years. The HR director and chief medical officer have openly expressed support for promoting diversity among health professionals and senior staff. One result of this support is that a number of diversity goals are included in the draft version of the department's new strategic plan. This is on target with the business model, which advises that an organization's diversity strategy should be linked to a significant business need or objective. Additionally, EDAC is currently developing an assessment of the organizational climate, as well as an assessment of minority recruitment, hiring, promotion, and retention practices. An EDAC subcommittee is in the research phase of creating the department's own business case for diversity. Finally, to promote future leaders of color, each year the Colorado Turning Point Initiative raises funds and offers scholarships for minority health professionals to participate in a yearlong leadership training institute.

Examples of Translating the Business Case

What is public health's bottom line? Public health's bottom line is clearly not profit. Public health's bottom line is our ultimate effectiveness at promoting and protecting the health of a diverse public, usually measured in health outcomes. Each failure to serve communities of color diminishes our bottom line.

Who are public health's clients? All members of the public are technically our clients, but at a more tangible level, public health's clients are the diverse recipients of the direct services (for example, clinics and WIC) offered by most health departments. According to the business case, workforce diversity can help us attract new clients and improve our ability to tailor services to client needs.

What are public health's markets? Public health expends considerable resources on marketing prevention messages and programs. A diverse workforce will help us better identify, communicate with, and engage our diverse markets.

What is public health's competition? Our competition comes in many forms (for example, media, policy, social norms). To compete effectively, we must thoroughly know what we are up against. We need the expertise and experience of health professionals who know minority communities and can help us identify the forces that compete, for example, with the health of Vietnamese youth or Mexican elders.

Threats to population health are complex and multi-systemic. They demand creative, innovative solutions. Evidence from the crucible of the business world demonstrates that a diverse workforce can enhance the kind of public health problem solving that will lead to timely health outcomes relevant for all of Colorado's inhabitants—which are, after all, public health's bottom line.

Elizabeth M.S. Krause, SM, is a public health prevention specialist working with the Colorado Turning Point Initiative.

Partnering to Leverage Resources

Catharine Riley

Since 2001, the Arizona Turning Point Project (AzTPP) has been collaborating with several partners, including the Arizona Health Sciences Library (AHSL) at the University of Arizona, to begin building Public Health Information Centers in local libraries and health departments across the state. In 2003, after a year and a half of researching and planning, it became evident that the central component of this project needed to be a Web-based resource that would facilitate access to public health and consumer health information for public health professionals and the citizens of Arizona. In addition we needed to market the new resource, solicit local input for the database supporting the Web-based resource, train librarians and public health workers on how to use the resource, and identify long-term sustainability plans.

AzTPP contracted with AHSL to develop the Web site and facilitate the training component. Since Turning Point's funding is limited, the contract with AHSL was also limited, and although the contract provided funding to develop the Web site, it was minimal in comparison to the industry's going rate for the development of a searchable Web site of this kind. The library put a significant amount of in-kind support into this project because it shared the vision of making health information more accessible to the people of Arizona. Although in-kind support is not new or innovative, in this case, the type of support was unique, as it involved a nontraditional partner, the state's only publicly funded academic health sciences library, which valued the partnership and was dedicated from the beginning to long-term sustainability. This unique partnership allowed Turning Point to go beyond what could have been accomplished with Turning Point dollars alone.

Although in-kind support is not new or innovative, in this case, the type of support was unique, as it involved a nontraditional partner, the state's only publicly funded academic health sciences library, which valued the partnership and was dedicated from the beginning to long-term sustainability.

The final product is AZHealthInfo.org, a Web site with information and links to pertinent public health statistics and consumer health information resources in each county, as well as state, national, and international resources. The training team from AHSL has completed visits to every county to train public librarians and local health department officials on how to access AZHealthInfo.org and other health information resources on the Web such as MedlinePlus and PubMed. During the training sessions, the librarians and public health workers are encouraged to submit local information to be added to the database. This makes the Web site more relevant at the local level and encourages local partners to feel connected to the project. Another benefit of this project is the connection between the local public libraries, medical libraries, and local health departments, which gives the public more access to up-to-date, authoritative public and consumer health information.

The Arizona Turning Point Project will finish its four-year grant cycle in June 2004, but AZHealthInfo.org will continue. The Arizona Health Sciences Library is committed to housing the Web site, expanding the site's database, and facilitating ongoing training. To accomplish this, the library is applying for national and local grant and contract money. In addition, the library, with support from the Arizona Turning Point Project, will apply for a competitive subcontract award from the Arizona State Library, Archives, and Public Records Agency. These grants and awards are examples of nontraditional funding sources that public health is able to pursue only because of the successful partnership between public health and the state libraries.

Catharine Riley, MPH, is director of the Arizona Turning Point Project.

Healthy Aging

Marleyse Borchard

We live in a world that cares about individual stories and individual needs. Healthy aging will continue to be of interest as our population ages and as we see the effect of preventable chronic disease.

The Turning Point Initiative has long been focused on building public health infrastructure and transforming public health through system change. We have made our mark in public health by collaborating on the development of health departments, institutes, training centers, accreditation programs, information systems, and policy. Our work is seldom focused on a specific health issue, but behind the Turning Point Initiative is a firm belief that health outcomes will improve with the improvement of public health systems. One of the central principles of Turning Point is that collaborative planning through diverse community partnerships will bring to the surface the most important health priorities of each state and community. So for the first few years, Turning Point states focused on building partnerships, assessing health status and systems, and developing priorities.

Back in 1998, the Oklahoma Turning Point partnership focused on changing the way the Oklahoma State Department of Health does business. They had been operating under a top-down model for a long time, and wanted to take public health prioritizing back to the community level. Since that time, Oklahoma Turning Point has been developing collaborative partnerships at the community level to inform state and local health planning and resource allocation. This philosophical and structural change has brought about numerous new programs in healthy aging, such as:

- Development and growth of senior nutrition centers
- Free transportation for seniors to senior nutrition centers
- Nutrition resource rallies to recruit eligible families for programs and to collect data on nutrition
- Development of an exercise and fresh air area for a nursing home and community
- Mobilization of local citizens to participate on a senior citizen's center advisory committee
- Development of a volunteer program to clean yards for the elderly and disabled
- Development of an independent living center for the elderly
- Promotion of flu clinics for the elderly
- Reduced-cost prescriptions and access to care for low-income individuals
- Monthly food packages at a reduced price for low-income families

Other Turning Point states have implemented programs that focus on improving services to the elderly. In Nevada, Turning Point staff are trained in leading chronic disease self-management classes and have led these courses to build skills and promote positive ways of dealing with ongoing illness.

Healthy aging is just one area where Turning Point is making a difference for both systems and individuals.

Getting the Best Bang for the Buck

Neil Hann

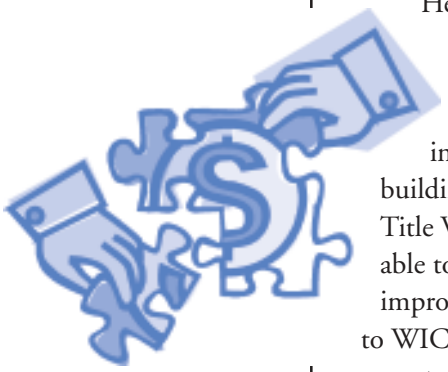
Leveraging resources for community partnership development has real potential for advancing the principles of Turning Point and transforming public health. The possible revenue streams are numerous at the local, state, and federal levels.

Local resources

One of the best examples of leveraging resources at the local level in Oklahoma involves the Harper County Turning Point Partnership. This small, but effective partnership identified the lack of public health services as its major problem and decided to establish a county health department as its top priority. However, to accomplish this, partnership members needed to find funds. They began meeting with many leaders in the community and gained public support for designating 14 percent of a one-cent sales tax to establishing a new county health department. After many community meetings and input from many people, the sales tax proposal passed by a positive vote of 91 percent. Although 14 percent of a one-cent sales tax was by no means a windfall, it was enough to get state matching dollars, and now Harper County has a county health department.

State and federal resources

Turning Point in Oklahoma has evolved from a single director and three pilot sites to a staff of seven and more than forty-five community partnerships. This happened only because we have been able to leverage funds from a number of sources. In addition to the original Robert Wood Johnson Foundation grant, funding to support Turning Point in Oklahoma comes from federal Maternal and Child Health (MCH) Title V, Tobacco Use Prevention, Women, Infants, and Children (WIC), and immunization funds, as well as state general revenue funds.



These funding sources often recommend or require community involvement in program implementation. Turning Point's emphasis on building community partnerships helped us meet those requirements. With MCH Title V funds (federal funding to improve health for mothers and children), we are able to document partnerships that have addressed maternal and child health improvement activities. We have partnerships that are working to improve access to WIC foods as well as nutrition education activities at the local level. Several of our partnerships have addressed tobacco use prevention, working with local schools and student groups such as Students Working Against Tobacco. We also have had partnerships work with local communities to increase immunization rates for children. Finally, many state legislators have been active in our local Turning Point partnerships and see the value of using some minimal amount of state general revenues in order to reap potentially big benefits, such as new community health clinics.

Perhaps the most important message is that community partnerships work and are one of the most effective ways to get the "best bang for the buck." Programs at the state level have realized this in Oklahoma and have actively sought out Turning Point's help to get state goals accomplished at the local level.

Neil Hann is chief of the Community Development Service at the Oklahoma State Department of Health.

Site Visit

The Public Health Information Systems Catalog

The Public Health Information Systems Catalog will provide information about software useful for conducting specific public health activities, as well as the technical requirements needed for running the software. The catalog provides an easy-to-use interface to a database of the current information systems initiatives at public health departments at the local, state, and federal levels throughout the nation. Users can browse or search the site by characteristics of a specific health problem and find data on the information systems used by communities throughout the United States to address the same or similar health problems. Plans are to have the catalog up and running in May 2004. It will be housed on the Information Technology Collaborative Web site, at www.infotechnet.org.

RWJF Update

Local Initiative Funding Partners

Local Initiative Funding Partners (LIFP) is a partnership program between RWJF and local grantmakers. It supports innovative, community-based projects to improve the health of and health care for society's most vulnerable people. Since 1988, the LIFP program has awarded more than $63 million in partnership with more than 1,000 local grantmakers to support 197 community-based health and health care projects. LIFP seeks to bring national attention to new ideas and approaches that focus on improving health and health care for underserved and vulnerable populations. The community-based projects should be ambitious expansions of recent efforts or present innovative solutions to local health problems that may be unique to the region. LIFP operates on an annual funding cycle. The upcoming deadline for submission of a Stage 1 proposal and accompanying materials is July 14, 2004.

To learn more about this program and the projects already funded, see a list of frequently asked questions (FAQs), or pose your own question, visit the Local Initiative Funding Partners Web site, at www.lifp.org.

Dates to Note

May 11-13, 2004. Turning Point Showcase Conference: States of Change. The Turning Point Initiative will share accomplishments, stories, and products of the 21 Turning Point states with health officials and local, state, and federal public health colleagues from across the nation. Denver, Colorado. For more information call (206) 616-8410 or visit www.turningpointprogram.org.

May 20-21, 2004. NNPHI Annual Meeting. New Orleans, Louisiana. www.nnphi.org.

June 14-16, 2004. The Public's Health and the Law in the 21st Century Conference. Atlanta, Georgia. www.aslme.org.

July 14-17, 2004. NACCHO Annual Meeting. St. Paul, Minnesota. www.naccho.org.

September 28-October 1, 2004. ASTHO Annual Meeting. St. Paul, Minnesota. www.astho.org.

November 6-10, 2004. APHA Annual Meeting: Public Health and the Environment. Washington, DC. www.apha.org.

Transformations in Public Health is a publication of the *Turning Point: Collaborating for a New Century in Public Health* initiative. The goal of this initiative is to transform and strengthen the public health infrastructure in the United States so that states, local communities, and their public health agencies can respond to the challenge to protect and improve the public's health in the 21st century. The University of Washington School of Public Health and Community Medicine serves as National Program Office for the initiative.

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