Volume 4 / Issue 3
A Publication of
Turning Point: Collaborating for a New Century in Public Health

Autumn 2002

Transformations in public health

In This Issue

Turning Point Sets the Stage for Bioterrorism Preparedness

Betty Bekemeier and Jan Dahl

It's 4 A.M., and an airplane unexpectedly flies over a nuclear power plant. Who is the pilot? What are his intentions? How should we respond? A year ago, we might not have asked such questions. But times have changed. Asking questions like these and knowing how to find the answers has become crucially important not only for traditional emergency responders but also for public health professionals.

In spring 2002 the Centers for Disease Control and Prevention (CDC) asked public health departments across the country to write emergency preparedness plans for their states. CDC required public health departments to work with a variety of partners to develop a comprehensive plan for the use of the proposed federal bioterrorism (BT) appropriations. The Turning Point partners' previous collaborative efforts paid off during the planning process.

Turning Point coordinators surveyed

Shortly after the states submitted these plans to CDC, National Program Office staff talked to Turning Point coordinators about their experiences with the planning process. We asked participants from each of the Turning Point states about how their Turning Point partnerships—members, model, and products—may or may not have been related to the application process and development of bioterrorism plans. The findings demonstrate how prior practice and experience in collaborative planning and employing the Turning Point partnership model can increase effectiveness and speed in responding to a call for action during an emergency.

We found that in the majority of Turning Point states, the focus on public health system development and collaborative partnerships had laid a foundation for the multisector involvement CDC required.

The previous Turning Point work had a strong, positive influence on how quickly and effectively a state was able to move into the planning and application process. The importance of knowing the players and having trusting relationships based on work

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TurningPoint

A National Program Supported by The Robert Wood Johnson & The W.K. Kellogg Foundations

From the Turning Point National Program Office

Seeking Solutions Through Policy

Bobbie Berkowitz, Director

This issue of *Transformations* coincides with the anniversary of the terrorist attacks of September 11, 2001. Over time we may come to regard this event as a turning point of its own, one that turned the attention of the public and Congress to the capacity of our public health infrastructure to support bioterrorism preparedness. The anthrax attacks precipitated criticism that the system was unprepared. As a result, Congress appropriated millions of dollars for bioterrorism preparedness to state and local health departments nationwide. This bolus of money did not signal the beginning of public health preparedness. Work had been underway for several years to increase our capacity to manage a bioterrorism attack. It is hard to say whether the public has been aware of this advancing knowledge about bioterrorism or plans by public health to respond.

Just as this new money for bioterrorism was not the beginning of our work in preparedness, we should not send a signal to the public or Congress that public health infrastructure will be "fixed" by this appropriation. Our message must be one that clearly details the critical work of public health in seeking solutions for and applying interventions to a wide range of health and environmental threats in addition to bioterrorism. What steps can we take to ensure that our voices are heard by the policy makers?

The National Program Office has plans underway that will head us toward effective use of policy. We must first educate ourselves about how and when to seek solutions for public health problems through policy. We know that policy development is one of our most important public health core functions. However, as a system, policy development is one of our weakest functions, and our ability to engage with policy makers has been challenged by the politics involved in the policy process.

Beginning with this issue, *Transformations* will feature a Policy Corner. Each issue will present a policy issue that represents a dilemma for public health. Alternative views on the policy issue will be discussed by selected colleagues and debate will continue on the Turning Point Web page. We will summarize the results of that dialogue in the subsequent issue of *Transformations* and present a new policy issue. This process of dialogue and debate will increase our ability to discuss and select alternatives to a policy issue.

Our second step is to engage and communicate with policy makers about the work of public health. Toward that end, Turning Point will host a Policy Summit in Washington, DC, in May 2003. The purpose of the summit is to provide an opportunity for Turning Point partners to share experiences with members of Congress and illustrate for them effective solutions for improving the public's health.

Seeking effective solutions for public health problems through policy initiatives is a very important step for Turning Point. Preparation is underway to ensure that we deliver a message about public health improvement that creates a turning point for the public's health.

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accomplished together in Turning Point was frequently emphasized as critical to successful and more immediate emergency preparedness planning. As one Turning Point coordinator said, "We couldn't have had the quick, collaborative, broad-based work without Turning Point. The relationships were [already] there."

Not only were the important relationships in place, but many of the individuals involved had already developed the skills to convene and manage a large planning process. For example, the CDC grant application called for creating a governance structure. One respondent said about the process, "If it had been three years ago, I wouldn't have known how to [create one]. Our collaborative process taught me. The state advisory meeting was like a Turning Point meeting. We understand how to manage a process like that."

Turning Point staff involvement

In many cases Turning Point staff or partners were asked to play key roles in the emergency preparedness budget and plan because of their involvement with Turning Point and its activities related to building public health systems.

In some Turning Point states, for example, Turning Point staff or steering committee chairs were appointed to such lead positions as director of Emergency Preparedness. In many Turning Point states, Turning Point staff were asked to participate in the core planning group, to take the lead on an emergency preparedness advisory committee to provide specific expertise in collaborative planning, or to write whole portions of the CDC emergency preparedness grant application. One respondent remarked, "I was asked to be on the team to review *all* of the focus areas of the application for continuity and clarity. I reviewed and edited the whole 150 pages. I was pretty integral to the development of the package that was delivered."

The participation that Turning Point staff and partners had in this process also had much to do with the planning roles these people already played in their organizations. "We all wear so many hats," said one respondent. "People involved in Turning Point are also involved in BT and infrastructure initiatives. It is hard to separate who is wearing what hat when."

At the same time, Turning Point involvement did not happen in all states. Particularly in the states where Turning Point is housed outside of the state health department, some Turning Point staff or their partnerships had little involvement in the development of preparedness plans. However, even Turning Point staff or partners who had little involvement with the development of the plan or who did not have their work incorporated still took steps to participate in general preparedness. In one of these states, for example, Turning Point staff published a summary of the CDC and HRSA grant proposals in lay language so their partners could understand what was happening and how they might be involved.

The inclusion of Turning Point work

In many of the Turning Point states, products, models, or recommendations by Turning Point partnerships were directly applied to or used in preparedness plans. "[Before September 11, our state plan already] had work groups specifically for emergency preparedness planning," said an interviewee. "Local partners received special training and developed the chapter for the plan. This included looking at the surveillance system, active partnering with community and government agencies, communications, and workforce."

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"In Turning Point, we were focused on the base of the pyramid [public health infrastructure], but with BT funds we are focusing on the next level up. BT is standing on the shoulders of Turning Point work."

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Most of those interviewed felt that the fit between the systems development work of Turning Point and the coordination of the preparedness applications was a natural one and that they were sometimes called on specifically because they could introduce a collaborative model or expertise developed in their Turning Point activities.

Turning Point coordinators and others we interviewed described the strong relationship between bioterrorism preparedness planning and the broader framework of public health system development. Turning Point staff, state staff, and community partners who had major roles in developing their state plans for bioterrorism response were able to influence the contribution of their plans toward building a stronger public health infrastructure.

Many saw the plans for emergency preparedness as an extension of Turning Point work to strengthen the public health system. As a result, many of the preparedness plans included efforts to support and expand the infrastructure activity that Turning Point initiatives were already facilitating. As one respondent said, "In Turning Point, we were focused on the base of the pyramid [public health infrastructure], but with BT funds we are focusing on the next level up. BT is standing on the shoulders of Turning Point work." Another respondent observed that "preparedness provides areas to test out Turning Point activities."

Creative vs. nonproductive tensions

Most of those interviewed described some level of tension—creative and ultimately positive, or largely nonproductive—that came with the infusion of large amounts of money to address emergency preparedness. Six states, for example, described tensions related to addressing the "next bioterrorism event" versus improving the basic public health infrastructure to address not only bioterrorism but a variety of other public health issues. Four states specifically described tensions related to the difference between a "military, top-down" approach versus a "collaborative public health approach." Familiar state-versus-local tensions emerged over distribution of funds, control, input, and involvement, as well as over regional approaches that were resisted in some cases by local public health staff. Struggles over inclusion and control at the state level emerged in ten states. States managed the tensions in various ways—from isolating certain groups to negotiating a middle ground.

Turning Point work has facilitated the development of valuable partnerships, given public health partners' experience and training in planning and collaboration, and has helped communities and public health agencies understand the need for effective public health infrastructure. Many Turning Point staff found that much of this laid the groundwork for effective collaboration when these states had preparedness plans to write and the CDC grant applications to develop.

The Turning Point initiative cannot take full credit for the rapid and effective response to the grant applications, of course. As those interviewed stated, work based on effective partnerships cannot be pinned to a single factor or program for its success. What the Turning Point initiative can claim in these states, though, according to those interviewed, is that it influenced the way people think about and see the role of public health, helped establish new partnerships, and gave people practice in working successfully together.

Betty Bekemeier is deputy director of the Turning Point National Program Office. Jan Dahl is a senior consultant.

Turning Point Member Profile

Gregory Nycz

Gregory (Greg) Nycz, is one of the Turning Point Initiative's collaborative leaders. He is also the director of Health Policy at Marshfield Clinic, a large not-for-profit regional health system in north central Wisconsin, and the director of Family Health Center of Marshfield, Inc., a community health center serving vulnerable populations. He possesses the ability to translate the complexities of public health science into practice in ways that enable people and communities to understand, embrace, and appreciate the value of what the public health system has done, is doing, and can do to protect and promote the health of the public.

Greg is a "master gardener" on many dimensions. To till the soil—whether that soil is a large backyard garden, a family, an organization, or the soil of Wisconsin's public health system—requires education, experience, dedication, and focus. Greg has all of these.

Greg's backyard garden is a celebration of diversity with domestic and international selections including over 160 varieties of hot and sweet peppers and dozens of varieties of potatoes, garlic, and shallots.

He and his wife Grace, a sixth grade teacher, created a nurturing environment for their two children, now 23 and 21, to develop into contributors to society. His wife describes him as "passionate about his work and his hobbies and always doing everything to the fullest extreme."

As a gardener of communities and organizations, Greg's far-reaching leadership roles include grant/program administration in areas such as mental health, primary health care, rural health, and immunization capacity building. He is a prolific publisher, public speaker, and recipient of many awards. In 1997 he was a U.S. Public Health Service Primary Care Policy Fellow.

Finally, as a gardener in the state soils, Greg has served since 1998 as a sustained partner, policy leader, advocate, and activist in the transformation of Wisconsin's public health system. He has been appointed to the Turning Point Transformation Team and the Executive Committee. He models integrity and collaborative leadership in word and deed. He has also led the development of a 10-year implementation plan for one of five infrastructure priorities entitled "Community Health Improvement Processes and Plans." This lays the groundwork for systemic change at the local and statewide public health system levels. As a result of his work and our public health system partners, a full-scale public health system transformational framework, "Healthiest Wisconsin 2010: A Partnership Plan to Improve the Health of the Public," has been created. This framework represents the architecture for Wisconsin's state health plan that was required by the legislature.

Careful tilling and planting by Greg and our diverse partners has readied Wisconsin's fertile soil for a harvest of good health under a strong public health system.

Nominate a Turning Point member to be profiled in a future issue.
Email us at turnpt@u.washington.edu

Bioterrorism Exercises Reveal State Preparedness Needs

Jerry Street

Planning a response to terrorist activity requires a shift in the way we look at potential problems.

The terrorist attacks on September 11, 2001, and the following anthrax incidents changed the definitions of both emergency management and public health and plunged the two fields into a new world. Prior to these events, terrorism was not even on the radar screen for many local public officials. Not so for the policy makers in Jefferson County, Oregon.

In June 2001, as the director of Health and Human Services in Jefferson County, Oregon, I recommended that Emergency Management be part of my department. With a combined 20 years of experience in local public health and emergency management, I believed that the two fields needed to be more connected. County law enforcement and fire representatives supported my recommendation to the local Board of Commissioners. Even with this foresight, three months later I found I had gravely underestimated the critical importance of that connection.

In our new reality public safety and public health officials realize they are now expected to work in areas outside their current expertise. They have to think about and plan for scenarios that a year ago would have been considered unthinkable. Local officials did not have a manual, class, or course that described what they needed to do. Now we needed to develop them.

Exercises in response

In Oregon, state and local public leaders partnered to address emergency preparedness, including an emergency exercise program. The state's Department of Human Services (DHS) Public Health Preparedness Program (PHPP) has developed several exercises for counties to use in developing, evaluating, and revising their public health emergency readiness. The Office of Emergency Management (OEM) provides technical assistance and some financial support for counties conducting preparedness exercises. Within the next year DHS-PHPP will facilitate a statewide preparedness exercise. In this exercise state and local agencies will test the statewide capability to bring together state and local first responders, as well as the public safety, public health, and medical communities in response to a bioterrorism (BT) event.

Every county in Oregon has an all-hazards plan that could address a BT event. Sixty percent have a separate annex or response process for a BT event. To date, 10 of the 36 counties have conducted some sort of BT exercise, many with assistance from different programs and agencies in the state. These exercises are simulations of BT events designed to test a county's emergency plan and its readiness to implement that plan. Conducting a BT exercise, whether a "tabletop" or a functional exercise, is a complex, time-consuming task and varies greatly from county to county depending on the local players, the size of the community, and the local political philosophy regarding the importance of planning.

Although the experience varies by jurisdiction, counties unanimously report that the exercise was an extremely

useful and enlightening experience. (*See "Three Different BT Exercise Experiences."*)

Lessons learned

Although there were major differences in the types of exercises, participants, community sizes, and to a large extent community cultures, the lessons learned shared a number of similarities.

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Three Different BT Exercise Experiences

Three emergency managers who facilitated exercises—from a metropolitan, a regional and a rural area—comment on their experiences.

Metropolitan Experience

Ruth Obadal, planning chief from Lane County, coordinated a BT exercise with the city of Eugene using a nerve gas as the causative agent. Participants included representatives from the hazardous materials response team, emergency management, local hospitals, local law enforcement, ambulance providers, local fire departments, public health department, directors of departments from the City of Eugene, and the city manager. According to Ms. Obadal, one of the mistakes they made was identifying the agent before the event. She said, "It made the response personnel much more cautious than they would have otherwise been." She felt more gaps would have been identified if the participants had been required to make more assumptions as the exercise evolved.

Regional Experience

Matthew Marmor, deputy emergency program manager for Wallowa County, coordinated a regional exercise with the Department of Agriculture, the Forest Service, and Union and Baker counties. The causative agent for their exercise was foot-and-mouth disease. They started with a tabletop exercise and followed it with a more detailed functional exercise. The participants in their exercises included representatives from public health, agriculture extension, Board of Commissioners, transportation, public works, fire, law enforcement, emergency medical services, and community livestock farmers. Mr. Marmor reported, "Planning at the regional level is different from planning at the local level." One of the major lessons was that what happens in one county has implications for nearby counties because of movement of the causative agent or vector (in this case, cattle).

Rural Experience

Susan Fuller, emergency coordinator for Jefferson County, described their rural event as "progressive," starting with a tabletop exercise with plague as the causative agent, followed by a functional exercise using a smallpox scenario. The participants were similar for both exercises and included representatives from the local hospital, law enforcement, fire, emergency medical services, public health, school district, dispatch, tribal health, tribal fire, and tribal law enforcement. Ms. Fuller reported, "This was the first exercise the participants could remember in the county. We identified the need for more community involvement and more planning."

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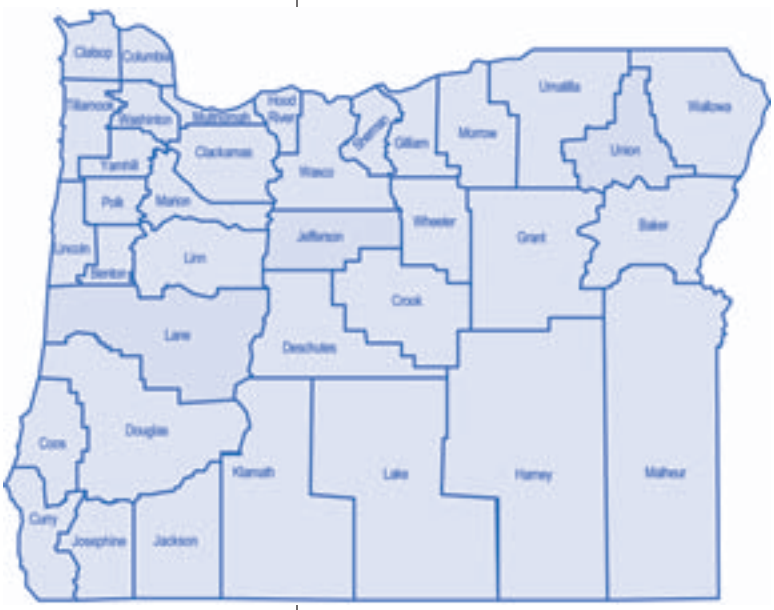
In a BT event, because the partners involved cover a much wider scope of the community than in other types of emergencies, communication challenges are increased.

It is difficult for many emergency agency representatives to grasp the concept of fighting something that you cannot see and that must be identified using the principles of epidemiology. The public health partners need to be prepared to give a simple explanation of their tools and what to realistically expect in an actual BT emergency, including the fact that a BT event will probably be very complex and require a great amount of planning time and effort.



Oregon counties

The response to a BT incident is a community-wide activity, and community organizations that may not be included in a typical emergency planning exercise need to be included as partners in the BT exercise. Local partners that must be involved in a BT exercise include local and regional hospitals, the medical community, the agricultural community, veterans, transportation representatives, school representatives, the Red Cross, and partners from surrounding communities, in addition to the normal emergency agencies such as police, sheriff, ambulance providers, dispatch, fire, and public works.

A BT event will probably develop more slowly and last longer than a general emergency. It could be days or weeks after the actual initial exposure before it is even recognized as a BT event. The responding agencies need to be prepared for a long-term response and one that will have no clear end—no embers cool to the touch.

Most public health responders do not understand the Incident Command System (ICS) or Emergency Operations Center (EOC) systems that are universally used by public safety to manage an emergency event. Public health administrators and staff need to be trained in these emergency management tools.

Planning for a response to terrorist activity requires a shift in the way we look at potential problems. We must think about and prepare for what we considered unthinkable before September 11. We need to learn to look at issues from the perspective of terrorists if we are to prepare for what they might do. For many this is an uncomfortable exercise and a difficult challenge, but one in which we must be successful if we are to be effective in fulfilling our public health roles and responsibilities.

Jerry Street is director of Health and Human Services in Jefferson County, Oregon.

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.

Policy Statement

Bioterrorism funds should go mostly to large metro areas rather than be distributed evenly to all areas of a state.

Responses

Last fall demonstrated that no matter where a bioterrorism (BT) event starts the resources of every local public health agency—metropolitan and rural—will be focused on the local response. A BT event will not be limited by geographical or jurisdictional boundaries and an effective "response system" must include local coordination and communication to ensure rapid detection and response. Public health history has repeatedly shown that local agencies' surveillance and response is the most efficient way, and many times the only way, to stop the spread of communicable diseases.

If most of the BT funding goes to large metro areas, the rural and smaller urban communities will not be given the capacity to ensure early detection and response. With our highly mobile society the contagion will spread from community to community before it can be detected and controlled. As a result, disease will become geographically widespread, take longer to control, cause increased morbidity and mortality, and have a greater chance of entering new, or reentering previously infected, high population areas. Our "system" will not be responsive to the needs of the state.

Jerry Street
Director, Jefferson County Department of Health and Human Services, Oregon

A funny thing happened on the way to strengthening the infrastructure of public health. After 9/11, the efforts of Frist and Kennedy to support the nation's public health system were transformed into a focused effort to protect our nation against bioterrorism. The good news is a renewed awareness of public health in our country and increased funding; the bad news is yet another narrow categorical funding stream to support public health.

There is hope for the nation's public health system if we take a broader view of homeland security and use this new funding stream to create systems not only to respond to a bioterrorist threat but also to any public health emergency. The sentinel systems designed to quickly detect anthrax exposure can also be used to identify a foodborne outbreak. The advanced training in epidemiology can also be employed to track and analyze chronic disease or injuries in a community.

We need to support the entire public health system in all areas. A rural area may not be a target for anthrax but, like an urban area, will need to quickly respond to a West Nile virus outbreak or other threats to the public's health.

Terry Brandenburg
Health Commissioner, City of West Allis Health Department, Wisconsin

What is your response to today's Policy Statement?
Register your thoughts on this important issue at the Turning Point Web site:
www.turningpointprogram.org

Introducing a new feature in *Transformations*

Your responses will determine if the Policy Corner becomes a continuing feature of *Transformations*. We hope you encourage this discussion of public health policies. Each issue of *Transformations* will contain a new topic and two introductory comments. We encourage readers to contribute to the discussion by visiting our Web site and submitting their respectful and reasoned thoughts. In each subsequent issue of *Transformations,* we will summarize the Web discussion on the previous topic and present a new topic.

Deadline for responses to these comments: November 19, 2002

www.turningpointprogram.org

Supporting Community Collaboration Post-9/11

Marose Quiogue

One year after the terrorist attacks and the collapse of the World Trade Center buildings, the clouds of smoke from the ensuing blaze and dust from pulverized construction materials and other particulates have gone away. However, uncertainty about our environmental, physical, emotional, and mental health conditions remains. At the same time, the effects of the attacks have intensified demand for services while nearly exhausting the resources available to deliver them.

In the year following September 11, Turning Point's spirit of collaboration and community has taken on greater meaning. New York City is fortunate to have a number of groups that build community through collaboration. One such group is the Manhattan Public Health Network. The Network is one of five borough committees for the local Turning Point partner, New York City Public Health Partnership. It contributes to a post-9/11 renewal by regularly bringing together and mobilizing a diverse set of public health stakeholders.

Under the leadership of its coordinator Hemansu Mangal, the Network serves as a hub for brokering information and connections among individuals and organizations working to improve the health and safety of Manhattan residents. The Network's collective goals are to facilitate the networking of Manhattan public health stakeholders; to inform and mobilize public health stakeholders; to engage the community at large as a critical partner in public health planning, programming, and decision-making; and to develop a sustaining plan for the Network.

The Network gathers together assets that can be used by the members, their affiliates, and the larger community. It multiplies opportunities for resource sharing and brings new services to the communities of the Network members.

The Network's membership roster comprises representatives from a wide range of local communities and institutions, such as the American Cancer Society, Children's Defense Fund, Columbia University, William F. Ryan Community Health Center, Community Board 7, Community Board 9, East Harlem Community Health Committee, Manhattan Borough President's Office, New York Academy of Medicine, Northern Manhattan Community Voices Collaborative, and the New York Public Library, to name a few.

Two means of outreach

The Network uses publications (bulletins and newsletters) and meetings to achieve its goals. Network members use weekly bulletins and monthly newsletters to post and gather information about meetings and conferences around town, community events, and employment and funding opportunities. These tools promote community healing of the trauma caused by the 9/11 events by providing a place to share information on community activities to reconnect and rebuild the city's communities. For example, a recent bulletin invited its audience to participate in a community forum giving 5,000 participants an opportunity to consider plans for the redevelopment of Lower Manhattan and the creation of a permanent memorial to the victims of 9/11 ("Listening to the City: Remember and Rebuild," July 2002). The bulletin also encouraged Network members to get involved in the planning for a September 2002 Wellness Month.

The monthly meetings make the Network's collaboration a productive endeavor. Clearly the WTC disaster has affected the dynamics among members, giving these monthly get-togethers a sense of purpose and the members a need to finish each session with tangible results.

A typical meeting (*see box below for a description of one meeting*) is sponsored by one of the members and held at a community location. The agenda includes a guest speaker touching on a topic of interest to New York City residents, followed by a period of member presentations, freewheeling discussions, and networking. Each meeting provides concrete accomplishments and positive results for the participants.

Since the Network's regular monthly meetings began, we see new faces at the table every month. Consequently, new assets, resources, and service opportunities are brought to the Network and, through Network members, to Manhattan's many communities. These meetings have become something the Network participants look forward to because they have been so enriching and productive.

The positive results of the Manhattan Public Health Network's activities contribute to more cohesive New York City communities. Ultimately, the Network's actions to broker information and connections among individuals and organizations are helping, slowly but surely, to make recovery possible.

Marose Quiogue is senior reference librarian for CHOICES in Health Information for the New York Public Library and a member of the Manhattan Public Health Network. To learn more about the Manhattan Public Health Network, contact Hemansu Mangal at HMangalBMC@nyc.rr.com or 917-334-9285.

Networking Meets Many Needs

A description of the May meeting illustrates the many benefits achieved through these meetings.

It is 9:30 A.M. at the Jefferson Market Regional Branch Library auditorium. As people arrive, they are greeted with refreshments and the opportunity for informal networking. Pleasant morning greetings are exchanged before Hemansu Mangal calls the meeting to order. Hemansu lightens up the introductions with an added twist, "Give your name, the institution you are representing, and because we are in the library, the title of your favorite book."

The guest speaker is Glen Pasanen, from City Project, a nonpartisan city budget education group. His presentation gives insight into recent budget proposals and the related implications for Network members and public health activities.

Glen's talk is followed by an announcement from the local American Cancer Society on the availability of free mammography screenings to women with disabilities and non-English-speaking immigrant women. Another member requests assistance in starting a neighborhood vegetable-gardening group. Both the announcement and request are met with a positive response by other network members—a New York Public Library health information librarian connects with the Cancer Society to discuss cancer screening for library patrons, and yet another member offers to connect high school student volunteers to the gardening project.

A few more issues are brought to the table and more brainstorming occurs. When the formal meeting adjourns, most participants do not leave, but continue their discussion and resource exchange.

Understanding Employers' Perspectives on Health

By Jeff Wilson

Economic prosperity and improved health are clearly linked. Let's face it—those with financial means have better access to health care services and can afford to devote time and resources to health promotion activities. However, if it is so obvious that prevention and wellness programs reduce health care utilization costs and improve productivity, why don't more businesses, especially in this time of double-digit health care inflation, invest in the health of their employees?

To find an answer to this question, the Virginia Center for Healthy Communities recently hosted a business roundtable event entitled "The Impact of Good Health on Your Bottom Line." The Center believes employers' perspectives are critical if we are to encourage their participation and seek their support for community health improvement activities. During the roundtable, eight diverse employers engaged in a highly interactive discussion about their experiences related to recent trends in health care coverage and expenditures, the effect of and incentives for employer-sponsored employee wellness programs and other prevention activities, and the incentives participants felt were important to encourage employers to engage in health improvement strategies.

What Business Leaders Said

- When employees talk about the cost of benefits, they're usually thinking of copayments. Consumers are shielded from the real costs in a variety of ways. It's easy for them to think of extra tests, for example, as a "free lunch" since they're covered. They don't realize that in the end someone's paying for it, either the individual, through a reduction in health benefits, or the employer, through higher costs. The public needs good clinical information that they can understand and that helps them be prudent buyers.
- We need to start changing the cultural mind-set of people. We're trying to swim upstream in a culture that isn't geared toward wellness and health improvement. The whole model has to change. As a culture, we need to begin accepting that the health improvement strategy comes first. This will not work as some type of nice adjunct or add-on that we can put on a sick care system.
- Employers have found that even by offering financial incentives or time off for employees to go through a health awareness program, the healthier people participated, but the others didn't. The challenge is to get unhealthy people to participate.

Report available

The Center plans to use the information gathered at the roundtable to develop programs and services that will provide incentives for the business community to be involved in community health improvement. For a copy of the entire report, "The Impact of Good Health on Your Bottom Line," or for more information about the work of the Virginia Center for Healthy Communities, visit our Web site at www.vahealthycommunities.com.

Jeff Wilson is the Turning Point and Strategic Planning coordinator for the Virginia Department of Health. He also serves as the director of the Virginia Center for Healthy Communities.

Update on Collaboratives

Turning Point's National Excellence Collaboratives are an increasingly prominent feature on the Turning Point landscape. Here are some of the things they are doing.

Public Health Statute Modernization Collaborative

The Collaborative has completed and published an assessment of state public health law, (available on line at www.hss.state.ak.us/dph/deu/turningpoint/PDF%27s/assesment_report.pdf). For a printed copy, contact Patricia Nault at (907) 465-8617 or e-mail a request to patricia_nault@health.state.ak.us. Work continues on drafting a Model State Public Health Statute. The full draft of this model statute will be released in October 2002 for public review and comment. Although the Collaborative was not involved in the CDC-funded drafting of the Model State Emergency Health Powers Act (MSEHPA), the Collaborative's earlier work in planning the emergency powers section of the Model State Public Health Statute served as a basis for the MSEPHA. The Collaborative plans to publish a brief commentary on the Model State Emergency Health Powers Act, providing background and history related to the MSEHPA and describing its relationship to the Model State Public Health Statute.

Leadership Development Collaborative

The Collaborative recently published the proceedings of its April 2001 expert panel of leadership development scholars. It also convened a reactor panel of experts to discuss collaborative leadership in different settings and to comment on what should be included in collaborative leadership curricula. Several elements of the curriculum are already in development. Currently the Collaborative is also developing a feedback tool to assess collaborative leadership skills for individuals and organizations.

Social Marketing Collaborative

The Collaborative is in the process of publishing a literature review and collection of case studies on social marketing. It recently published a set of training materials for public health audiences, *Social Marketing 101.* It also conducted a review of CDCynergy software to evaluate the feasibility of developing a version for a social marketing training tool. It is currently working with the Academy for Educational Development and CDC to develop a new training tool for social marketers based on this software.

Performance Management Collaborative

The Collaborative has made significant progress in defining performance management and developing a conceptual framework for a performance management system. It has published two pieces of analytic work: *Performance Management in Public Health: A Literature Review* and *A Survey of State Public Health Performance Management Practices*. Both documents can be downloaded from the Turning Point Web site. The Collaborative is currently working through its contractor, the Public Health Foundation, on its next product, *From Silos to Systems: Performance Management in Public Health*. This guide will describe a four-pronged approach to managing performance. The four essential elements are: Performance Standards, Performance Measurement, Reporting of Progress, and a Quality Improvement Process. The guide will provide illustrative examples of performance management practices taken from the Collaborative's learning projects and from information in the state survey of performance management practices. The guide will be available in spring 2003.

Information Technology Collaborative

The Collaborative sent a survey to 3000 local health departments across the United States to determine the use of computers and computer programs in health departments. The Collaborative reviewed the preliminary results to determine next steps in August. The purpose of this effort is to acquire information about which programs are most used and most successful at supporting public health efforts. The Collaborative plans to develop best practices for information technology using the results of the survey.

Meet Our New Deputy Director: Betty Bekemeier

The Turning Point National Program Office welcomes Betty Bekemeier as the new deputy director. In third grade Betty wrote the memorable poem, *I wanna be a nurse, and carry a white purse, and wear a white dress, and clean up all the mess.* (More verses followed, but we won't go into that here.) Although Betty *is* a nurse, you will seldom see her in a white dress or carrying a white purse. Her lifelong career passion as an adult has been public health. Public health has its messes to clean up too, however.

Betty brings skills and experience in working with qualitative data as well as with public health practice.The National Program Office is looking forward to having her apply these skills to the mountains of qualitative data that Turning Point has acquired. With Betty's help we plan to use the data to continue to document and communicate the best practices and findings of the Turning Point initiatives.

Although Betty began in this position in May 2002, she is known to Turning Point partners in our Northwest states for her previous role as program manager at the Northwest Center for Public Health Practice. In working at the Northwest Center (which is directed by Turning Point senior consultant Jack Thompson), Betty developed strong relationships with public health practitioners throughout the Northwest. In particular, she helped facilitate collaboration among them and their academic partners who are working on public health workforce development in the region. Her experience with the Northwest Center's HRSA Public Health Training Center and CDC Preparedness Center grants provides a valuable backdrop for working with Turning Point states on public health infrastructure.

Betty has a long history of experience in public health, largely in the local public health practice setting. After getting her start in international health while working in Papua, New Guinea, she did work in field public health nursing, epidemiology, community assessment, environmental health, and local public health management. Betty is a council member of the APHA Public Health Nursing Section and a board member of the Washington State Public Health Association. She also provides editing for a professional journal and does consulting for local public health agencies.

Betty is an avid outdoorswoman, and she is likely to be skiing or white-water kayaking on weekends. She also has dramatic interests. Occasionally, people Betty doesn't know will say she looks familiar and then realize they saw her in her role as Lillian Wald in *Lillian Wald: At Home on Henry Street*. This one-woman play was directed by Betty's mother, and the duo took the play around the Northwest for three years, playing for public health and nursing audiences at conferences and universities.

Welcome to Turning Point, Betty!

University of Washington School of Public Health and Community Medicine

The mission of the University of Washington School of Public Health and Community Medicine is to promote better health, prevent illness and injury, and ensure more efficient and cost-effective health care and public health services, through training, research, service, and evaluation programs.

Site Visit: www.apha.org/ppp/challngfund.htm

Challenge Grants from APHA

Many Turning Point initiatives have developed significant partnerships with their state public health associations. These partnerships may be eligible to apply for Challenge Grants from the American Public Health Association (APHA). For the last several years APHA has made funds available, on a competitive basis, to state Affiliates to conduct priority projects that cannot be funded through existing resources. Last year the APHA Executive Board allocated a total of $20,000 to finance selected projects at $1,000 to $2,500 for a 12-month period. On a case-by-case basis the Executive Board will consider funding projects up to $5,000. Read about the grants awarded last year and watch for an announcement of new grant opportunities on the APHA Web site (www.apha.org/ppp/challngfund.htm).

RWJF Update

Health in America Depends on Strong Public Health Partnerships

"Health in America—The Sum of Its Parts," an editorial in the *Journal of the American Medical Association,* May 22/29, 2002, by J. Michael McGinnis, MD, RWJF senior vice president and director of the Health Group, summarizes the 2002 *JAMA* article "State trends in health risk factors and receipt of clinical preventive services among US adults during the 1990s," by Nelson, Bland, Powell-Griner, et al. In his editorial Dr. McGinnis describes the implications of the findings for public health and the need for stronger public health capacity. "Achieving the best outcome, and achieving it for all, will require stronger public health and stronger partnerships than currently exist, across sectors and across levels. The health of the American people—in the parts and in the whole—depends on it." The full editorial and original article (for-fee) can be found on the *JAMA* Web site (http://jama.ama-assn.org/issues/v287n20/ffull/jed20023.html).

Dates to Note

November 9-13, 2002. American Public Health Association Annual Meeting: Putting the Public Back into Public Health. Philadelphia (www.apha.org)

November 14-17, 2002. International Leadership Association 4th Annual Conference: Bridging Boundaries and Borders in Leadership. Seattle (www.academy.umd.edu/ila/meeting.htm)

May 6-8, 2003. Turning Point Policy Summit. Washington, DC (www.turningpointprogram.org)

October 7-9, 2003. Turning Point State Partnership Grantee Meeting. Location TBA (www.turningpointprogram.org)

November 15-19, 2003. American Public Health Association Annual Meeting: Behavior, Lifestyle and Social Determinants of Health. San Francisco (www.apha.org)

NACCHO

NACCHO is the national organization representing local public health agencies (including city, county, metro, district, and tribal agencies). NACCHO works to support efforts that protect and improve the health of all people and all communities by promoting national policy, developing resources and programs, and supporting effective local public health practice and systems.

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 may 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.

National Program Office

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PRINTED WITH SOY INK

GRAPHIC COMMUNICATIONS INTERNATIONAL UNION GCIU LABEL 1265-M

printed on recycled paper

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