



Turning Point: Collaborating for a New Century in Public Health

An RWJF national program

SUMMARY

Turning Point: Collaborating for a New Century in Public Health, a national program of the Robert Wood Johnson Foundation (RWJF) and the W.K. Kellogg Foundation, defined its mission as to "transform and strengthen the public health system in the United States to make the system more effective, more community-based and more collaborative."

RWJF and the W.K. Kellogg Foundation partnered to support 22 states and 41 local communities in those states in working together to strengthen their public health systems. RWJF also supported five National Excellence Collaboratives that allowed states to work together on important public health infrastructure challenges.

Key Results

According to national program office staff, evaluators from the Public Health Institute, RWJF program officers and the W.K. Kellogg Foundation program director:

- *Turning Point* strengthened the public health infrastructure through state/local partnerships that engaged stakeholders that had not previously been involved with public health activities (e.g., businesses, educators, faith communities and community organizations).
- *Turning Point* contributed to the national movement toward accreditation for state and local health departments.
- *Turning Point* contributed to the expansion and growth of statewide public health institutes.

Key Findings

Evaluators from the Public Health Institute reported the following key findings from the outcomes evaluation of *Turning Point* to RWJF:

- Improved relationships between state and local public health entities have contributed to better use of public health funds, enhanced coordination of emergency response systems and, to a limited extent, improved local input into priority-setting for state health issues.
- Infrastructure changes in the *Turning Point* states have made it easier to recruit public health workers, helped retain the workforce and facilitated the development of leaders.
- Despite many political and funding changes over time, most of the *Turning Point* states were able to sustain the public health system changes they made during the program.

Program Management

The RWJF national program office was located at the School of Public Health and Community Medicine at the University of Washington in Seattle. Bobbie Berkowitz, PhD, RN, FAAN, was the director.

Funding

RWJF's Board of Trustees authorized *Turning Point* in January 1996. RWJF provided \$33 million and the W.K. Kellogg Foundation provided \$17 million for the program from 1996 to 2006.

THE PROBLEM

Public health, according to an Institute of Medicine (IOM) report, is "what we, as a society, do collectively to assure the conditions in which people can be healthy." The public health system engages in "organized community effort to address the public interest in health by applying scientific and technical knowledge to prevent disease and promote health" (*The Future of Public Health*, 1988).

In contrast to medicine, which focuses on one patient at a time, public health is concerned with safeguarding and improving the health of the community as a whole. Public health activities have been responsible for many of the major improvements in the health and longevity of Americans, including control of infectious diseases, safe water and food and a dramatic drop in maternal and infant mortality.

Disarray in the U.S. Public Health System

By 1988, the nation had lost sight of its public health goals, and allowed public health to fall into disarray, according to *The Future of Public Health*.

The report noted that America's public health system was expected to do too much with too few resources. It also stated that capabilities for effective public health actions were inadequate, and the health of the public was "unnecessarily threatened as a result."

The Future of Public Health called states the "central force in public health" and noted that they bore primary public sector responsibility for public health. It also identified weaknesses in the infrastructure of state public health systems, including lack of funding, the need for private sector partners and deficiencies in leadership, data-gathering and data analysis.

Growing public health concerns also had an impact on the discussion. For example, researchers at the U.S. Department of Health and Human Services concluded that only 10 percent of the premature deaths from the nation's 10 leading causes of death in 1990 could have been avoided through improved access to medical care (*Journal of the American Medical Association*, 1993).

By contrast, they attributed 52 percent of the early deaths to personal risk behaviors, such as smoking, poor diet, lack of physical activity and use of alcohol and illicit use of drugs. Environmental risks, such as infectious agents and toxic chemicals, also played a significant role. The study showed that public health has the potential to prevent many early deaths by addressing these factors.

Functions and Essential Services of Public Health

In 1994, the Public Health Functions Steering Committee, which included representatives of the American Public Health Association, the Association of Schools of Public Health, the Association of State and Territorial Health Officials, the U.S. Public Health Service and others, identified six specific functions of public health and 10 essential public health services.

The six functions of public health are to:

- Prevent epidemics and the spread of disease.
- Protect against environmental hazards.
- Prevent injuries.
- Promote and encourage healthy behaviors.
- Respond to disasters and assist communities in recovery.

- Assure the quality and accessibility of health services.

The 10 essential public health services are to:

- Monitor health status to identify and solve community health problems.
- Diagnose and investigate health problems and health hazards in the community.
- Inform, educate and empower people about health issues.
- Mobilize community partnerships and action to identify and solve health problems.
- Develop policies and plans that support individual and community health efforts.
- Enforce laws and regulations that protect health and ensure safety.
- Link people to needed personal health services and assure the provision of health care when otherwise unavailable.
- Assure a competent public health and personal health care workforce.
- Evaluate effectiveness, accessibility and quality of personal and population-based health services.
- Conduct research to gain new insights and identify innovative solutions to health problems.

Actors in Public Health

Government public health agencies—at the federal, state and local levels—are the backbone of the nation's public health system. They work in partnership with health care providers, employers, private insurers, consumers, academics and others in the private and not-for-profit sectors.

Public Health at the Federal Level

At the federal level, the Public Health Service, part of the U.S. Department of Health and Human Services, is involved with a wide range of public health activities from research and training to primary care and health protection.

Key players in public health include the Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA):

- CDC works with states and other partners to provide a health surveillance system to monitor and prevent disease outbreaks and maintain national health statistics. The agency also provides immunization services, supports research into disease and injury prevention and guards against disease transmission across international borders.
- HRSA is the primary federal agency for improving access to health care services for [medically underserved populations](#), including funding community health centers and

primary care programs for uninsured populations, people who are homeless and residents of public housing.

Many other government agencies operate programs with an impact on public health, including the Agency for Healthcare Research and Quality, Centers for Medicare & Medicaid Services, Food and Drug Administration, Indian Health Service, National Institutes of Health and Substance Abuse and Mental Health Services Administration.

Federal grants help fund public health services at the state and local levels, with most funding going to the states.

Public Health at the State Level

The U.S. Constitution gives the states the power and duty to safeguard the health of their citizens. Each state has an official state health agency. According to the book *Public Health: What It Is and How It Works* (2001), about two-thirds of the states have freestanding public health agencies and about one-third place their public health agencies within a multipurpose health or human services agency.

Typically, more than 20 other agencies within a state—ranging from the department of aging to the state board of education and the fire marshal—also have some degree of public health responsibilities. This fragmentation creates challenges for official state health agencies.

While public health services in each state vary considerably, the most frequent essential services provided in the mid-1990s included:

- Enforcing laws.
- Monitoring health status.
- Diagnosing and investigating health hazards.
- Informing and educating the public.

Public Health at the Local Level

Local health agencies are "where the rubber meets the road," according to *Public Health: What It Is and How It Works*. "These agencies are established to carry out the critical public health responsibilities embodied in state laws and local ordinances and to meet other needs and expectations of their communities."

States retain significant authority and share responsibilities with local entities. Most often, local government forms and manages its own local health agency or board of health. Alternatively, the state may operate local health agencies directly, or provide services locally.

A local public health agency serves one or several counties, a unified city-county, a city, a town or some other governmental unit. The number of local health agencies varies widely among the states. For example, *Public Health: What It Is and How It Works* noted that in 1993, Rhode Island had no local health agencies while Connecticut and Massachusetts each had more than 100 local health agencies.

The services available through local public health agencies vary considerably but typically include:

- Communicable disease control programs.
- Immunizations and health screenings.
- [Epidemiological](#) surveillance and community health assessments.
- Sexually transmitted disease counseling and testing.
- Primary care services.

CONTEXT

In 1990, RWJF set assuring that all Americans have access to basic health care as one of three new goals. Advancing public health was one strategy to accomplish this objective.

Early RWJF national programs to improve the public's health were one-time responses to specific challenges in public health. They focused on:

- Strengthening the capacity of city health departments to provide primary care (*Municipal Health Services Program*).
- Developing immunization tracking systems (see [Program Results Report](#) on *All Kids Count*).
- Combating tuberculosis (see [Program Results Report](#) on *Old Disease, New Challenge*).
- Combating AIDS (*AIDS Health Services Program and AIDS Prevention and Service Projects*. See RWJF Anthology [chapter](#) on RWJF's AIDS programs).

By the mid-1990s, members of RWJF's Public Health Team believed that the time was right for a strategic public health initiative to strengthen the public health infrastructure. Health care providers had an economic interest in promoting good health and health care leaders had begun to advocate for public health. Although state budgets were somewhat unstable, more flexible federal funding was available for public health.

A working group led by Nancy Kaufman, RN, MS, then a vice president at RWJF, and Marilyn Aguirre-Molina, EdD, a senior program officer, began meeting to devise ways to help modernize and strengthen state public health departments.

At about the same time, the [W.K. Kellogg Foundation](#) was exploring ways to strengthen local public health departments. The Kellogg Foundation's health programming in the United States focuses on improving individual and community health, and improving access to and the quality of health care.

Staff from RWJF and the Kellogg Foundation learned that they were working toward similar goals at a November 1996 retreat held for a small group of public health leaders in connection with activities of the Institute of Medicine (IOM). Recognizing that revitalizing the public health system would require states and communities to work together, the two foundations decided to jointly sponsor a program that became *Turning Point: Collaborating for a New Century in Public Health*.

Around the same time, RWJF began to support work to strengthen the public health profession, launching two major efforts in 1997, one in 1998 and one in 1999:

- *Public Health Pipeline: The Future Generation of Public Health Professionals*, a \$2 million national program to build the capacity of educational systems to improve science education for students in grades six through nine. For more information, see [Program Results Report](#).
- Cooperative Actions for Health Program, a \$1.1 million initiative to support 19 state and local collaborative projects by state and local medical societies and public health associations. The American Medical Association and American Public Health Association jointly managed the program. For more information, see [Program Results Report](#) on the initiative and [Program Results Report](#) on publications about public health and medicine collaborations.
- *State Health Leadership Initiative*, launched in 1998 and running to May 2010, is a \$9.4 million program, directed by the Association of State and Territorial Health Officials (ASTHO) to accelerate the development of leadership capacity of state health officers as policy-makers, administrators and advocates for the health of the public.
- Management Academy for Public Health at the School of Public Health and the Kenan-Flagler Business School of the University of North Carolina at Chapel Hill was supported by \$2.8 million in grants from RWJF (ID# 033489), the W.K. Kellogg Foundation, the federal Health Resources and Services Administration and the Centers for Disease Control and Prevention. From 1999 to 2003 the academy enrolled 639 public health managers, of whom 593 graduated. See [Program Results Report](#) for more information.

RWJF has also supported many other projects in public health in recent years, including assistance to national organizations, bioterrorism preparedness, an Institute of Medicine report on public health and dialogue between medical and public health schools.

With grant funds, for example:

- The *Medicine/Public Health Initiative* nurtured partnerships between the public health and medical communities at the state and local levels from 1996 to 1999. For more information, see [Program Results Report](#).
- The National Association of County and City Health Officials surveyed local public health agencies across the country in 1999 to profile local public health infrastructure. For more information, see [Program Results Report](#).
- From 1998 to 2003, *Public Health Pipeline: The Future Generation of Public Health Professionals* supported efforts to improve science education during the middle-school years. For more information, see [Program Results Report](#).
- A 2003 conference, jointly sponsored by the American Society of Law, Medicine and Ethics and the Centers for Disease Control and Prevention, focused on strengthening the use of law as a foundation for public health practice. For more information, see [Program Results Report](#).
- From 2003–04, the Public Health Foundation created a nationwide Web-based clearinghouse to provide information to public health professionals about continuing education opportunities. For more information, see [Program Results Report](#).
- A Rand Corp., white paper, *Quality Improvement in Public Health: A Way Forward*, published in 2006, suggested ways to speed the integration of quality improvement into public health practice. For more information, see [Program Results Report](#).

PROGRAM DESIGN

In 1996, RWJF and the Kellogg Foundation launched *Turning Point: Collaborating for a New Century in Public Health*. *Turning Point's* defined mission was to "transform and strengthen the public health system in the United States to make the system more effective, more community-based and more collaborative."

The program provided support to states (with RWJF funding) and local communities (with Kellogg funding) to improve their public health functions through strategic development and implementation processes.

RWJF and Kellogg collaborated closely, including issuing a joint call for letters of intent. The two foundations expected public health agencies within states and local communities to accomplish their goals by developing collaborative partnerships with each other and with other state and local health agencies, schools of public health, the business community, health maintenance organizations (HMOs), hospitals, community and environmental organizations and faith-based groups.

Once the partnership structure was in place, the partners were expected to develop and implement strategic plans at the state and local levels to:

- Address public health challenges.
- Restructure public health agencies, where appropriate.
- Evaluate the use of technology.
- Analyze financial and human resources.
- Implement local plans as directed by local and state priorities.

Each state, and as many local public health partnerships as desired, could submit one application.

When *Turning Point* started, RWJF expected to provide 15 to 20 states with two-year planning grants of up to \$300,000, each staggered over a six-year period. RWJF planned to consider implementation grants, and funding to add more states, later in the program. Kellogg planned to fund up to 60 local health partnerships in the same states with combined planning and implementation grants of up to \$60,000 for two or three years.

RWJF and Kellogg expected states and their local partnerships to obtain additional financial and in-kind resources to develop and implement their plans.

THE PROGRAM

With a total of \$50 million, RWJF and Kellogg collaborated to create the largest privately funded effort to strengthen the public health system in the nation's history. RWJF contributed \$33 million (including grants outside its authorization for the program), and Kellogg contributed \$17 million to *Turning Point*.

Administration

Since *Turning Point* was such a large program, RWJF and Kellogg each established a national program office. RWJF established its office at the University of Washington's School of Public Health and Community Medicine in Seattle. The Kellogg national program office was located at the National Association of County and City Health Officials (NACCHO) in Washington, D.C.

Bobbie Berkowitz, PhD, RN, FAAN, alumni endowed professor of nursing and director of the Center for the Advancement of Health Disparities Research at the University of Washington School of Nursing, served as director of the RWJF national program office during most of *Turning Point's* existence.

Gilbert S. Omenn, MD, PhD, dean of the School of Public Health and Community Medicine, University of Washington, Seattle, was director for part of the first year, while Berkowitz was deputy director. The other deputy directors were Jan Dahl, RN, MA, (1998–2001) and Betty Bekemeier, PhD, MPH, RN, assistant professor in the School of Nursing (2001–2006). Vincent Lafronza, EdD, MS, headed up Kellogg's national program office.

A coordinating council, comprised of representatives of RWJF, Kellogg and both national program offices, met regularly to coordinate the program. See [Appendix 1](#) for a list of members.

Staff from the two national program offices had a "very close working partnership," according to Berkowitz. "Our primary responsibility was for the states and NACCHO's primary responsibility was for the communities, but in reality, we all worked jointly on the states and communities."

A national advisory committee provided guidance, primarily on site selection. For a list of members, see [Appendix 2](#).

The RWJF national program office provided extensive technical assistance to the participating states, including:

- One or two site visits to each state every year and regular individual and group conference calls.
- Two grantee meetings every year to share successful strategies, discuss challenges and access resources, including training. These meetings also enabled participating public health professionals to develop a network of colleagues.
- Creating National Excellence Collaboratives in 1999, which enabled states to work together to analyze and address public health system infrastructure challenges. For more information, see [Program Evolution: National Excellence Collaboratives](#) and [National Excellence Collaborative Results](#).
- Supporting statewide public health agendas by:
 - Disseminating the health improvement plans that each state prepared during the planning phase.
 - Disseminating information about *Turning Point*.
 - Training and supporting government officials at two grantee meetings every year.

The national program office also collaborated with the major funders and stakeholders in public health. Early in *Turning Point*, the collaboration was informal. After the national program office created the National Excellence Collaboratives, staff established formal

partnerships with national partners that advised the national program office, and participated in grantee meetings and the collaboratives. The national partners were:

- [American Public Health Association](#)
- [Association of State and Territorial Health Officials](#)
- [Centers for Disease Control and Prevention](#)
- [National Association of Local Boards of Health](#)
- [Public Health Foundation](#).

The Centers for Disease Control and Prevention stationed an employee from its Office of the Chief of Public Health Practice at RWJF's national program office to serve as an expert advisor to several collaboratives.

The Planning Phase

In November 1996, RWJF and Kellogg sent out their joint call for letters of intent. In late 1997, RWJF awarded two-year planning grants averaging \$300,000 to 14 states. RWJF awarded planning grants to seven more states in 1999 and 2000, and to an additional one in 2002.

Kellogg provided \$9.8 million in grant funds to its national program office at the National Association of County and City Health Officials in late 1997. NACCHO distributed a total of \$2.46 million in three-year planning and implementation grants of up to \$60,000 (\$20,000 per year) to 41 communities in these same states.

See [Appendix 3](#) for a summary of all RWJF and Kellogg *Turning Point* grants. For contact information about the RWJF grantees, see the list of projects in [Appendix 4](#).

Most of this report focuses on the RWJF-funded work of the states under *Turning Point*, with some additional information provided about the Kellogg-funded local public health partnerships.

During the planning period, the states:

- Assessed their public health systems and the strategies required to address the gaps in system capacity.
- Submitted to RWJF public health improvement plans with specific goals.
- Identified their highest-priority public health infrastructure strategy.

Common Strategies

Creating public health improvement plans enabled states to make a credible and in-depth case for their individual needs. Strategies varied, but the most common ones focused on:

- **Developing and improving local public health capacity.** For example:
 - *Louisiana* planned to expand access to, and quality of, health care for people living in rural areas through statewide forums and learning communities, public health assessments, documenting and promoting public health practices, collaborative leadership training and a marketing campaign.
 - *Maine* planned to create local health districts to cover the entire state. These districts were to create a framework that would guide local public health services and coordinate existing services.
 - *Nebraska* planned to expand the number of local public health departments to cover everyone in the state.
- **Eliminating health disparities.** For example:
 - *Colorado* planned to support the development of organizations that would work to eliminate health disparities and to train leaders from communities that were experiencing health disparities.
 - *Kansas* planned to develop a new data system to identify and track health disparities.
- **Improving data systems, with the primary focus on developing integrated systems and making existing data accessible locally.** For example:
 - *Alaska* planned to create a public health information system by combining existing information from state, local, tribal, public sector, private sector and nonprofit organizations.
- **Developing technical assistance, education and training models focused on building local capacity.** For example:
 - *Montana* planned to establish a public health training institute for state and local public health personnel.

The Implementation Phase

In October 1999, the RWJF Board of Trustees authorized an additional \$15 million over six years to implement *Turning Point* and to establish [National Excellence Collaboratives](#).

In March 2000, RWJF awarded four-year implementation grants of up to \$500,000 to 13 of the 14 states that had received planning grants in the first round of funding. New

Mexico, where state and local agencies had difficulty cooperating effectively, did not receive an implementation grant. In 2001, RWJF awarded implementation grants to the seven states that received the second round of planning grants.

States could also participate in up to two National Excellence Collaboratives. They received additional funding of up to \$150,000 for each National Excellence Collaborative in which they participated.

To encourage long-term sustainability, RWJF required both the states that received implementation grants and the collaboratives to obtain a 25 percent match of some combination of funding and/or in-kind support.

Implementation Activities

Each state, working with its local partners, began to implement the highest priority public health infrastructure strategy identified in its health improvement plan. As they secured additional funding and recognized other opportunities, the states were able to expand their activities. "These things had a way of changing, for the better," said Berkowitz. "We encouraged the states to be creative and innovative and to listen to their partners."

Turning Point brought state agencies together with local health care providers, businesses, educators, faith communities, community organizations, representatives of criminal justice and others to collaborate on improving the public's health. Ultimately, they focused on:

- Developing the public health workforce.
- Building public health infrastructure.
- Creating tools to improve public health practice.
- Developing ways to eliminate health disparities.
- Leveraging resources for public health.

Kellogg's Participation Winds Down

Kellogg's participation in *Turning Point* was winding down when RWJF awarded its implementation grants. In late 1998, Kellogg informed its grantees that it would not continue to participate in *Turning Point* beyond its initial \$17 million commitment. Kellogg gave additional three-year grants (2000 to 2002) of up to \$100,000 to 17 of its original 41 grantees to complete their activities.

Total Kellogg funding for *Turning Point* was distributed as follows:

- \$4.16 million in grants to the local partnership sites.

- \$5.64 million to the National Association of County and City Health Officials (NACCHO) to manage Kellogg's national program office.
- \$7.2 million to the Lewin Group, as partial support for an evaluation, and to other grantees (including the Center for the Advancement Collaborative Strategies in Health, New York Academy of Medicine and the University of Medicine and Dentistry of New Jersey) to support the program.

After Kellogg funding ended, RWJF maintained the program's premise of state and local partnerships working together. During the implementation phase, RWJF provided extra funds to allow the original 13 state-level grantees to continue to work with their community partners. There was no comparable funding at the community level for the second round of state grantees.

"We continued to see the communities as an integral part of *Turning Point*," said Berkowitz. "We paid closer attention to what was going on with the communities."

The National Association of County and City Health Officials remained involved with *Turning Point* after Kellogg funding ended. Staff members worked with the RWJF national program office and the local partnerships, although with less intensity. "We saw them as a partner right through to the end," said Berkowitz. "They continued to support the local communities."

Program Evolution: The National Excellence Collaboratives

Recognizing that many states faced common challenges, RWJF and the *Turning Point* national program office decided to create an opportunity for states to tackle specific public health system infrastructure challenges together. Staff at RWJF and the national program office identified these challenges through site visits, meetings of representatives of the grantee organizations and reports from the grantee states—as well as through feedback from representatives of other states who attended meetings.

As they pursued their implementation activities, the states could also participate in up to two RWJF-funded National Excellence Collaboratives and apply to lead one. The lead state convened the collaborative and served as a liaison with the national program office and consultants. Five to eight states participated in each collaborative:

- **Information Technology:** Focused on using information technology to collect, analyze and disseminate information, improve data access and community participation in public health decisions and enhance the performance of the public health system. Oklahoma led the collaborative.
- **Leadership Development:** Focused on increasing collaborative leadership capacity at all levels of public health practice. Minnesota led the collaborative.

- **Performance Management:** Focused on developing performance measurements to help set goals, prioritize resources, inform managers and report success. Illinois led the collaborative.
- **Public Health Statute Modernization:** Focused on developing tools to help state and local governments assess and update their existing public health laws to address the range of public health issues. Alaska led the collaborative.
- **Social Marketing** (the use of marketing principles to achieve a social good): Focused on promoting the application of social marketing principles and practices to improve public health service delivery. New York led the collaborative.

Each National Excellence Collaborative:

- Reviewed the literature in the field and examined public health practice.
- Built an innovative practice model based on the literature review. For example, the [Information Technology National Excellence Collaborative](#) created a catalog describing the software used by public health agencies and the purpose for which it is used.
- Tested and disseminated the practice model. For example, the [Performance Management National Excellence Collaborative](#) distributed a guidebook, a toolkit and case studies on performance management.
- Recommended policies that would support the adoption of best practices. For example, North Carolina, a member of the Social Marketing National Excellence Collaborative, built coalitions, trained staff and took other steps to institutionalize social marketing.

Members of the collaboratives participated in monthly conference calls and meetings that were held at least twice a year. A staff member from the national program office provided technical assistance and other support.

See [Appendix 5](#) for a complete list of the states and other partners participating in each collaborative. See [National Excellence Collaborative Results](#) for accomplishments of the collaboratives.

Special Program Elements

As part of the *Turning Point* initiative, RWJF established a special opportunities fund at the national program office to support special studies and customize technical support in selected states from 1999 to 2002 (ID#s 036428 and 038912).

RWJF made a number of special grants in order to learn more about what is needed to improve public health, to follow trends in the field and to monitor relevant legislative activities:

- [Kirby Marketing Solutions](#), in Solana Beach, Calif., planned an impact and transition meeting (December 16–17, 2003 at RWJF), which brought together 70 public health leaders to discuss and evaluate the ideas, models and best practices generated during *Turning Point* (ID# 049093).
- Kirby Marketing Solutions conducted marketing research to help improve the dissemination of lessons from *Turning Point* and increase the projects' sustainability (ID# 053347). As part of that research, Kirby staff interviewed 11 key opinion leaders and used these data to design an online survey.

Fielded in September 2006, the survey generated responses from 156 public health professionals, including *Turning Point* participants. Respondents identified five topics, in rank order, that they considered of prime importance to improve public health:

- Performance management/accountability
- Marketing public health systems
- Social marketing principles
- Integrating nontraditional partners into public health systems
- Collaborative leadership.

Survey participants indicated that expert technical assistance, how-to kits and knowledge management were resources of primary interest, whereas face-to-face meetings and peer-to-peer technical assistance were not. They were eager for opportunities to share success stories.

- From 1996 to 1998, the [Association of State and Territorial Health Officials](#) in headquartered in Alexandria, Va., advised RWJF on state-level activities, trends and challenges in public health and promoted *Turning Point* among association members (ID# 030095).
- Researchers conducted two complementary projects, beginning in 2005, to assess the impact of the *Turning Point* Model State Public Health Act, a comprehensive model statute developed by the Public Health Statute Modernization National Excellence collaborative. For more information, see [National Excellence Collaborative Results](#).
 - Researchers at the [Centers for Law and the Public's Health](#), a joint program of Johns Hopkins University and Georgetown University, monitored state public health legislative activity to assess public health laws and regulations related in part or whole to the *Turning Point* Model State Public Health Act (ID# 055379).
 - Researchers at Columbia University's Center for Health Policy focused on documenting changes in public health practice and health outcomes as a result of state laws influenced by the *Turning Point* Model State Public Health Act (ID# 055377, ending August 2008).

Columbia researchers developed a model for ongoing data collection and analysis and wrote case studies on Alaska, Nebraska, South Carolina and Wisconsin. They published an article comparing state public health law reform in Alaska and South Carolina in *Public Health Reports* (2007).

Linking With Other States

The national program office provided technical assistance to existing initiatives in New Jersey and California and invited their representatives to *Turning Point* grantee meetings.

New Jersey was receiving separate RWJF funding through *New Jersey Health Initiatives* (ID# 035112). (Grants through RWJF's i program support innovative approaches to health and health care needs in RWJF's home state.) This grant supported a joint initiative of the Medical Society of New Jersey and the N.J. Department of Health and Senior Services to form Public Health C.A.R.E. (Crafting A Restructured Environment), a public/private partnership to restructure the delivery of public health services in New Jersey.

California's Partnership for Public's Health program, funded by the California Endowment, was similar to *Turning Point* but had a local focus.

Collaboration Between RWJF and Kellogg

The partnership between RWJF and Kellogg on *Turning Point* was unusual for both foundations.

"We were better known for state and system work. Kellogg had more experience in community-oriented work. Both entities are important in the public health infrastructure," said Susan B. Hassmiller, PhD, RN, FAAN, RWJF program officer for *Turning Point*. "Together, we brought visibility to the fact that it takes both state and local entities working together to improve public health."

Although collaborations among national foundations seem to make sense, they can be difficult to establish and maintain. *Turning Point* was no exception.

RWJF and Kellogg Work Through Their Differences

RWJF and Kellogg faced challenges as they worked together on *Turning Point*, but staff from both foundations felt the partnership enriched the program, and they persevered through the difficulties. Staff at RWJF and Kellogg had some initial concerns about combining state and local partnerships in *Turning Point*. By keeping the state and local elements separate, for the most part, they were able to address these concerns. Each foundation established its own national program office, while a coordinating council provided overall guidance.

Cultural differences between RWJF and Kellogg quickly became apparent. "The two foundations have fundamentally different values," said Berkowitz. "Kellogg is a community-oriented, grassroots kind of organization really interested in the community. Robert Wood Johnson Foundation is more large-scale [and] systems-oriented, and interested in having a major impact nationally." Throughout *Turning Point*, these differences showed up in discussions about expectations for grantees, the call for letters of intent, selection of sites and program funding and evaluation.

RWJF is more precise about what it expects of potential grantees, whereas Kellogg is more responsive to community desires. For RWJF, a call for proposals is a detailed, carefully prepared document based upon research in the field and outlining program expectations. At Kellogg, a call for proposals is more of an announcement asking the field for ideas. RWJF and Kellogg compromised on the *Turning Point* call for letters of intent, which included the program's goal and certain expected outcomes but was not as detailed as other RWJF call for proposals.

During site selection, RWJF was more focused on achieving a national impact, while Kellogg wanted to ensure diversity among the states and the communities within them. Again, staff compromised in selecting sites in order to satisfy the concerns of both foundations.

Despite these fundamental differences in values and operating styles, staff members at RWJF, Kellogg and the two national program offices remained committed to the program and trusted one another.

"It was a very positive relationship in that we achieved many of the objectives we set out to achieve, but it was not without its bumps in the road," said Kellogg Program Director Barbara Sabol, MA, RN, who directed Kellogg's piece of the *Turning Point* initiative. "Susan Hassmiller and I had a very good relationship. The leadership at the National Association of County and City Health Officials and the leadership at the University of Washington was also good. Between the four of us we were typically able to identify the issue and figure out a way of addressing it."

RWJF's Hassmiller and Kaufman also noted that personal relationships were key to the program's work. "If Barbara and I didn't have a trusting, respectful relationship, I don't know what would have happened," said Hassmiller.

"The people at Kellogg were fabulous," added Kaufman. "They got what we were trying to do, even though there were struggles about what we were trying to do and what they were trying to do."

Communication became a major issue in late 1998, when Kellogg informed its grantees that its participation in *Turning Point* was coming to an end. Kellogg did not notify RWJF or its national program office about this decision before informing grantees.

RWJF was planning to continue *Turning Point*, and had expected Kellogg to do the same, according to Hassmiller. "We were surprised by Kellogg's decision," she said. "Together, we made a big statement that improving public health infrastructure took state and local partners working together and all of a sudden, Kellogg was backing out [of the local part]."

Kellogg, however, felt that it had fulfilled its commitment to the program and done what it set out to do. "*Turning Point* was designed to cover a particular period of time with a defined amount of resources," said Sabol. "When RWJF decided to fund additional states, we were not prepared to fund any additional communities. We believed there were enough lessons and leverage to move public health without additional funding."

By this time, program officers at both foundations felt the partnership was making a difference. "We were able to support some incredible public health partnerships that never would have occurred without *Turning Point*," said Sabol. "The melding of the two cultures made *Turning Point* a terrific opportunity to learn from each other," said RWJF's Kaufman. RWJF and Kellogg wanted to maintain their collaboration until Kellogg's participation ended. To turn around the flagging collaboration, representatives from the two foundations and the two national program offices scheduled a retreat, where they addressed communication and trust issues, and established a communication plan.

The RJWF/Kellogg *Turning Point* partnership gave RWJF and other foundations "a model to study," according to Hassmiller. With *Turning Point* as a successful example of collaboration, Hassmiller and other RWJF program officers have been establishing more partnerships on national programs with other foundations.

For more information, see "Partnerships Among National Foundations: Between Rhetoric and Reality" in RWJF's [2001 Anthology](#).

EVALUATION

RWJF funded separate evaluations of the planning and implementation phases of *Turning Point*.

The Formative Program Evaluation

From 1997 to 2001, [The Lewin Group](#), a health care and human services consulting firm in Falls Church, Va., conducted a formative program evaluation of *Turning Point* (ID#s 032843 and 033272). Raymond J. Baxter, PhD, led the evaluation team.

RWJF and Kellogg collaborated and jointly funded this evaluation of the 14 states and 41 local communities participating in *Turning Point* from 1997 to 2000. The Lewin Group produced separate reports on the states for RWJF and on the local communities for Kellogg. RWJF then funded Lewin to evaluate the seven states that joined *Turning Point* in 1999 (ID# 037153).

The Lewin evaluation was designed to:

- Capture, articulate, share and provide feedback about lessons learned across the *Turning Point* states and local communities.
- Assess and attempt to explain change that may unfold through the grantees' work.

Evaluators reviewed program documents and conducted telephone interviews every year with multiple people from each *Turning Point* state and local community partnerships.

The key evaluation questions were:

- What techniques and factors contribute to developing productive partnerships to address public health planning involving diverse constituencies, organizations and sectors?
- What is the range of issues, problems and objectives that will constitute a new vision of public health for the 21st century emerging out of the collective work of all grantees?
- What benchmarks will emerge from strategic plans developed by grantees collectively for tracking and measuring progress along the 10 dimensions that characterize transformational change? (See [Appendix 6](#) for the 10 process and systems dimensions of change created by the evaluators.)
- What techniques and factors contribute to strengthened working relationships between state and local partnerships and constituencies?

See [Findings from the Formative Program Evaluation](#) for more information.

The Outcomes Evaluation

From 2001 to 2007, the [Public Health Institute](#), an independent, nonprofit organization based in Oakland, Calif., and dedicated to promoting health, well-being and quality of life, evaluated the qualitative outcomes of *Turning Point* in the RWJF-funded states (ID# 041558). Todd Rogers, PhD, and Dianne C. Barker, MHS, led the evaluation team.

Evaluators conducted telephone interviews with national program office and RWJF staff (quarterly); state project directors and other key informants (annually); and leaders of collaboratives (semiannually). They also conducted face-to-face interviews, observed semiannual grantee meetings and collaborative meetings and reviewed program documents.

The key evaluation questions were:

- How has the public health system changed in the *Turning Point* states since the inception of the initiative?
- What is the likelihood that these changes may be sustained over time?
- What lessons can be shared with other states and key national stakeholders as they try to improve their public health systems?

Working with RWJF and the national program office, the evaluators measured six outcomes:

- New public health legislation or regulations.
- New or enhanced information systems.
- Increased numbers of trained public health workers.
- Increased public receptivity to public health issues.
- Development of new local infrastructures and relationships between the state and local communities.
- New or enhanced funding for public health.

Based on the findings, the Public Health Institute staff:

- Wrote a case study describing the impact of infrastructure change on local public health.
- Developed a chart on the sustainability of public health system change in the *Turning Point* grantee states.
- Developed a presentation on principles and practices of emerging and established public health institutes.

See [Key Findings From the Outcome Evaluation: Infrastructure Changes](#) for more information.

OVERALL PROGRAM RESULTS

Results According to Program and Foundation Staff

Staff from the national program office, RWJF program officers and the Kellogg program director agreed that *Turning Point* strengthened the public health infrastructure. "*Turning Point* had very lasting effects across all of public health," said Susan B. Hassmiller, PhD, RN, FAAN, RWJF program officer.

Many *Turning Point* leaders and other public health professionals told national program office staff that *Turning Point* products, strategies and principles created significant change in their own settings, or nationally.

National program office and RWJF staff reported the following results:

- ***Turning Point* increased awareness of the need for state public health agencies to partner with local communities, and it engaged stakeholders that had not previously been involved in public health activities.** *Turning Point* was able to build more effective partnerships by emphasizing the importance of integrating collaborative leadership into public health leadership development, and by providing training in collaborative leadership.

A number of program people involved with *Turning Point* spoke about the value of the partnerships:

- *"The local sites and the state sites learned a lot about each other," said Nancy Kaufman, RN, MS, the RWJF vice president who helped to create Turning Point. "They had been fairly isolated from each other. They built trust and had the opportunity to work more closely together."*
- *"Turning Point really emphasized the need to partner effectively with other partners in the community. The program took that notion that there's the public health agency and the overall public health system and then tied them together in a collaborative fashion," said Pamela G. Russo, MD, MPH, head of RWJF's Public Health Team.*
- *"Turning Point resulted in the development of partnerships among and between organizations and institutions and people that I firmly believe never would have happened otherwise, and many of which continue today," said Program Director Bobbie Berkowitz, PhD, RN.*
- *These partnerships conveyed the key message that "everybody has a stake in public health. Because everybody has a stake, you have to make room for those other voices to move a public health agenda," said Kellogg Program Director Barbara Sabol, MA, RN. "The inclusiveness of many voices changed the environment in which you could look at public health issues."*

"Turning Point got the message out that public health infrastructure is helpful to all of us, not just public health folks," added Hassmiller.

- **The five National Excellence Collaboratives developed educational materials, practice tools and policy recommendations aimed at improving the public health system.** For more information about the collaboratives, see [National Excellence Collaborative Results](#).
- **RWJF funding for *Turning Point* enabled the states to leverage approximately \$130 million from public and private sources to strengthen public health**

infrastructure. This result, reported by national program office staff in the Journal of Public Health Management & Practice (2007), was based on surveys and interviews with leaders from 17 *Turning Point* states. These sources indicated the funds would not have been allocated for public health system improvements without their participation in *Turning Point*. For more information, see [Findings on Leveraging Resources](#).

- ***Turning Point* contributed to the national movement toward accrediting state and local health departments.** The Performance Management Collaborative's work to create a better process for using information from performance standards tools sparked a national movement to accredit state and local health departments. "The collaborative generated the energy and raised the visibility of the concept of accreditation in public health," said Russo.

As a result of *Turning Point*, RWJF began working with the Association of State and Territorial Health Officials, Centers for Disease Control and Prevention, National Association of County and City Health Officials, National Network of Public Health Institutes and others to develop a voluntary accreditation system for state and local public health departments. See After the Program for more information about the Exploring Accreditation project.

- ***Turning Point* contributed to an emphasis on developing national performance standards for public health systems.** For example, the work of the Performance Management National Excellence Collaborative contributed to the [National Public Health Performance Standards Program](#). The goals of this program are to:
 - Provide performance standards for state and local public health systems.
 - Improve the quality and accountability of public health practice.
 - Systematically collect and analyze performance data.
 - Develop a science base for public health practice improvement.

Participating partners represent the national organizations and individuals that will use the performance standards at the state and local levels, including the American Public Health Association, the Centers for Disease Control and Prevention and the Association of State and Territorial Health Officials, among others.

- **Many states incorporated parts of the *Turning Point* Model State Public Health Act, created by the Public Health Modernization National Excellence Collaborative, into their laws.** Researchers from Johns Hopkins University and Georgetown University reported that:
 - The subject matter or specific language from the model statute was featured or introduced in whole or part through 125 bills or resolutions in 33 states from January 2003 to February 2007. The extent to which the act's provisions are featured in these bills varies widely.

- Twenty-six states passed 44 laws or resolutions drawing in part or whole on the *Turning Point* Model State Public Health Act.

For a description of the research conducted to assess the impact of the model legislation, see Special Program Elements. For a description of the work of the Public Health Statute Modernization National Excellence Collaborative, see National Excellence Collaborative Results.

- Researchers from Johns Hopkins University, Georgetown University and Columbia University published an article explaining how legislation can be used to improve public health infrastructure and outcomes; described the *Turning Point* Model State Public Health Act and its importance; and assessed the use, and potential use, of the model law (Journal of Law, Medicine & Ethics, Spring 2006).

- ***Turning Point* contributed to the expansion and growth of state-wide public health institutes and the development of the National Network of Public Health Institutes.**

Public health institutes are nonprofit, multisector entities that rely on partnerships and collaborations among federal, state and local public health agencies, universities, foundations, businesses and other key organizations to improve public health structures, systems and outcomes. They function as conveners.

- During *Turning Point*, the number of public health institutes grew dramatically, due in major part to the influence of the program, according to Hassmiller and Russo. "Although *Turning Point* didn't start public health institutes, [the number of] these institutes boomed under the program. Public health institutes could work much more quickly than governmental public health to solve the issues of the day," said Hassmiller.
- The development of public health institutes expanded the ability of a number of *Turning Point* states to respond to public health issues, according to the Public Health Institute evaluators. Evaluators summarized their findings about 26 established and eight emerging public health institutes in the United States (all but one of the existing entities) at a National Network of Public Health Institutes conference (May 2006):
 - Public health institutes, as they evolve, become more involved in relationship-building and data-related activities.
 - Regardless of their years in existence, few public health institutes were engaged in activities typically conducted by state and local public health departments.

For more findings about public health institutes, see [Appendix 7](#).

- The [National Network of Public Health Institutes](#) is a nonprofit organization established in 2001 with funding from RWJF and the Centers for Disease Control and Prevention. During and after *Turning Point*, RWJF funded the National Network of Public Health Institutes to:
 - Assess the needs of emerging public health institutes and provide them with technical assistance (ID#s 047439 and 057396, which ends in 2009).
 - Conduct collaborative projects on accreditation and bioterrorism (ID#s 053228, 056024 and 056935, under the national program, *Lead States in Public Health Quality Improvement*).

"Through the National Network of Public Health Institutes, *Turning Point* provided an opportunity for public health professionals to come together to share their best practices, compare what they were doing and collaborate across states," said Russo.

Findings on Leveraging Resources

Based on a study by the national program office, in which staff surveyed and interviewed leaders from 17 *Turning Point* states, researchers concluded: "Significant funds [in both the public and private sectors] can be leveraged by states to build new public health structures and capacity through innovation brought about by grant funding that supports planning and partnerships" (*Journal of Public Health Management & Practice*, 2007).

Study findings were published in two articles in the *Journal of Public Health Management & Practice* (2007):

From "Leveraging Finances for Public Health System Improvements: Results from the *Turning Point* Initiative":

- **Of the \$131 million leveraged by the *Turning Point* states for public health infrastructure, 61 percent (\$79.6 million) went directly to the *Turning Point* grantee agency.** They used these funds for the public health infrastructure improvement efforts initiated during the implementation phase of *Turning Point*.
 - **Grantee partners leveraged the remaining funds (\$51.4 million) for additional infrastructure improvements identified in the public health improvement plans created by each state.**
 - **Of the \$79.6 million leveraged by *Turning Point* grantee agencies, federal funding accounted for approximately \$11 million and state funding for \$63.1 million.**
- Federal funding was primarily from:
 - Centers for Disease Control and Prevention preparedness funds (five states)

- Health Resource and Services Administration workforce training funds (two states)
- Maternal Child Health Bureau block grant funds (two states).
- State health department funds of \$8.2 million came from a variety of sources, including programmatic activities and general revenues.
- A few states leveraged all together tens of millions of additional dollars from their state legislatures. These funds came from tobacco settlement dollars and other state resources, and were new funds allocated for statewide public health system infrastructure support with ongoing funding authorization.
- Five grantees secured \$1.3 million in funding from private foundations.

From "Making the Case: Leveraging Resources Toward Public Health System Improvement in *Turning Point* States":

- **A comprehensive planning process that led to the development of a broadly endorsed plan, combined with a broad-based partnership, was crucial in securing resources to expand public health system improvement efforts.** The two concepts overlap, since effective planning occurred largely through a partnership process:
 - *Turning Point* participants reported that the comprehensive and inclusive planning environment provided credibility and direction. This helped them persuade policy-makers and others to provide resources and respond to opportunities.
 - Respondents often described their public health improvement plan, and the process they used to develop it, as "nontraditional":
 - Individual and organizational representatives could come together around a common goal on neutral ground where they would be guaranteed a voice.
 - The planning process was bigger than, and not driven or dominated by, the state health department. Partners represented many sectors, including business, health care, private foundations, insurance companies and communities of faith.
- **External events were necessary catalysts for "making the case" for resources for public health system improvement efforts.** *Turning Point* participants often described fortuitous timing, money and leadership as essential for providing opportunities to leverage resources. These opportunities included the state tobacco settlement funds, federal emergency preparedness grants and changes in state government leadership.

National Excellence Collaborative Results

National program office staff and representatives of participating states reported the following results from the collaboratives on the *Turning Point* website, and in journal articles, reports to RWJF and other publications:

- **The Information Technology National Excellence Collaborative.** It promoted public health systems improvement through the effective use of information technology. Members of this collaborative developed:
 - An information systems survey of local health departments, for use in creating an Internet-based resource to help public health professionals make decisions about information technology. In 2002, collaborative members mailed the survey to 3,131 local health departments and received 344 usable responses.
 - *Public Health Information Systems Catalog*, an online catalog of software applications used by state and local public health agencies. The catalog was compiled through the information systems survey. Categories of software include:
 - Clinical services
 - Disease surveillance
 - Environmental licensure and inspection
 - Screening
 - Registry
 - Data analysis and mapping.

Along with descriptions of software, the catalog describes the:

- Technical infrastructure or architecture required to use these applications.
 - Specific public health purposes for which the system is used.
 - Community resources necessary to support public health activities.
- **The Leadership Development National Excellence Collaborative.** It focused on collaborative leadership-which members considered critical to improving capacity throughout the public health system. Members of the Leadership Development Collaborative developed:
 - Six self-assessment tools for exploring key capacities that are important to effective collaborative leaders:
 - Assessing the environment
 - Creating clarity: visioning and mobilizing

- Building trust
 - Sharing power and influence
 - Developing people
 - Self-reflection.
- A comprehensive modular curriculum on collaborative leadership, available in two versions:
 - *Collaborative Leadership: Fundamental Concepts Learning Module*: This learning module helps people understand collaborative leadership and sets the stage for the Comprehensive Series. It includes many hands-on activities, brief leadership scenarios on video and opportunities for dialogue and interaction.
 - *Collaborative Leadership Learning Modules: A Comprehensive Series*: This series of seven modules provides instruction to build the key skills necessary for collaborative leadership. The series is adaptable for learners with different level of experience and can be customized.
 - Summary analysis and proceedings of expert panelists describing collaborative leadership in the context of public health challenges, published in *Academics and Practitioners on Collaborative Leadership*.
 - A literature review, published in *Collaborative Leadership and Health: A Review of the Literature*.
 - Training for trainers at national public health meetings, including the American Public Health Association and the National Public Health Leadership Development Network.
 - **The Performance Management National Excellence Collaborative.** It worked to create a process to better use information that states and communities receive from the use of performance standards tools. The capacity to measure performance creates a framework for understanding "what a great public health department should look like," according to RWJF program officer Susan Hassmiller.

The collaborative subcontracted its research activities to the [Public Health Foundation](#), a national, nonprofit organization that focuses on research, training and technical assistance.

Members of the Performance Management Collaborative developed:

- A literature synthesis.
- A survey on performance management practices in states, designed to characterize state health agency efforts to measure and manage public health performance. Forty-seven states responded to the Web-based survey, which researchers conducted in 2001.

- A model of performance management that included four components:
 - *Performance standards*: Establishing organizational or system performance standards, targets and goals and relevant indicators to improve public health practice.
 - *Performance measures*: Applying and using performance indicators and measures.
 - *Reporting of progress*: Documenting and reporting progress in meeting standards and targets, and sharing that information through feedback.
 - *Quality improvement*: Establishing a program or process to manage change and achieve quality improvement in public health policies, programs or infrastructure based on performance standards, measurements and reports.
- A [Performance Management Self-Assessment Tool](#) to help public health professionals identify the extent to which they have the components of a performance management system.
- A *Guidebook for Performance Management* covering:
 - Basic information about performance measurement in general, and specifically in public health.
 - Reasons to develop a performance management process.
 - Performance measurement strategies tried by public health practitioners across the country and by other public and private sector organizations.
- A guide to performance management, called *From Silos to Systems: Using Performance Management to Improve the Public's Health*. This guide helps state health agency leaders understand performance management and how its practice can improve an agency's ability to carry out the 10 essential public health services.
- [Performance Management in Action: Tools and Resources](#), a toolkit to help public health professionals implement the collaborative's model for performance management.
- [Case examples and learning reports](#):
 - The case studies cover the performance improvement efforts of five states: Florida, Missouri, New Hampshire, Oklahoma and South Carolina.
 - The learning reports provide a quick overview of leading public health and private sector performance management initiatives.
- **The Public Health Statute Modernization National Excellence Collaborative.** It focused on helping states develop clear and up-to-date laws by creating a model

public health law. Collaborative members worked with researchers from Johns Hopkins University and Georgetown University, who helped draft the act.

— By creating the *Turning Point* Model State Public Health Act in 2003, collaborative members gave professionals in public health agencies a model for assessing their public health laws and identifying areas that need to be updated or improved. The act reflects modern constitutional, statutory and case-based law, as well as scientific and ethical principles at the forefront of modern public health practice. It covers:

- Public health infrastructure, which is often missing from state laws.
- Collaboration and relationships with public and private sector partners.
- Public health authorities and powers.
- Public health emergencies.
- Public health information privacy.

— Collaborative members developed a variety of other publications that include:

- State Public Health Law Assessment Report, which collaborative members and researchers used to develop the *Turning Point* Model State Public Health Act.
- [Public health law assessments](#) on a number of topics.
- [Reports](#) that track legislative activity.
- Fact sheets on public health laws, modern health threats and public health law, lobbying rules and other subjects.

- **The Social Marketing National Excellence Collaborative.** It promoted the use of [social marketing](#) principles and practices, and developed tools to strengthen social marketing skills among public health professionals. Members of the collaborative developed:

— The *CDCynergy-Social Marketing Edition Version 2.0: An interactive multimedia decision support tool* providing step-by-step guidance for developing and documenting a successful social marketing program. The CD-ROM contains:

- Case studies.
- Commentary from experts in the field of social marketing.
- Tutorials for each stage of effective program development.
- An extensive resource library.
- Tips for managers who oversee social marketing programs.

- Training on *CDCynergy-Social Marketing* and social marketing case studies:
 - The collaborative offered four training sessions in the fall of 2006, ranging from a half day to two days, on *CDCynergy-Social Marketing*. The training included a one-day session at the 2006 American Public Health Association preconference.
 - Tools of Change "webinars" were hour-long live, interactive sessions led by public health leaders who had organized innovative programs. Participants viewed PowerPoint® presentations and other visuals using their Web browsers while listening to the webinars. Using a telephone, they could ask questions, make comments and exchange advice.
 - The [Third Thursday Breakfast Broadcast](#) series (T2B2), a monthly one-hour satellite broadcast on public health issues. One example is [Social Marketing on a Shoestring Budget](#), featuring Rebecca Brookes, Director of Social Marketing for Planned Parenthood Federation of America. During this broadcast, Brookes discussed how to put the "customer" at the center of the marketing and publicity process.
 - Four reports about social marketing, each of which can be used as a stand-alone tool or integrated with other reports and resources:
 - *Social Marketing Resource Guide*.
 - *Social Marketing and Public Health: Lessons from the Field*.
 - *The Basics of Social Marketing*.
 - *The Manager's Guide to Social Marketing*.

Selected Key Project Results

The national program office and representatives of selected *Turning Point* states reported the following results in reports to the field and to RWJF.

Arizona Turning Point

- **Developed a broad-based partnership to strengthen the public health infrastructure in Arizona.** Staff at the Arizona Department of Health Services and the Maricopa County Department of Public Health led the partnership.
- **Focused on public health workforce needs, information dissemination and public health advocacy.** This included:
 - Designing and implementing the Arizona Academy Without Walls, training programs to enable public health workers to build the skills to better address the state's public health concerns.

- Creating *AZHealthInfo.org*, a Web-based source of public health and consumer health information for public health professionals and the public. Project staff collaborated with the Arizona Health Sciences Library and other partners to develop the website.
- Developing and implementing training sessions to help communities advocate for their health needs and to encourage their participation in statewide public health planning. Project staff collaborated with community groups, local organizations, coalitions and local *Turning Point* initiatives to develop the training sessions.
- **Participated in the Public Health Statute Modernization National Excellence Collaborative and the Leadership Development National Excellence Collaborative.** For more information about these collaboratives, see [National Excellence Collaborative Results](#).

Minnesota Turning Point

- **Developed the Minnesota Health Improvement Partnership, led by staff at the state Department of Health.** The partnership was a collaborative of public, private and nonprofit sector organizations that worked to strengthen public health infrastructure in Minnesota.
- **Focused on strengthening the public health system and expanding partnerships by:**
 - Engaging the private and nonprofit sectors to work with state and local public health agencies in setting statewide goals and making difficult policy decisions.
 - Influencing policy direction. For example, partners identified key public health policy issues to be addressed and educated partners about these issues.
 - Providing direction to public health partners.
 - Establishing minimum standards for local public health services and activities.
 - Refocusing local planning requirements on outcomes, local priorities and strategies.
- **Established the Emerging Leaders' Network, a year-long training program to identify public health professionals with leadership potential, and mentor and train them.**

The network was a collaboration among Minnesota *Turning Point*, the Minnesota Public Health Association and the Local Public Health Association of Minnesota. Staff started the network while participating in the *Turning Point* Leadership Development Collaborative, and used its collaborative leadership concepts and practices to develop programming.

- **Led the Leadership Development National Excellence Collaborative and participated in the Social Marketing National Excellence Collaborative.** For more information about these collaboratives, see [National Excellence Collaborative Results](#).

Nebraska Turning Point

- **Developed the Nebraska Community Health Partners Stakeholder Group, led by staff at Nebraska's Health and Human Services System.** The broad-based partnership worked to strengthen public health infrastructure in Nebraska.
- **Developed a public health improvement plan that focused on building public health infrastructure at the regional level through multicounty, community-based public health departments.**
- **Successfully advocated for \$5.7 million in annual funding for public health infrastructure from state tobacco settlement funds.** When the state legislature passed the Nebraska Health Care Funding Act in 2001, it appropriated annual funding to establish regional public health departments throughout the state.
- **Established 16 regional public health departments covering every county in the state by the end of the grant period.** The regional public health departments provided the core functions of public health and some of the 10 essential public health services. (For a list of the 10 essential public health services see [Appendix 8](#).)
- **Led Nebraska Health and Human Services System to establish the Office of Public Health (now called the Office of Community Health Development).** Nebraska *Turning Point* staff became part of that office.
- **Participated in the Public Health Statute Modernization and Leadership Development National Excellence Collaboratives.** For more information about these collaboratives, see [National Excellence Collaborative Results](#).

New Hampshire Turning Point

- **Developed a broad-based, state-level partnership, led by staff at the New Hampshire Public Health Association, to strengthen New Hampshire's public health infrastructure.** The partnership included state public health agencies, hospitals, health centers, networks and coalitions, academic institutions, businesses, nonprofit agencies, legislators, civic organizations, faith organizations and foundations.
- **Focused on developing a system of regional community collaboratives, called the New Hampshire Public Health Network.** This network is comprised of 14 local public health partnerships serving nearly 50 percent of New Hampshire towns and 70 percent of New Hampshire residents. Participants include local health departments and health officers, firefighters, police, emergency medical services, health care providers, social service agencies, schools, media and advocacy groups and leaders in

business, politics and the faith community. The network: Works to assure coordinated and comprehensive delivery of essential public health services. (For a list of essential public health services, see [Appendix 8](#).)

- **Serves as a local liaison with state agencies.**
- **Participated in the Information Technology and Performance Management National Excellence Collaboratives.** For more information about these collaboratives, see [National Excellence Collaborative Results](#).

New York Turning Point

- **Developed the New York State Community Health Partnership, led by the New York State Department of Health.** The broad-based partnership worked to strengthen public health infrastructure in New York.
- **Developed a public health improvement plan that identified capacity building as the state's most pressing need.** As a result, *New York Turning Point* focused on developing and delivering training to state and local health care workers statewide.
- **Developed practical and easy-to-attend training programs that used distance learning where possible.** This included satellite broadcasts, known as the [Third Thursday Breakfast Broadcasts](#), as well as continuing education courses.
- **Obtained annual funding to train the public health workforce.**
- **Raised the visibility of the needs of New York's public health workforce, which contributed to the establishment of a state task force to strengthen the public health workforce.**
- **Led the Social Marketing National Excellence Collaborative and participated in the Performance Management National Excellence Collaborative.** For more information about these collaboratives, see [National Excellence Collaborative Results](#).

Oklahoma Turning Point

- **Developed a broad-based partnership to strengthen public health infrastructure, led by the Oklahoma State Department of Health.**
- **Developed a public health improvement plan that focused on change at the community level and called for developing local partnerships throughout the state.**
- **Established local partnerships in 50 counties.** These partnerships assessed local public health needs, developed and implemented community health improvement plans and evaluated progress.

- **Hired new staff to support the local partnerships.** Seven field consultants were hired to provide technical assistance and an epidemiologist was hired to identify the top health issues in each county.
- **Led the Information Technology National Excellence Collaborative and participated in the Leadership Development National Excellence Collaborative.** For more information about these collaboratives, see [National Excellence Collaborative Results](#).

Virginia Turning Point

- **Developed a community partnership to strengthen public health infrastructure, led by the Virginia Department of Health and the [Virginia Hospital & Healthcare Association](#).**
- **Developed a public health improvement plan that included an assessment of the economics of disease prevention, a community health needs assessment and a public awareness campaign.**
- **Established the Virginia Center for Healthy Communities, an independent, nonprofit public health institute, to implement the plan and institutionalize Virginia Turning Point.**
- **Focused on creating a new community health data tool, the [Virginia Atlas of Community Health](#).** The atlas is a free Web-based tool that provides local data on population demographics, economics and health status. Users can generate reports and maps to quickly evaluate community health at the local and ZIP code levels.
- **Conducted health improvement activities in partnership with the business community.** This included three health-related roundtables and a workplace-based diabetes screening program.
- **Participated in the Leadership Development and Social Marketing National Excellence Collaboratives.** For more information about these collaboratives, see [National Excellence Collaborative Results](#).

Wisconsin Turning Point

- **Developed the *Turning Point* Transformation Team, led by staff at the Wisconsin Department of Health and Family Services, to strengthen public health infrastructure in Wisconsin.** The team included representatives of city, county and state government, community organizations, education, health care professionals, hospitals, insurers and local and state public health departments.
- **Developed and implemented Healthiest Wisconsin 2010, a strategic plan to improve public health that focused on health promotion, disease prevention and building a strong public health system with partners from many sectors outside government.** Healthiest Wisconsin 2010 helped to raise awareness that public health

is not solely a government responsibility, and that it takes the work of many people and sectors to improve health. The plan outlines core functions, essential services, goals, priorities and desired outcomes.

- **Developed policy recommendations to improve public health laws and better protect state residents.**
- **Created model practices, such as countywide coalitions that exceed national early childhood immunization goals.**
- **Established formal partnerships with the University of Wisconsin Medical School and the Medical College of Wisconsin to advance health statewide.**
- **Participated in the Public Health Statute Modernization National Excellence Collaborative.** For more information about this collaborative, see [National Excellence Collaborative Results](#).

Communications Results

The national program office developed an extensive array of material to disseminate *Turning Point* findings and products, and expand the literature on best practices in improving public health. Most of this is available on the program's [website](#), which also provides an overview of the program and the work done by the participating states.

Communications products include:

- The *Turning Point CD-ROM Toolkit*, with more than 100 tools for social marketing, collaborative leadership, performance management, information technology and public health law modernization.
- Special issues of the *Journal of Public Health Management and Practice*, published in January 2002 and March/April 2005, which featured articles from staff of the national program office, selected *Turning Point* states and the collaboratives as well as national experts.
- Newsletters and other publications.
- Presentations at more than 100 national and local meetings, including the American College of Preventive Medicine and the American Public Health Association.

See the [Bibliography](#) for details.

[The Watson Group](#), a marketing communications firm in Wayzata, Minn., helped the national program office promote and disseminate the CD-ROM toolkit from 2005 to 2006 (ID# 051880). This work included:

- Distributing the toolkits to state health departments, community health organizations, federal health agencies and other organizations.

- Working with partner organizations and others to distribute the toolkit.
- Developing a Webcast about the toolkit for the Maternal and Child Health Bureau of the federal Health Resources and Services Administration.

Watson Group staff also developed ways to drive traffic to the *Turning Point* website in order to disseminate its online resources.

RWJF established a communications and dissemination fund at *Turning Point's* national program office to support testing and dissemination of products, processes and tools created by the National Excellence Collaboratives from 2003 to 2005 (ID# 047288). All five collaboratives received money from the fund.

EVALUATION FINDINGS

Findings From the Formative Program Evaluation

Evaluators from the Lewin Group reported the following findings, covering the first three years of the program (1997 to 2000), in *What Turning Point Tells Us: Implications for National Policy* (2000):

- ***Turning Point* has broadened participation in public health beyond official state and local public health agencies to include new constituents and fresh perspectives.** By engaging individual citizens, community organizations, businesses and civic organizations outside the health field, it has broadened the definition of what constitutes public health, changed the language used to describe it and expanded a sense of "ownership" in *Turning Point* communities.
- ***Turning Point* sites transformed the traditional public health function of assessment.** Partnerships that combined needs assessments with action projects-and that used the assessment activity to develop broad participation among diverse interests-were able to move ahead.
- **By building broad-based linkages, *Turning Point* has been able to integrate and enhance the skills and resources available in the community.** Partnerships have improved the capacity to scan the environment more thoroughly, mobilize communities and share information and resources. This supplements and boosts the capacities traditionally associated with public health (e.g., information technology, trained professional personnel and up-to-date laboratories).
- ***Turning Point* has shown that its partnership approach can directly inform policy.** Partnerships have:
 - Changed smoking regulations, disease reporting practices and public health laws.

- Sponsored organizational changes to affect policy, such as revitalizing existing entities (e.g., local health departments) and creating new organizations (e.g., neighborhood planning teams and regional authorities).
- ***Turning Point offers a new foundation for national public health policy.*** It demonstrates that developing strong local linkages among public health and other sectors of government and the public can create new support and resources for public health interventions and maximize the value of investments in personnel and technology.

Evaluators from the Lewin Group reported the following findings, covering 1997 to 2000, in *Communities Sustain Public Health Improvements Through Organized Partnership Structures* (2003).

- **Partnerships organized and focused their planning in three ways:**
 - ***Health department-focused partnerships:*** Some partnerships focused first on assessing the functions performed by official health departments or agencies, which led to plans to develop new capacity. These partnerships often dealt with governmental programs, such as immunizations and screenings and with policy.
 - ***Problem-focused partnerships:*** Some partnerships developed community-wide processes to identify and address specific public health priorities, such as adolescent health, teen pregnancy, public safety and disease prevention.
 - ***Community-focused partnerships:*** A few partnerships focused on local involvement in public health, attempting to empower community groups to lead health improvement activities selected by community members.
- **Partnerships used three types of organizational structure:**
 - ***Government-sanctioned organizations:*** Typically, health departments, states or county and city governments authorized these organizations through executive or legislative action. The authorizing agency often provided funding and oversight. For example:
 - The Tri-County Partnership in New Mexico required each participating county to establish a formal county health council.
 - The Twin Rivers Partnership in New Hampshire facilitated collaboration among local public health officers in the state.
 - ***Independent entities affiliated with government agencies:*** Many partnerships created organizations that had strong affiliations with governmental agencies, but were not officially part of the government. These organizations, typically representing an array of constituencies, worked closely with government agencies but were less restricted by government bureaucracy, political agendas and funding limitations. For example:

- The New Orleans Partnership in Louisiana developed the Center for Empowered Decision Making, which provides educational resources and leadership training for community members, and assisted in conducting community needs assessments and developing public health improvement plans. The city of New Orleans Health Department was a charter member; the partnership survived Hurricane Katrina.
- The Decatur Community Partnership in Illinois established a Family Enrichment Center, with support from the Illinois Department of Human Services and the Decatur County Health Department. The center provides many community services under one roof.
- **Community networks:** Some partnerships engaged community groups to conduct grassroots public health work. Often, a larger umbrella organization replicated this strategy in multiple neighborhoods and provided overall coordination. For example:
 - Five towns within Cochise County, Ariz., worked with community groups to gather input from the community about priority health concerns and to plan activities to address them. A county-wide leadership team supported these local partnerships. This team served as the fiscal agent for *Turning Point* and brought together the partnerships to share experiences and participate in technical assistance activities.
- **By forming new structures for organizing public health activities, *Turning Point* partnerships expected to sustain their work beyond the life of the grant period.** Partnerships helped to sustain the following functions:
 - Community voice
 - Public health awareness
 - Community oversight
 - Community resources
 - Programs
 - Networking.

Key Findings From the Outcome Evaluation: Infrastructure Changes

Evaluators from the Public Health Institute reported the following key findings based on comparing changes in three *Turning Point* states (Oklahoma, Nebraska and New Hampshire) from 2000 to 2004 to changes in three similar states that did not participate in the program (Idaho, Tennessee and Vermont).

Overall

- **The three *Turning Point* states changed their public health infrastructures more than the three comparison states.** Changes included:
 - New or reorganized public health advisory councils.
 - New issue-specific public health workgroups or task forces.
 - New or reorganized public health coalitions.
- **The only infrastructure change that was not significantly different between *Turning Point* and comparison states was the presence of a new or reorganized office of emergency preparedness.** The federal government has made emergency preparedness funding available to all states since 2001, which may help to explain this.

Partnerships

- **Although both *Turning Point* states and comparison states developed new partnerships, *Turning Point* states built longer-lasting partnerships across state agencies, and pursued more long-term collaboration with local public health entities.** Comparison states usually sought state-local partnerships for short-term needs, such as delivering a specific public health service or addressing public health issues defined by federal funding priorities.
- ***Turning Point* improved relationships between states and local public health entities by facilitating new partnerships and improving communication with partners.**
- **Improved relationships between states and local public health entities have contributed to a better use of public health funds, enhanced coordination of emergency response systems and, to a limited extent, improved local input into state health priority-setting.**

Communication

- **Although comparison states improved their information system capabilities with federal emergency preparedness funding, the improvement was less than what was seen among *Turning Point* states.** *Turning Point* states were able to use federal and state resources to support local infrastructure changes, which helped to improve the use of data systems at the local level.
- ***Turning Point* states appear to have invested more extensively in relationship-building and interpersonal connections than those from comparison states.**

Planning and Collaboration

- At the local level, *Turning Point* states improved significantly more than comparison states both in developing policies and plans that support individual and community health efforts, and in their search for new insights and innovative solutions to health problems.

Coordination to Improve Emergency Preparedness and Response

- *Turning Point* states reported greater improvement than comparison states in coordinating responses to disease outbreaks, epidemics and natural disasters. However, there was no significant difference in local capacity to organize emergency preparedness efforts.
- The lack of communication about the role of public health, or a common definition of "emergency," has challenged relationship-building between public health and emergency response personnel in both *Turning Point* and comparison states. *Turning Point* states, however, seem to have an advantage in improving collaboration among agencies due to the positive relationships they developed through their partnerships.

Funding

- *Turning Point* states were able to influence the funding of local public health services in two ways:
 - Structures put in place as a result of *Turning Point* helped leverage and streamline state and federal funding for local activities.
 - *Turning Point* and its collaborative structures helped to facilitate funding for activities that local public health representatives identified as priorities.

In comparison states, local actions depended on funding priorities established "from the top," such as emergency preparedness.

- *Turning Point* states were more able than comparison states to direct emergency preparedness funding to bolster the broader local public health infrastructure. In comparison states, this funding remained category-specific and was rarely used to expand local public health capacity beyond emergency preparedness.

Delivery of Public Health Essential Services

- *Turning Point* states showed greater improvements in their capacity to deliver six of the 10 essential services than comparison states. See [Appendix 8](#) for a list of the essential services.
- Educating people about the essential services has been a major activity in the *Turning Point* states.

Leadership and Workforce Development

- **Infrastructure changes in the *Turning Point* states facilitated recruitment of public health workers, helped retain the workforce and facilitated the development of leaders.**

For additional findings from the outcome evaluation about infrastructure changes, see [Appendix 9](#).

Findings From the Outcome Evaluation: Sustainability

Overall, evaluators from the Public Health Institute reported that as of winter 2007, most of the *Turning Point* states were able to sustain the public health system changes they made during the program, despite many political and funding shifts over time.

They rated each accomplishment as either (1) a direct result of *Turning Point*; (2) one in which *Turning Point* served as a catalyst; or (3) one in which *Turning Point* was an indirect influence:

- **The structures most likely to be sustained were those created during *Turning Point* at the state and local level, but not formally affiliated with the public sector. New or enhanced information systems were also likely to be sustained:**
 - Six states (Illinois, Missouri, Montana, North Carolina, Oklahoma and Virginia) sustained nongovernmental structures created at the state level during *Turning Point*. All states except Montana created new public health institutes. Montana established the Association of Montana Public Health Officials.
 - Direct result of *Turning Point*: Illinois, Missouri, Montana, North Carolina and Virginia
 - *Turning Point* served as a catalyst: Oklahoma.
 - Four states (Nebraska, New Hampshire, Nevada and Oklahoma) sustained nongovernmental structures created at the local level during *Turning Point*:
 - Direct result of *Turning Point*: Oklahoma
 - *Turning Point* served as a catalyst: Nebraska and New Hampshire
 - *Turning Point* was an indirect influence: Nevada.
 - Nine states (Alaska, Arizona, Colorado, Illinois, Kansas, Nebraska, Oklahoma, Virginia and West Virginia) sustained information systems they established or enhanced during *Turning Point*:
 - Direct result of *Turning Point*: Colorado, Illinois, Kansas and Virginia
 - *Turning Point* served as a catalyst: Alaska and Nebraska

- *Turning Point* was an indirect influence: Arizona, Kansas, Oklahoma and West Virginia.
- **Eleven states sustained investments in workforce development made during *Turning Point*:**
 - Direct result of *Turning Point*: Illinois, Missouri, New York and South Carolina
 - *Turning Point* served as a catalyst: Illinois, Minnesota, Montana, South Carolina and West Virginia
 - *Turning Point* was an indirect influence: Alaska, New Hampshire, North Carolina and Oregon.
- **Six states sustained entities created during *Turning Point* as part of the official state infrastructure:**
 - Direct result of *Turning Point*: Colorado
 - *Turning Point* served as a catalyst: Kansas, Montana and South Carolina
 - *Turning Point* was an indirect influence: New Hampshire and Wisconsin.
- **One state (Alaska) sustained new public health legislation passed during *Turning Point*.** This legislation was a direct result of the program.

LESSONS LEARNED

Lessons From the National Program Office

1. **Collaborate with others to advance public health systems.** Powerful, active, inclusive and broad-based partnerships can strengthen the infrastructure of the nation's public health system. (Program Director/Berkowitz)
2. **Use thoughtful planning to obtain buy-in and build credibility.** A broad-based and inclusive planning process is essential to gain buy-in from key public and private sector partners, identify and prioritize strategies for system improvement and communicate a common vision. "The planning grants energized planning in public health. All participating states say the planning and partnerships established in *Turning Point* gave them credibility and depth," said Berkowitz. (Program Director/Berkowitz)
3. **Use frequent and multilayered communication to spread the word about a program's vision and message.** The national program office communicated with public health professionals and other audiences through e-mail, newsletters, peer-reviewed publications, meetings with elected officials and community members—and through its website. The national program office also encouraged the grantees to communicate broadly and supported them in their efforts. (Program Director/Berkowitz)

4. **To secure additional funds, develop broad-based, multisector partnerships that engage in comprehensive planning.** The *Turning Point* states were able to leverage significant additional funds in this way. (Program Director/Berkowitz; Deputy Director/Bekemeier)
5. **Consider structures and resources that will enable partnerships to recognize and respond effectively to unforeseen events, changes in political landscapes and evolving fiscal environments.** The *Turning Point* partnerships were able to leverage significant additional funds by being ready when opportunities, such as the state tobacco settlement funds and federal emergency preparedness grants, arose. (Program Director/Berkowitz; Deputy Director/Bekemeier)

Lessons From the States

6. **Providing the right incentives to a small group can reap good results.** In Nebraska, a small core of people who were very interested in public health successfully developed regional health departments. "You don't need hundreds of people to get this done, particularly in rural areas like we have in Nebraska," said Project Director David Palm, Ph.D. (Project Director/Nebraska)
7. **Avoid duplication of health services.** Nebraska *Turning Point* ensured that the new regional public health departments did not provide services already covered by the state, such as immunizations, and instead focused on services that were not available, such as health promotion. (Project Director/Nebraska)
8. **Use emergencies as an opportunity to increase the focus on public health.** The events of September 11, 2001 made people focus on the need to strengthen the public health infrastructure in New York, and provided an infusion of money to do so, according to Project Director Sylvia J. Pirani, M.P.H., M.S. (Project Director/New York)
9. **Be prepared for the challenges of working with newly formed partnerships.** Members of the New York State Community Health Partnership, the steering committee for the state's *Turning Point* project, had differing perspectives on such issues as hospital financing. Some also competed for the same grants as New York *Turning Point*, according to Pirani. "We had to address those challenges and keep our focus on community health," she said. (Project Director/New York)
10. **Help the public and policy-makers understand public health.** "Most people think public health means dealing with emergencies," said Pirani of New York. "Public health is invisible when everything is going well." New York *Turning Point* worked to educate the public and policy-makers about the roles of public health beyond emergency response. (Project Director/New York)
11. **Obtain support from organizational leaders to leverage additional funds to continue the work.** Leaders in the New York State Department of Health, which directed the *Turning Point* project, persuaded the state to appropriate an annual

training budget to continue a successful program initiated with grant funds. (Project Director/New York)

12. **Ensure that high-level representatives of local and state partners attend key meetings.** Where collaboration is fundamental to project success, decision-makers must be at the table, or represented by someone who reports directly to that decision-maker. Some partner agencies in New Mexico did not operate in this manner, and its participation in *Turning Point* ended after the planning grant. (Final Report to RWJF/New Mexico)
13. **Focus on getting the work done, not on who gets the credit.** That focus enabled Oklahoma *Turning Point* to "develop the kind of relationships that were necessary to really have effective partnerships with our local community as well as our state partners," said Neil E. Hann, M.P.H., chief of community development in the Oklahoma State Department of Health. "We can be so much more effective when it's the partnership that takes the credit, not any one agency or group." (Supervisor to Project Director/Oklahoma)
14. **Consider using an epidemiologist to help communities understand the health issues they face.** Oklahoma *Turning Point* found it very beneficial to fund an epidemiologist, who presented data linking health issues to cost in a way the general public could understand and helped motivate the counties to take action. (Project Director/Oklahoma)
15. **Provide technical support to community partnerships.** After hiring field consultants to provide technical support to the community partnerships, Oklahoma *Turning Point* "found that [technical] support is more important than funding," said Hann. (Supervisor to Project Director/Oklahoma)
16. **Consider using a nongovernmental fiscal agent for a collaborative project; it can speed up the schedule.** Using the Virginia Hospital & Healthcare Association as the fiscal agent enabled Virginia *Turning Point* project staff to buy what they needed quickly, rather than following government purchasing rules and regulations, according to Project Director Jeff Wilson, M.H.S.A. (Project Director/Virginia)
17. **Involve all stakeholders early in strategic planning.** By involving stakeholders from all sectors in developing Virginia's public health improvement plan, project staff gained buy-in on the state's approach to improving the public health infrastructure and support for the recommendations. (Project Director/Virginia)
18. **Be honest with partners about goals.** By communicating and accomplishing clear goals, project staff members overcame any reservations that representatives of their partners might have had about working together. (Project Director/Virginia)
19. **Consider the different perspectives of partners in setting goals.** Government public health professionals in Virginia wanted to see improvements in population health, which take many years to accomplish, while partners from the business

community were more focused on short-term results. "Those are very different needs that you have to balance," said Wilson.

To satisfy both sets of partners, Virginia *Turning Point* set goals that could be measured fairly quickly, but that could also lead to long-term changes in population health. For example, the immediate goal of the workplace diabetes project was to conduct screening in a certain number of workplaces while the long-term goal was to reduce the incidence of diabetes. Staff made a point of keeping all partners apprised of progress. (Project Director/Virginia)

20. **Realize that "profit is not a four-letter word."** Government public health professionals involved with Virginia *Turning Point* initially believed that business partners were motivated only by self-interest. Project staff fostered discussions to help government employees recognize that business people are part of, and care about, the community. (Project Director/Virginia)
21. **Use a neutral forum for controversial discussions.** By serving as a neutral forum, the Virginia Center for Healthy Communities was able to facilitate controversial discussions about the role of public health. "We became a safe place where some of these difficult issues could be discussed," said Wilson. (Project Director/Virginia)

AFTERWARD

Most of the states that participated in *Turning Point* have institutionalized the changes they made to strengthen their public health infrastructure during the program, according to Berkowitz.

National Excellence Collaboratives

As of September 2007, two National Excellence Collaboratives were still operating:

- **Leadership Development National Excellence Collaborative:** This collaborative continues under the management of the [National Public Health Leadership Development Network](#) at Saint Louis University.
- **Social Marketing National Excellence Collaborative:** This collaborative continues under the management of the [Watson Group](#).

The resources created by the other three collaboratives remain available:

- **Information Technology National Excellence Collaborative:** Project staff in Oklahoma, which led the collaborative, maintain the collaborative's website.
- **Performance Management National Excellence Collaborative:** The Public Health Foundation has incorporated the collaborative's work in its Public Health Infrastructure Resource Center.

- Public Health Statute Modernization National Excellence Collaborative: The [Centers for Law and the Public's Health](#) has incorporated the collaborative's work into its website section on [model state public health laws](#).

RWJF Activities

Turning Point has had a significant influence on the public health funding at RWJF, according to Pamela Russo, MD, MPH, head of the RWJF Public Health Team, which provided oversight to *Turning Point*. "The state health improvement plans in every state are helping us figure out our priorities, how to make more effective public health practice and policy," said Russo.

RJWF Activities in Public Health Accreditation

Through a series of grants to the National Association of County and City Health Officials (ID#s 053182, 056262, 052676 and 057248) and to the Association of State and Territorial Health Officials (ID#s 055274 and 050045), RWJF convened stakeholders to develop a common understanding about the responsibilities and structure of local and state public health services and to explore voluntary accreditation for public health agencies.

Those grants led to the Exploring Accreditation initiative, funded by RWJF and the CDC. The National Association of County and City Health Officials and the Association of State and Territorial Health Officials coordinated the project. The American Public Health Association and the National Association of Local Boards of Health provided additional support.

Another RWJF-funded program, the *Lead States in Public Health Quality Improvement*, (originally called the *Multistate Learning Collaborative for Public Health*) also has worked on accreditation and quality improvement efforts. Managed by the National Network of Public Health Institutes, the program provides information on quality improvement strategies in public health departments and existing public health accreditation practices, in essence serving as a "learning laboratory" for Exploring Accreditation. Six *Turning Point* states (Illinois, Kansas, Minnesota, Missouri, New York and North Carolina) are participating in the 10-state collaborative.

Building on the information provided by the collaborative, Exploring Accreditation released its recommendations for a voluntary national accreditation program in September 2006. The recommendations are intended to:

- Promote high performance and continuous quality improvement.
- Recognize high performers that meet nationally accepted standards of quality and improvement.

- Illustrate health department accountability to the public and policy-makers.
- Increase the visibility and public awareness of governmental public health, leading to greater public trust and increased health department credibility, and ultimately a stronger constituency for public health funding and infrastructure.
- Clarify the public's expectations of state and local health departments.

Appendix 10 provides brief summaries of these recommendations. *Final Recommendations for a Voluntary National Accreditation Program for State & Local Public Health Departments* has the complete recommendations.

In response to the recommendation to create a nonprofit organization to oversee voluntary accreditation, RWJF is partnering with the CDC to establish the Public Health Accreditation Board (ID# 061340, which ends in May 2008). The Public Health Accreditation Board will develop and administer the voluntary, national accreditation program.

RWJF Activities in Public Health Law

In 2007, RWJF issued a call for proposals for *Advancing Public Health Practice and Policy Solutions*, which funds projects to:

- Build the evidence for effective public health practice and policies.
- Improve the performance and impact of local and state health departments.
- Increase advocacy for public health policies and resources for the public health system.

RWJF is also funding the *Public Health Law Association* to create an agenda for building public health law capacities at multiple levels and communication linkages that could provide a useful tool for health policy change (ID# 059022, which ends in February 2008).

Kellogg's Work After Turning Point

The W.K. Kellogg Foundation has funded several projects that build on its work under *Turning Point*, including:

- The Center for Empowered Decision Making, which assists Louisiana *Turning Point* sites and neighboring communities in recovery and rebuilding efforts after Hurricane Katrina.
- The *Turning Point* Montserrat Project, a grant to the health department in Montserrat to help the Caribbean island recover from a series of volcanic eruptions that destroyed infrastructure, forced more than half of the residents to leave their homes and made two-thirds of the island uninhabitable.

Kellogg also launched Community Voices: Healthcare for the Underserved, which is designed to help ensure that safety-net providers survive and to strengthen community support services.

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Sidebars

NEBRASKA DEVELOPS A RESPONSIVE PUBLIC HEALTH SYSTEM

Site Profile

In 1997, local public health departments in Nebraska served only 18 of the state's 93 counties. Local public health departments were located primarily in small rural counties and generally had few staff and limited funds, making it impossible for them to provide most essential public health services (listed in [Appendix 8](#)).

Turning Point enabled Nebraska to transform its public health system, according to David Palm, PhD, a staff member in the Nebraska Department of Health and Human Services and director of the *Turning Point* project. A broad-based partnership, known as the Nebraska Community Health Partners Stakeholder Group, guided *Turning Point* activities.

Key partners were:

- Creighton University
- Nebraska Hospital Association
- Nebraska Medical Association
- University of Nebraska.

Other partners in the Stakeholder Group included local health departments, the state health agency, community action agencies, area agencies on aging, faith-based organizations, the business community, racial and ethnic minority organizations and environmental groups.

Staff from the two Kellogg-funded community partnerships also participated:

- Buffalo County Community Health Partners, Kearney, Neb.
- North Central Community Care Partnership, Loup City, Neb.

"*Turning Point* helped us build consensus across the state that the number one thing we needed to do was build a public health infrastructure," said Palm. "It also helped us produce a plan that provided visibility and momentum for change in the public health community—and among policy-makers in the governors' office and the legislature."

From 1997 to 1999, the Stakeholder Group developed a public health improvement plan that focused on building public health infrastructure at the regional level through

multicounty, community-based public health departments. The Buffalo County Community Health Partners and the nine-county North Central Community Care Partnership, which were both implementing strategies to meet local health needs, served as models.

In 2000, Nebraska *Turning Point* awarded grants to build or establish four multicounty, community-based public health departments:

- North Central Community Care Partnership (nine counties)
- Northeast Community Partnerships (nine counties)
- South Central Community Health Partners (five counties)
- Bridging Health (six counties).

That same year, to facilitate the state's public health infrastructure work, the Nebraska Department of Health and Human Services established the Office of Public Health (now called Office of Community Health Development), which housed Nebraska *Turning Point* staff. David Palm was named administrator.

Having a public health improvement plan enabled Nebraska *Turning Point* to successfully advocate for funding for public health infrastructure from state tobacco settlement funds. When the state legislature passed the Nebraska Health Care Funding Act in 2001, it appropriated \$5.7 million annually to establish regional public health departments throughout the state.

Staff in the Office of Public Health used their experience in working with the four multicounty public health departments to help other communities and partnerships establish something similar. Local communities had substantial flexibility, choosing the counties with which they wanted to partner, and determining how they would provide essential public health services.

Initially, Office of Public Health staff provided technical assistance to the regional public health departments, focusing on coalition building, needs assessment, setting priorities, developing service strategies and developing evaluation and outcome measures. As the departments got up and running, staff focused on training staff and board members.

By 2004, 16 regional public health departments covered every county in the state, providing the core functions of public health and some of the 10 essential public health services. By 2006, these departments provided nearly all of the essential public health services, as well as services not available through the Nebraska Health and Human Services System, including:

- Identifying and tracking disease outbreaks, such as West Nile virus.

- Partnering with local emergency management coalitions to develop plans to handle bioterrorism or a natural disaster.
- Establishing health promotion and disease prevention programs on obesity and chronic disease.

Nebraska *Turning Point* provided seed money to help establish the [Great Plains Public Health Leadership Institute](#), a year-long program to build and enhance the leadership skills of senior and emerging public health leaders in Iowa, Nebraska and South Dakota. The institute began in 2005.

"Part of our infrastructure is educating and training our workforce and building leadership capacity," said Palm. "The Great Plains Public Health Leadership Institute has been an extremely good investment."

In 2006, the state of Nebraska appropriated \$1.8 million annually to support the regional public health departments. "*Turning Point* was the catalyst for change in Nebraska. We think we have a public health system in place now that will be here for a long time," said Palm.

Grant ID: 39012

NEW YORK TRAINS ITS PUBLIC HEALTH WORKFORCE

Site Profile

To prevent disease and promote health among its 18.1 million residents, New York state needed a large and skilled public health workforce. The state health department and 58 local health departments found it difficult to recruit, retain and train enough public health professionals to meet the needs of New Yorkers.

In 1997, the New York State Department of Health, which managed the state's *Turning Point* initiative, created the New York State Community Health Partnership as the steering committee for *Turning Point*. The partners include:

- Business Council of New York State
- Cornell University
- Healthcare Association of New York State
- Healthcare Trustees of New York State
- Medical Society of the State of New York
- New York State Association of County Health Officials
- New York State Nurses Association

- New York State Public Health Association
- State Communities Aid Association.

The New York State Community Health Partnership also included the three Kellogg-funded community partnerships in key meetings. The Kellogg partnerships were:

- Chautauqua County *Turning Point* Partnership, Mayville, N.Y.
- Healthy Capital District Initiative, Albany, N.Y.
- New York City *Turning Point* Partnership, New York, N.Y.

In 1999, these partners developed a state public health improvement plan that covered six areas:

- Capacity building
- Community health data and information
- Communication and mobilization
- Restructuring investments
- Access
- Quality improvement.

"Capacity building was clearly a need identified during the planning process," said Sylvia J. Pirani, MPH, MS, director of the New York State Department of Health's Office of Local Health Services and director of New York *Turning Point*.

"The roles of public health departments were changing. They needed to be up-to-date on emerging public health issues. They were moving away from a focus on providing care to a real focus on prevention. They needed training in these areas, and they needed training programs that were accessible to them."

Project partners and staff focused on developing and delivering practical, easy-to-attend training to state and local health care workers, using distance learning where possible. To develop the curriculum and identify expert teachers, they worked closely with:

- Columbia University Mailman School of Public Health
- New Jersey Public Health Training Center
- New York State Nurses Association
- Northeast Regional Public Health Leadership Institute
- State University of New York

- University at Albany School of Public Health and Continuing Education Program.

Training programs included:

- [Third Thursday Breakfast Broadcasts](#) (T2B2): These monthly, one-hour satellite broadcasts provided essential information for addressing emerging public health issues.
- Continuing education programs to develop public health skills: Offered regionally at state offices or hotels so that they are accessible and affordable, these programs have included:
 - Public Health 101
 - Basic Environmental Health
 - Annual New Local Public Health Director/Commissioner Orientation
 - Public Health Nursing Continuing Education
 - Confidentiality Training.

Participating in *Turning Point* enabled the New York State Department of Health to secure an annual training budget from the state to support the Third Thursday Breakfast Broadcasts, which are now available to anyone for free, and other continuing education programs.

Turning Point also raised the visibility of the needs of New York's public health workforce, according to Pirani. In 2003, the state's Public Health Council published a report titled [Strengthening New York's Public Health System for the 21st Century](#). "The report definitely benefited from our *Turning Point* work," said Pirani.

That report led to the establishment of the New York State Public Health Workforce Taskforce, which published its recommendations in [Roadmap: Strengthening the Public Health Workforce in New York State](#) (2006).

Grant ID: 33307

SATELLITE BROADCASTS BRING QUALITY TRAINING TO NEW YORK

Site Story

Frustrated with the lack of appropriate training opportunities and hampered by the limited resources available for public health, New York *Turning Point* leaders were searching for ways to help public health professionals develop their skills. After partnering with continuing education staff at the State University of New York (SUNY) at Albany School of Public Health, they identified one solution: satellite broadcasts.

Launched in 1999, the Third Thursday Breakfast Broadcasts (T2B2) provide training on public health issues in eight areas:

- Public health basics
- Maternal-child health
- Environmental health
- Community health
- Chronic disease
- Obesity, nutrition and exercise
- Health communication
- Public health preparedness.

Each one-hour broadcast features an expert discussing a public health issue. During the last 10 minutes of each program, participants can ask questions via phone or fax.

The topics covered in each T2B2 are broad, from injury-free children to emergency preparedness, from Lyme disease to ethics in public health. For example:

- In an August 2000 broadcast, Barbara Barlow, MD, director of surgery at Harlem Hospital, highlighted the hospital's *Injury-Free Coalition for Kids* (funded by the Robert Wood Johnson Foundation). This program started out helping build a safe community in Harlem by cleaning up playgrounds, and offering children's programs in dance, art, cycling, counseling and more. It evolved into a coalition of programs run by children's hospitals in communities around the nation. See [Program Results Report](#) for more information.

- After September 11, 2001 and the anthrax scare, T2B2 featured a broadcast on emergency preparedness. Kristine Gebbie, DrPH, RN, FAAN, from Columbia University, reviewed core competencies in emergency preparedness.
- Lyme disease was the subject of a broadcast in May 2002. Dennis White, PhD, director of the Arthropod-Borne Disease Program for the New York State Department of Health and a faculty member at SUNY at Stonybrook, highlighted the geographic spread of Lyme and other tick-borne diseases and provided an overview of Lyme disease diagnosis, prevention and control.

"Before T2B2, we had virtually nothing," said Jan Chytilo, director of health education in Broome County, N.Y., and site coordinator of T2B2 in her county. "Now I sit at my desk and look across at the bookshelf of taped episodes of T2B2. We lend them to our partners and watch episodes during our 'Learning Lunches.' T2B2 helps us gain both technical skills and a broader picture of what is being done in public health."

The New York State Department of Health co-sponsored the series with the New York State Association of County Health Officials, the New York State Community Health Partnership and SUNY at Albany. In 2001, the partners made the series available to public health professionals nationally through the Public Health Foundation's Training Network and other organizations, including the California Learning Network and the Johns Hopkins Training Center for Public Health. They also created a lending library of videos for local public health departments.

T2B2 broadcasts are now available for free nationally via Webcasts managed by SUNY at Albany. Past broadcasts are also available via the Web site in Webstreaming and videotape formats, and as handouts. Nurses, physicians and certified health education specialists can earn continuing education credits for current and past broadcasts.

OKLAHOMA DEVELOPS LOCAL PARTNERSHIPS TO DRIVE PUBLIC HEALTH CHANGE

Site Profile

In the 1990s, Oklahoma had one of the best public health infrastructures in the nation, with public health departments in 69 of its 77 counties. Nonetheless, the state had some of the nation's highest rates of the four leading causes of death (heart disease, cancer, cerebrovascular disease and chronic obstructive pulmonary disease), according to a 1997 report from the Oklahoma State Board of Health (*The State of the State's Health*).

"We had a very good infrastructure with a well-trained public health workforce, yet we were not making an impact. We figured out that the problem was our approach to public

health," said Neil E. Hann, Chief of the Oklahoma State Department of Health's Community Development Services.

"We have traditionally had a very centralized system where decisions about public health were made in Oklahoma City and we tried to implement them in a cookie cutter fashion across the state. That wasn't working."

Turning Point provided the opportunity to develop partnerships between the state and local communities in order to pursue tailored local solutions to community-specific needs, conditions and concerns.

From 1997 to 1999, project staff from the Oklahoma State Department of Health worked with an advisory board, public and private sector partners and three Kellogg-funded community partnerships to develop a public health improvement plan.

- The advisory board was comprised of local community members and representatives of business, educational institutions, faith communities, government and health care and voluntary agencies.
- Key public and private sector partners were:
 - Chesapeake Energy Corp.
 - INTEGRIS Health
 - Oklahoma Institute for Child Advocacy
 - Oklahoma State Chamber of Commerce
 - State of Oklahoma Governor's Office.

Other partners included community organizations, faith-based organizations, foundations, government and health care providers.

- The Kellogg-funded community partnerships were:
 - Community Health Coalition and Health Services Council of Cherokee County, Tahlequah, Okla.
 - Texas County *Turning Point*, Guymon, Okla.
 - Tulsa *Turning Point* Partnership, Tulsa, Okla.

In 2000, Oklahoma began implementing its public health improvement plan, which emphasized that communities, not the state, need to drive public health change. Using the counties of Cherokee, Texas and Tulsa as models, the plan called for developing local partnerships throughout the state.

In 2001, Oklahoma *Turning Point* hired seven field consultants and stationed them across the state to provide technical assistance to local partnerships, helping them to become established, analyze data, set priorities, develop work plans and more. The advisory board, which became the *Turning Point* Council in 2002, also provided technical assistance to the local partnerships.

Oklahoma *Turning Point* hired an epidemiologist, who identified the top four health issues in each county and their cost implications, and explained them in language suitable for the general public. "This enabled the counties to relate the cost of poor health to money. It motivated them to do something," said Larry Olmstead, the project director.

Oklahoma *Turning Point* provided the local partnerships with access to data, Internet-based video conferencing and e-mail policy alerts, and helped to promote collaborations. For example, when the state Department of Mental Health and Substance Abuse Services wanted to fund local methamphetamine and suicide prevention programs, staff asked Olmstead if any of the local partnerships were interested. The result: Four Oklahoma *Turning Point* partnerships received funding.

By 2004, 50 counties had developed local partnerships. These partnerships assessed local public health needs, developed and implemented Community Health Improvement Plans, and evaluated progress. Oklahoma *Turning Point* "transformed the way that public health is done in Oklahoma," according to Neil Hann, MPH. "We call Turning Point a philosophy, not a program."

The activities begun under Oklahoma *Turning Point* became part of the Oklahoma State Department of Health's Community Development Services after the program ended in 2004. Other divisions within the Department of Health have also adopted the *Turning Point* "philosophy" of working with communities, according to Hann.

By 2007, with local partnerships in 67 Oklahoma counties, evidence that *Turning Point's* philosophy has taken root was starting to emerge. For example: Walk This Weigh, a program to encourage people to exercise by walking, was spreading statewide. In Beaver, a small town in northwest Oklahoma, 300 people—25 percent of the town's population—participated in a Walk This Weigh event.

- Before *Turning Point*, Oklahoma had four federally-qualified health centers. By 2007, 12 health centers were operated at 22 sites.
- Many local partnerships were working on tobacco prevention programs, with grants from state tobacco settlement funds.

"We have the infrastructure now through our community partnerships where we will, within the next 10 years, really see some significant changes," predicted Hann. "*Turning*

Point has made a huge difference and it will continue to make a huge difference in Oklahoma."

Grant ID: 56151

VIRGINIA ESTABLISHES A PUBLIC HEALTH INSTITUTE

Site Profile

In the mid-1990s, signs of trouble had emerged in Virginia's health care system:

- The state's overall health status had fallen from 10th in the nation to 19th.
- The state was losing \$2.8 billion annually in direct medical costs and indirect costs related to diabetes and spending \$300 million per year to cover treatment for preventable injuries.
- More than one million Virginians did not have basic health insurance.

In order to strengthen the state's public health infrastructure, the Virginia Department of Health and the [Virginia Hospital & Healthcare Association](#) partnered to manage Virginia *Turning Point*. The Virginia Hospital & Healthcare Association acted as the fiscal agent. "Having the fiscal agent outside government gave us a certain amount of agility," said Christopher Bailey, senior vice president of the Hospital & Healthcare Association. "We didn't have to go by government purchasing rules and regulations. When we needed something, we could go get it."

Assembling community partners was the first step in Virginia *Turning Point*. Key partners included:

- Baptist General Convention of Virginia
- Virginia Chamber of Commerce
- Virginia Health Care Foundation.

Other community partners represented academia, the business community, the faith community, the health care delivery system, state and local agencies and nonprofit organizations.

The Kellogg community partnerships were:

- New Century *Turning Point* Partnership, Roanoke, Va.
- Norfolk *Turning Point* Partnership, Norfolk, Va.
- Prince William Partnerships for Health, Woodbridge, Va.

Representatives of all the partners formed a steering committee to develop the state's public health improvement plan. The plan included an assessment of the economics of disease prevention, a community health needs assessment and strategies to enhance public awareness.

To implement the plan and institutionalize Virginia *Turning Point*, project staff established the Virginia Center for Healthy Communities, in 2001 as an independent, nonprofit public health institute dedicated to improving the health of Virginia's communities. The center fosters collaboration and partnership among public health entities, health care providers and community stakeholders. Members of the Virginia *Turning Point* steering committee became the board of directors for the new organization.

During *Turning Point*, the Virginia Center for Healthy Communities focused on creating a new community health data tool and reaching out to the business community.

Projects included:

- **Virginia Atlas of Community Health:** This free [Web-based](#) tool is designed to help communities write grants, assess needs and evaluate programs.

The *Atlas* provides local data on population demographics, economics and health status, including numbers of births and deaths, hospitalization rates and health insurance coverage. Users can quickly generate reports and maps to evaluate the health of their communities at the local and ZIP code levels.

"The *Virginia Atlas of Community Health* has changed the way individuals and organizations in Virginia look at health data," said Jeff Wilson, the former strategic planning coordinator for Virginia *Turning Point* and director of the Virginia Center for Healthy Communities.

"Before *Turning Point*, many small, not-for-profit organizations did not have access to data about the health of their communities. Contracting with a consulting firm to develop the reports and maps was beyond their ability financially. Now, these organizations can effectively assess community health and justify why resources are needed to address a community health concern."

- **A Web-based health improvement program planning guide, including conducting a needs assessment, and designing, implementing and evaluating programs.**
- **Health improvement activities in partnership with the business community.** The Virginia Center for Healthy Communities sponsored three health-related roundtables to discuss employee wellness, rising health insurance rates and future trends in workplace-based prevention programs. About 100 people attended each roundtable, including business leaders, public health officials, health care providers, insurers, elected officials and representatives of local government agencies.

The center also worked with a local Chamber of Commerce to initiate workplace diabetes screenings.

The Virginia Center for Healthy Communities has maintained the *Virginia Atlas of Community Health* and other resources on health improvement planning on its Web site since *Virginia Turning Point* ended in 2004. Center staff continued to add data to the *Atlas* with funding from the Virginia Consortium for Health Philanthropy through mid-2007.

The *Atlas* served as a prototype for Virginia Performs, a statewide performance accountability system that creates a framework for state agencies to establish and measure objectives for programs and services. Virginia Performs began in 2006.

As of September 2007, the Virginia Department of Health was working with local communities and health departments to reduce infant deaths and chronic disease. Other projects were underway with funding from the National Governors Association, and in partnership with the Virginia Department of Education and school districts, to promote physical fitness in low-income neighborhoods.

Grant ID: 33312

LINKING WITH THE VIRGINIA BUSINESS COMMUNITY TO CURB DIABETES

Site Story

In the late 1990s, more than twice as many people were dying from diabetes in Wythe County, part of Appalachian Virginia, as in the rest of the state. Although diabetes screenings were available in the community and a community hospital offered classes for people newly diagnosed with the disease, those efforts were not reaching the highest-risk populations.

A diabetes screening program organized with the local business community had better results. The idea for workplace diabetes screenings came from the Virginia Center for Healthy Communities. After conducting research that showed the high rates of diabetes in Wythe County, and the cost to employers of uncontrolled diabetes, staff presented the idea to the Wythe-Bland Chamber of Commerce.

Recognizing that diabetes can mean many hours of lost work, the chamber was interested in a partnership. The center managed the project, bringing in the Mount Rogers Health District and the Wytheville Community Hospital to deliver services. These included conducting workplace diabetes screenings and educational sessions, and providing materials about preventing and managing the disease. The Chamber of Commerce encouraged local businesses to participate in the project.

During screening days, which were held at local businesses, a school and the community hospital, health care professionals screened and educated hundreds of employees. They also rushed two employees with dangerously high levels of blood sugar to the hospital for immediate care.

Based on the project's success, the Wythe-Bland Chamber of Commerce established a Health Task Force to manage future diabetes screenings and similar projects. Business leaders, health educators from the local health department and nurses from the hospital serve on the task force.

MISSOURI TURNING POINT IMPLEMENTS VOLUNTARY ACCREDITATION

Site Story

When *Turning Point* started, local public health departments in Missouri varied in the level of services they provided and how well they performed the core functions and essential services of public health.

Representatives of Missouri *Turning Point*, which was a member of *Turning Point's* Performance Management National Excellence Collaborative, became aware of the importance of measuring and managing public health performance. Going one step further, Missouri *Turning Point* decided to establish a voluntary accreditation program for its local public health departments.

The Center for Local Public Health Services, part of the Missouri Department of Health and Senior Services, worked with health care providers, the private sector, universities, health and human service associations and other state and local government agencies to develop the voluntary accreditation program.

To ensure that accreditation was independent, the state established the [Missouri Institute for Community Health](#) as the accrediting body. The institute is a not-for-profit corporation governed by a board of directors representing health care providers, academia, human service organizations and state and local government.

Missouri's Voluntary Accreditation Program for Local Public Health Agencies was launched in 2003. The first local public health agency was accredited the same year. The program lays out standards for agency infrastructure and for agency performance.

Performance indicators used to measure agency infrastructure are:

- Planning process

- Governance and leadership
- Facilities/service delivery
- Financial and resource management
- Workforce
- Information technology
- Communications
- Intergovernmental issues.

Agency performance is measured by indicators intended to evaluate the agency's ability to perform essential public health services.

Grant ID: 42379

EMERGING PUBLIC HEALTH LEADERS IN MINNESOTA BUILD CONFIDENCE AND SKILLS

Site Story

Combating Burnout

Kristin Schultz, the assistant director of a local public health department in rural Minnesota, was tired of always trying to do more with less and overwhelmed by the challenges of working in public health. She was thinking about leaving the field.

Then she applied to Minnesota *Turning Point's* Emerging Leaders Network. Participating in the training program was a professional and personal turning point for Schultz.

During a simulation of a public meeting in which she played an elected official, for example, she realized that she was a good leader. "I discovered that others had wanted my leadership. They valued my skills and my style in a way I had not expected," she said. "I gained a lot of confidence in my ability to lead and have become more willing to trust my instincts in difficult situations."

In another exercise, Schultz had to introduce herself to attendees at a statewide public health conference. She learned how to build a network that included people with different backgrounds and experiences, and to appreciate their different perspectives on public health.

Kristin "graduated" from the Emerging Leaders Network program with the confidence to tackle public health problems, and a renewed passion for strengthening the public health system.

"The Emerging Leaders Network connected me to the entire public health system in a totally new way," she said. "I now know that together we can take on tomorrow's challenges."

Managing Hospital Hazardous Waste

Fawzi Awad, another "graduate" of the Emerging Leaders Network, worked at the Environmental Health Section of the Ramsey County Department of Public Health, helping to protect the environment in Minnesota from hospital hazardous waste. Managing the waste required compliance with complex local, state and federal regulations, and collaboration with the state's hospitals.

Awad knew that he needed a collaborative approach to lead the committee developing a hazardous waste management plan for Minnesota hospitals. "To accomplish our task we would need to find ways to encourage everyone to do their part on this huge issue," said Awad.

He said that participating in the Emerging Leaders Network gave him the skills and tools of collaborative leadership that he needed to guide the committee.

For example, after every committee meeting he practiced self-reflection, one of six key practices of collaborative leadership identified by *Turning Point's* Leadership Development Collaborative. By being aware of the impact of his actions and words on committee members, Awad was able to adjust his behavior as needed to guide the committee.

Awad's Emerging Leaders Network training also taught him steps to use in conflict resolution, and ways to share power. As a result, committee members became comfortable sharing their concerns and learned to respect each other's perspectives.

"There is a difference between making people do things and making them want to do things," said Awad. "Collaborative leadership is about providing people with encouragement, guidance and consistency—and motivating them to stay focused on the task."

[Grant ID: 55807](#)

NEW PARTNERSHIPS HELP BUILD INFRASTRUCTURE

Site Story

South Carolina

Partners for a Healthy Community, a broad-based community coalition of organizations working to improve health in Anderson, S.C., and surrounding counties, was a key local partner in the state's *Turning Point* initiative. Becky F. Campbell chaired Partners for a Healthy Community and also chaired the South Carolina Turning Point Steering Committee.

Campbell guided the process of developing the state's public health improvement plan. After South Carolina received funding to implement its *Turning Point* project, she led one of three community health assessments. During this assessment, members of the community helped determine local health priorities.

Campbell said that participating in *Turning Point* changed the way she saw public health, and made Partners for a Healthy Community more effective in assessing community health and raising funds to improve it. "Because of *Turning Point* I see things differently. There's a better way of doing public health business in communities: seeking community input and direction, defining health broadly, aligning resources and sharing credit."

New Hampshire

Community leader Donna Tighe had already created Greater Derry Community Health Services, a network of physicians and dentists willing to provide care to uninsured patients in Derry, N.H. For the former labor and delivery nurse, participating in New Hampshire *Turning Point* was a "natural extension" of that work. "The people we see are the same ones most impacted by the growth of our community and the lack of a comprehensive public health system," she said.

Turning Point's flexible approach was crucial to the development of the New Hampshire Public Health Network, says Tighe. The network is a system of regional community collaboratives; each collaborative acts as a local liaison to state agencies in order to create a more effective and responsive local public health system.

Network members include local health departments and health officers, fire, police, emergency medical services, health care providers, social service agencies, schools, media and advocacy groups and leaders in business, politics and the faith community.

"*Turning Point* was not proscriptive," said Tighe. "It was broad enough to allow us to experiment with what could work for our community."

New York

Sue Ellen Wagner brought the health system perspective to New York *Turning Point*. Wagner is vice president of workforce and community health at the [Healthcare Association of New York State](#), a nonprofit organization that represents more than 550 nonprofit and public hospitals, nursing homes, home care agencies and other health care organizations.

As the association's *Turning Point* representative, Wagner focused her attention on helping hospitals and local health departments work together on community health assessments and community service plans. She facilitated forums with hospitals and local health departments to highlight best practices, and drafted legislation to encourage continued coordination of assessments between hospitals and health departments.

THE SOCIAL MARKETING NATIONAL EXCELLENCE COLLABORATIVE: CHANGING UNHEALTHY BEHAVIORS

Site Story

Social marketing is a way to use marketing principles to influence behavior and improve health outcomes. Social marketing campaigns can convince mothers to give their children low-fat milk instead of whole milk, kids to exercise, women to get a mammogram and everyone to eat more fruit and vegetables.

"Social marketing can be used to help you achieve your public health goals by focusing on behavior change in an audience you want to reach," said Sylvia J. Pirani, MPH, MS, director of New York *Turning Point*, which led the Social Marketing Collaborative. "It's a planned approach that focuses on evidence."

One of five National Excellence Collaboratives established under *Turning Point*, the Social Marketing Collaborative focused on helping public health professionals learn about social marketing and providing them with the tools they needed to use it.

In addition to New York, collaborative members included Illinois, Maine, Minnesota, North Carolina and Virginia. Some collaborative members had many years of social marketing experience while others were new to the technique.

Providing an Overview of Social Marketing

Members began their work by outlining the basic principles of successful social marketing campaigns:

- Know the audience: their needs and wants, barriers and motivations. Social marketers put the audience at the center of every decision.
- Action: Be clear about what you want the audience to do. Changes in knowledge are only good if they lead to action.
- Offer an exchange: Offer the audience something very appealing in return for changing behavior.
- Be aware of the competition: It always exists. The audience can always choose to do something else (e.g., taking the elevator instead of the stairs).
- Be aware of the "4Ps" of marketing: Product, price, place and promotion and how they apply to the program.
- Understand the role that policies, rules and laws can play in efforts to affect social or behavioral change.

A Tutorial on Health Communications

Collaborative members tied together these principles, along with lessons from the field and resources in an interactive multimedia decision support tool, *CDCynergy-Social Marketing Edition Version 2.0*, which provides step-by-step guidance for developing and documenting a successful social marketing program.

"It's a very accessible way to learn about social marketing: on your computer. It's an easy-to-use tool," said Pirani.

CDCynergy-Social Marketing Edition is based on *CDCynergy*, a CD-ROM tutorial for health communication that the Centers for Disease Control and Prevention (CDC) developed for public health practitioners.

The collaborative developed training in the use of the *CDCynergy-Social Marketing Edition*, and offered training to users and trainers (the train-the-trainer approach). Public health practitioners could attend in-person training sessions or participate in interactive Tools of Change "webinars."

Collaborative members distributed the product through the *Turning Point* website and through the CDC, the University of South Florida and the Academy for Educational Development.

Social marketing trainers from the collaborative trained staff from the [Quality Improvement Organization Program](#) of the federal Centers for Medicare & Medicaid

Services to use social marketing to persuade providers to help patients adopt healthy behaviors. The Quality Improvement Organization Program works with consumers and physicians, hospitals and other caregivers to ensure that patients, especially those from underserved populations, get the right care at the right time.

Institutionalizing Social Marketing

North Carolina

North Carolina emerged as a model for institutionalizing social marketing. Before *Turning Point*, the state had done some social marketing but had no uniform system in place for its use. Understanding of, and proficiency with, social marketing varied widely.

North Carolina used *Turning Point* funds to hire Mike Newton-Ward for a full-time social marketing position within the Division of Public Health. "Mike Newton-Ward set up a process for how to incorporate social marketing in the state health department," said Pirani.

"Social marketing gives us a 360 degree view of all of the things that contribute to the problem, and the things to focus on to change behavior. It provides us with one of the best ways to support lasting positive health changes in people," said Newton-Ward.

Newton-Ward spearheaded the development of a Social Marketing Matrix Team, comprised of staff from various public health programs. Team members develop resources and programs, build coalitions, train public health staff, work on policy change and develop branding strategies to strengthen public health at the state and local levels.

By the time *Turning Point* drew to a close, public health professionals in North Carolina were ready for "A to Z best practices social marketing," says Newton-Ward. Among the social marketing campaigns in the state:

- *An obesity campaign, focused on reducing the amount of soda and fruit juice that middle and high school students drink at school.* After gaining input from students, parents, PTA representatives and school administrators and teachers, public health staff decided the most effective approach would be to change policies allowing vending machines in schools.
- *Know Your Numbers, a campaign to prevent heart attacks and strokes in people with high blood pressure.* A series of public service announcements made people aware of the problem, and sought to persuade them to ask their health care provider about their "numbers."
- *In a collaboration with Subway Restaurants, a campaign to encourage people to eat lower fat foods.* Local Subway restaurants featured information about healthy eating, including cards that people could mail to the Division of Public Health to receive more information.

New York

With training from the Social Marketing Collaborative, New York incorporated social marketing into its federal STEPS to a HealthierUS grant. STEPS to a HealthierUS is a federal program that funds communities to create programs to prevent diabetes, obesity and asthma and promote healthy lifestyles. Collaborative members in New York taught STEPS staff how to integrate social marketing into project planning and an experienced social marketing consultant provided three days of training and technical assistance on developing a social marketing plan.

Beyond Turning Point: The Collaborative Continues

In 2005, RWJF awarded the Social Marketing National Excellence Collaborative a transition grant (ID# 039001) to update *CDCynergy-Social Marketing Edition*, provide training on it and develop a business plan to continue its work. Since that grant ended in 2007, [The Watson Group](#), a marketing communications firm in Wayzata, Minn., has been managing the activities of the Social Marketing Collaborative.

APPENDIX 1

Turning Point Coordinating Council Members

(Current as of the time of the grant; provided by the grantee organization; not verified by RWJF.)

Susan B. Hassmiller, PhD, RN, FAAN

Senior Program Officer
Robert Wood Johnson Foundation
Princeton, N.J.

Barbara Sabol

Program Director
W.K. Kellogg Foundation
Battle Creek, Mich.

Bobbie Berkowitz, PhD, RN, FAAN

Director, RWJF *Turning Point* National
Program Office
Alumni Endowed Professor of Nursing
Director, Center for the Advancement of
Health Disparities Research
University of Washington
Seattle, Wash.

Betty Bekemeier, PhD, MS, RN

Deputy Director, RWJF *Turning Point* National
Program Office
Assistant Professor
School of Nursing
University of Washington
Seattle, Wash.

Vincent Lafronza

Director, Kellogg *Turning Point* National
Program Office
National Association of County and City
Health Officials
Washington, D.C.

APPENDIX 2

Turning Point National Advisory Committee Members

(Current as of the time of the grant; provided by the grantee organization; not verified by RWJF.)

Gilbert Omenn, MD, PhD (chair)

Professor of Internal Medicine, Human Genetics and Public Health
University of Michigan
Ann Arbor, Mich.

Macaran A. Baird, MD, MS

Professor and Department Head
Family Practice & Community Health
University of Minnesota
Minneapolis, Minn.

Diana M. Bonta, RN, DrPH

Vice President of Public Affairs
Kaiser Permanente
Pasadena, Calif.

Ned Calonge, MD, MPH

Primary care physician
Colorado Department of Public Health and Environment
Denver, Colo.

Moses Carey, Jr.

Director
Orange-Chatham Health Services
Chapel Hill, N.C.

Mary Jane England, MD

President
Regis College
Weston, Mass.

Randy Gordon, MD, MPH

Deloitte Consulting
Mechanicsville, Va.

Sandra Harmon-Weiss, MD

Vice President, Medical Director & Head of Government Programs
Aetna US Healthcare
Blue Bell, Pa.

Sam Ho, MD

Vice President, Quality Initiatives
PacifiCare Health Systems
Cypress, Calif.

Harry S. Jonas, MD

Special Consultant to the Dean
University of Missouri, Kansas City
Kansas City, Mo.

Colleen Kivlahan, MD, MSPH

Senior Vice President of Medical Affairs
Schaller Anderson
Phoenix, Ariz.

M. Jane Oehm

Member of the Board
Lutheran Medical Center Foundation
Ridge, Colo.

Moises Perez

Executive Director
Alianza Dominicana
New York, N.Y.

Robert (Bobby) Pestronk, MPH

Health Officer
Genesee County Health Department
Flint, Mich.

Toni Plummer

Glasgow, Mont.

Peggy Rosenzweig

Senator
Wisconsin State Senate
Wauwatosa, Wis.

Beatrice Shelby

Executive Director
Boys, Girls, Adults Community Development Center
Marvell, Ark.

APPENDIX 3

The *Turning Point* States and Local Communities

The following is a summary of RWJF and Kellogg *Turning Point* grants to states and local communities:

State	RWJF Funding	W.K. Kellogg Foundation Funding
Alaska	1997–2005	Grants to 3 community partnerships from 1998–2000; 2 of these received additional grants from 2000–2002.
Arizona	1997–2004	Grants to 4 community partnerships from 1998–2000; 3 of these received additional grants from 2000–2002.
Colorado	2000–2004	No community funding.
Illinois	1997–2004	Grants to 3 community partnerships from 1998–2000; 2 of these received additional grants from 2000–2002.
Kansas	1997–2005	Grants to 2 community partnerships from 1998–2000.
Louisiana	1997–2000	Grants to 3 community partnerships from 1998–2000; 1 of these received an additional grant from 2000–2002.
Maine	1999–2006	No community funding.
Minnesota	2000–2006	No community funding.
Missouri	1999–2005	No community funding.
Montana	1997–2004	Grants to 4 community partnerships from 1998–2000; 2 of these received additional grants from 2000–2002.
Nebraska	1997–2004	Grants to 2 community partnerships from 1998–2000; 1 of these received an additional grant from 2000–2002.
Nevada	2002–2005	No community funding.
New Hampshire	1997–2004	Grants to 3 community partnerships from 1998–2000; 1 of these received an additional grant from 2000–2002.
New Mexico	1997–2000	Grants to 4 community partnerships from 1998–2000; 1 of these received an additional grant from 2000–2002.
New York	1997–2004	Grants to 3 community partnerships from 1998–2000; 2 of these received additional grants from 2000–2002.
North Carolina	1997–2004	Grants to 2 community partnerships from 1998–2000.
Oklahoma	1997–2004	Grants to 3 community partnerships from 1998–2000; 2 of these received additional grants from 2000–2002.
Oregon	1997–2004	Grants to 2 community partnerships from 1998–2000.
South Carolina	1999–2005	No community funding.
Virginia	1997–2004	Grants to 3 community partnerships from 1998–2000.
West Virginia	1999–2005	No community funding.
Wisconsin	1999–2005	No community funding.

APPENDIX 4

Projects Funded by RWJF

Alaska Turning Point

State of Alaska Department of Health and Social Services
Juneau, Alaska

Amount: \$1,250,000

Dates: December 1997 to December 2005

ID#s: 033297 and 039013

Contact

Patricia A. Nault, MPA

(907) 465-8716

patricia_nault@health.state.ak.us

Arizona Turning Point

Maricopa County Department of Public Health
Phoenix, Ariz.

Amount: \$497,761

Dates: April 2000 to September 2004

ID#: 039009

Contact

Catharine Riley, MPH

(602) 506-1248

catharineriley@mail.maricopa.gov

State of Arizona, Arizona Department of Health Services
Phoenix, Ariz.

Amount: \$299,058

Dates: December 1997 to February 2000

ID#: 033298

Contact

Nancy Thomann, MPH

(602) 506-1400

nancythomann@mail.maricopa.gov

Colorado Turning Point

State of Colorado Department of Public Health and Environment

Denver, Colo.

Amount: \$917,858

Dates: June 1999 to February 2006

ID#s: 036866, 039369 and 042381

Contact

R. Maurice Palacio

(303) 692-2329

Mauricio.Palacio@state.co.us

Northeast Colorado Health Department

Sterling, Colo.

Amount: \$150,000

Dates: November 2000 to October 2004

ID#: 040598 (collaborative funds)

Contact

Denise Hase

(970) 522-3741

deniseh@nchd.org

Illinois *Turning Point*

United Way of Illinois

Oak Brook, Ill.

Amount: \$840,847

Dates: April 2001 to December 2004

ID#: 041874

Contact

Elissa J. Bassler

(312) 793-0851

elissa.bassler@illinois.gov

State of Illinois, Illinois Department of Public Health

Springfield, Ill.

Amount: \$1,250,000

Dates: December 1997 to March 2001

ID#s: 033299 and 039008

Contact

Laura B. Landrum

(312) 814-2610

llandrum@idph.state.il.us

Kansas *Turning Point*

State of Kansas Department of Health and Environment

Topeka, Kan.

Amount: \$850,000

Dates: December 1997 to January 2005

ID#s: 033301, 039002 and 046303

Contact

J. Michael Moser, MD, MPH

(785) 296-1343

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APPENDIX 5

Turning Point National Excellence Collaboratives

	Information Technology	Leadership Development	Performance Management	Public Health Statute Modernization	Social Marketing
Alaska			Participant	Lead	
Arizona		Participant		Participant	
Colorado		Participant		Participant	
Illinois			Lead		Participant
Kansas	Participant				
Louisiana		Participant			
Maine	Participant				Participant
Minnesota		Lead			Participant
Missouri	Participant		Participant		
Montana			Participant		
Nebraska		Participant		Participant	
Nevada					
New Hampshire	Participant		Participant		
New Mexico					
New York			Participant		Lead
North Carolina					Participant
Oklahoma	Lead	Participant			
Oregon				Participant	
South Carolina	Participant	Participant			
Virginia		Participant			Participant
West Virginia			Participant		
Wisconsin				Participant	

Other Collaborative Partners	Information Technology	Leadership Development	Performance Management	Public Health Statute Modernization	Social Marketing
<i>All Kids Count</i> (an RWJF-funded project to improve children's health)	X				
American Public Health Association				X	
Association of State and Territorial Health Officials	X	X	X	X	X
Association of State and Territorial Local Health Liaison Officials			X		
Centers for Disease Control and Prevention		X	X	X	X
For Profit Marketing Firm					X
Health Resources and Services Administration	X				
National Association of County and City Health Officials	X	X	X	X	
National Association of Local Boards of Health				X	
National Conference of State Legislatures				X	
National Governors Association				X	
Nonprofit Health Organizations				X	X
Ohio Department of Health				X	
State and local public health agencies					X

APPENDIX 6

The Formative Program Evaluation: Process and Systems Dimensions of Change

Evaluators from [The Lewin Group](#) created ten process and systems dimensions of change as part of their formative program evaluation of *Turning Point*.

Process Dimensions

- Increased breadth, depth and penetration of partners participating in the planning process:
 - Evaluators defined increased breadth as, at a minimum, the inclusion of active partners whose primary focus extends beyond the agency in which the public health authority is housed.
 - Evaluators defined increased depth as, at a minimum, the involvement of more than a single individual representing a partner entity or group.
 - Evaluators defined increased penetration as, at a minimum, some activity within the organization and constituencies represented in the partnership designed to integrate information about the partnership's work into the work of the organization.
- Increased scope of public health activity encompassing a broadening of risk reduction and prevention frameworks. Evaluators defined increased scope as, at a minimum, an agenda of public health activity that has its focus outside the provision of personal health care services to individuals.
- Increased productivity within and across the partnership itself. Evaluators defined this in terms of the ability of the partnership to do work and the amount and quality of work performed. Increased productivity means that the partnership process moves beyond the partners getting to know each other to where they conduct needs assessments and define problems, and then develop action plans that are used to guide future decisions of the partner entities and other forces in the community.

Systems Dimensions

- Increased diversity in constituency participation in setting the public health agenda. The term diversity is intended to capture a broad range of populations inclusive of socioeconomic, ethnic, national origin, religious, age-related and lifestyle minorities as well as majority population groups.

- Increased "systemness" and improved system performance:
 - "Systemness" is a response to the fragmentation in funding streams and professional health-related experience invested in specialized topics, as well as a call for increased accountability.
 - System performance involves looking at how people do work in terms of efficiency, effectiveness, quality, continuity and acceptability to the consumer.
- Improved fit between capacities and characteristics supporting system performance and productivity of partners:
 - This dimension focused on identifying capacity changes reported by partnerships and assessing the extent to which these changes support or inhibit the work of the partnership in achieving *Turning Point* objectives.

Evaluators defined capacity as the ability and will to act on the part of an organization or group. They defined fit as capacities that support and do not undermine implementation plans developed by the partnership.

- Increased strength and fit at the interface between state and local efforts. This dimension focused on how the state and local partnerships related to each other over time, and the extent to which the interaction between state and local partnerships contributes to reported changes in the way any of the partners do business.
- Identification of and action to align policy in support of the emerging public health agenda. Evaluators defined policy as decisions that are formal and explicit, and govern the behavior of others beyond the decision-makers. They outlined indicators for change that ranged from increasing awareness of policy issues to strategic action plans for influencing policy and policy change.
- Increased public awareness and participation in setting and supporting the emergent public health agenda. Evaluators focused on how partnerships approach and influence the public beyond any specific constituency or interest group. They explored changes among average people in their perceptions about and knowledge of public health.
- Identification of and action to obtain funding to sustain implementation of the emergent public health agenda. Evaluators tracked the infusion of other funding into partnerships and the extent to which the partnership realistically addressed a strategy for financing the public health agenda.

APPENDIX 7

Findings About Public Health Institutes

Evaluators from the Public Health Institute summarized their findings about existing and emerging public health institutes at a National Network of Public Health Institutes conference (May 2006):

- Emerging and established public health institutes:
 - Build partnerships among different stakeholders (30 percent)
 - Conduct research and evaluation (27 percent) or
 - Implement programs (24 percent).
- Half of all established public health institutes have annual budgets of at least \$1 million. Most established public health institutes are involved in some combination of:
 - Bringing health-conscious people and organizations together to strengthen and transform public health systems.
 - Building consensus on health priorities.
 - Fostering multisectoral collaboration.
 - Gathering local data to develop community health profiles.

Fewer than 25 percent of emerging public health institutes have worked significantly in these areas.

- Emerging public health institutes are almost twice as likely to operate primarily to implement programs (38 percent), compared to established institutes (20 percent).
- Some emerging public health institutes are very involved in communicating local needs and priorities for health policy development, and in stimulating health care systems reform.
- Fewer than 25 percent of either established or emerging public health institutes are very engaged in workforce training, emergency preparedness, accreditation of local public health entities or modernization of public health statutes—all traditional functions of state and local public health departments. Few public health institutes operate primarily to provide technical assistance and training or to conduct advocacy efforts.

APPENDIX 8

Functions and Essential Services of Public Health

Six core functions and 10 essential services of public health were identified in 1994 by the Public Health Functions Steering Committee, which included representatives of the American Public Health Association, the Association of Schools of Public Health, the Association of State and Territorial Health Officials, the U.S. Public Health Service and others.

The six core functions of public health are to:

- Prevent epidemics and the spread of disease.
- Protect against environmental hazards.
- Prevent injuries.
- Promote and encourage healthy behaviors.
- Respond to disasters and assist communities in recovery.
- Assure the quality and accessibility of health services.

The 10 essential public health services are to:

- Monitor health status to identify community health problems.
- Diagnose and investigate health problems and health hazards in the community.
- Inform, educate and empower people about health issues.
- Mobilize community partnerships to identify and solve health problems.
- Develop policies and plans that support individual and community health efforts.
- Enforce laws and regulations that protect health and ensure safety.
- Link people to needed personal health services and assure the provision of health care when otherwise unavailable.
- Assure a competent public health and personal health care workforce.
- Evaluate effectiveness, accessibility and quality of personal and population-based health services.
- Research for new insights and innovative solutions to health problems.

(Source: Public Health Functions Steering Committee, 1994)

APPENDIX 9

Additional Findings from the Outcome Evaluation: Infrastructure Change

In addition to their [Key Findings](#), evaluators from the Public Health Institute reported these additional findings about infrastructure changes, based on comparisons between *Turning Point* and non-*Turning Point* states:

Additional Findings on Partnerships

- ***Turning Point* often functioned as a "bridge" by providing new structure and/or rationale for the development of new public health partnerships.** For example, *Turning Point*:
 - Served as the focal point for networking across state agencies to implement new initiatives.
 - Provided a structure for streamlining funding from various state agencies to local entities to implement new initiatives.

Additional Findings on Communication

- **Both *Turning Point* and comparison states received considerable emergency preparedness funding for new communications technology and data information systems.** They did not differ significantly in the way they used new communications technology at the local level.
- ***Turning Point* states were rated as improving communication more than the comparison states from 2000 to 2004.** These differences, however, were only statistically significant for the quality of communication between local and state leaders.
- **The lack of difference between *Turning Point* and comparison states in communication improvements may have been due to the increase in federal emergency preparedness funding made available to all states since the September 11, 2001, attacks.** Federal funds helped all states expand communications technologies, and many of these technologies were directly related to emergency preparedness. Improved communication for emergency preparedness, however, did not necessarily affect other areas of public health.

Additional Findings on Planning and Collaboration

- ***Turning Point* and comparison states conducted planning activities in generally similar ways.**

- **All states seem to struggle over power-sharing between local and state public health agencies, with states maintaining decision-making power.** Federal funding priorities often drove state health planning.
- **Local public health representatives from *Turning Point* and comparison states reported similar improvements in state-local collaboration in setting health priorities.** *Turning Point* states, however, used a more collaborative approach by inviting local leaders to help generate ideas or validate plans made at the state level.
- **The lack of formal collaborative structures to determine state health priorities may deter equal power sharing.**
- **Changes in local capacity in *Turning Point* states, such as improved local assessments and an increased number of trained data users, may eventually lead to more local input into setting state health priorities.** *Turning Point* state officials appear to be more knowledgeable about local priorities, and—at least in some states—appear to be willing to consider this information for state health planning.

Additional Findings on Emergency Preparedness and Response

- **Emergency preparedness funding has extended the reach of state health departments into local communities.** This has tended to increase the state's presence in the community but has not truly involved localities in state decision-making or as partners on public health initiatives.
- ***Turning Point* and comparison states were similar in their implementation of new or reorganized offices of emergency preparedness, an infrastructure change reported by virtually all local public health respondents.**
- **All the states used federal emergency preparedness funding to improve technology and develop new relationships for emergency preparedness.**
- **Both the interpersonal relationships and the infrastructure developed as a result of *Turning Point* have helped facilitate the interagency collaboration and exchange of information that federal emergency preparedness funding requires.**

Additional Findings on Funding

- ***Turning Point* and comparison states were no different in their ability to maintain public health priorities in response to state funding shifts.** This may be due to the leveling effect of federal funding for bioterrorism and emergency preparedness.
- **In comparison states, two infrastructure changes were significantly related to the ability of localities to maintain public health priorities despite funding cuts: a new or reorganized office of emergency preparedness and a new or reorganized regional health department or similar entity.**

- **Turning Point states improved their capacity to conduct local assessments and gather information.** Improvements in public health information systems, and the establishment of regional or local offices for public health data/information management, allowed localities in these states to maintain public health priorities in response to funding shifts.

Additional Findings on Delivery of Essential Public Health Services

- **Turning Point states were not significantly different from comparison states in improving the delivery of essential services that are likely to take time to develop.**
- **Turning Point states have used a number of strategies to improve delivery of essential services.** These include:
 - Contract requirements
 - Local assessments
 - Monitoring local public health outcomes
 - Partnerships
 - Innovation
 - Advocacy
 - Increasing responsibility for local public health entities
 - Streamlined funding mechanisms
 - Training public health personnel.
- **Improvements in the quality and frequency of communication between state and local public health departments were significantly associated with certain improvements in providing essential services.** However, the full effect of these improvements will take time to become apparent.
- **In Turning Point states, improved collaboration between state and local public health departments on setting priorities for the state was significantly related to improvements in the following essential services:**
 - Inform, educate and empower people about health issues.
 - Mobilize community partnerships to identify and solve health problems.
 - Link people to needed personal health services and assure the provision of health care when otherwise unavailable.
 - Assure a competent public health and personal health care workforce.

- Evaluate effectiveness, accessibility and quality of personal and population-based health services.

Additional Findings on Leadership and Workforce Development

- ***Turning Point*** and comparison states used different sources of funding and followed different paths for developing their public health workforce and leadership, which may have important long-term implications.
- Master of Public Health programs and training institutes have greatly enhanced public health training in the *Turning Point* states.
- There was a stronger relationship between leadership development and delivery of the 10 essential services in the *Turning Point* states than there was in the comparison states.
- In contrast to comparison states, public health leadership in *Turning Point* states has been developed largely independent of federal bioterrorism funding.

APPENDIX 10

Exploring Accreditation Recommendations

A complete list of recommendations developed as part of the Exploring Accreditation project is available in *Final Recommendations for a Voluntary National Accreditation Program for State & Local Public Health Departments* (September 2006). These recommendations are briefly summarized below:

"Governance. A new non-profit organization should be formed by the Planning Committee organizations to oversee the voluntary accreditation of state, territorial, tribal and local governmental public health departments. The Planning Committee should appoint the initial governing board of the new organization. Under its governing board, the organization would direct the establishment of accreditation standards; develop and manage the accreditation process; and determine whether applicant health departments meet accreditation standards. The organization would maintain the needed administrative and fiscal capacity and would evaluate the effectiveness of the program and its impact on health departments' performance. The governing board and the organization would advocate for available training and technical assistance for public health departments to meet the standards and to develop a culture of continuous quality improvement."

"Eligible Applicants. Any governmental entity with primary legal responsibility for public health in a state, territory, tribe, or at the local level would be eligible for accreditation. Eligibility to apply for accreditation would be determined in a flexible manner, given the variety of jurisdictions and governmental organizations responsible for public health."

"Principles to Guide Standards Development. Standards should be developed to promote the pursuit of excellence among public health departments, continuous quality improvement, and accountability for the public's health. The process for establishing standards should consider performance improvement experience among state and local public health departments.

"The Steering Committee created 11 domains for which state, territorial, tribal and local health departments should be held accountable. Standards should be established for each domain. Measures of compliance may differ but standards should be complementary and mutually reinforcing to promote the shared accountability of public health departments at all levels of government."

"Conformity Assessment Process. Health departments seeking accreditation would undergo an assessment process. It should include a review to determine readiness, a self-assessment, and a site visit, resulting in a recommendation on accreditation status. The final decision on accreditation would be made by the governing board. A public health department would be fully accredited, conditionally accredited, or not accredited. An appeals process would be established to resolve disputes."

"Financing. The new organization should seek initial start-up funding from interested grant-makers, government agencies, and organizations of state and local health departments, some of which may be in-kind support. Subsidies for initial operations will be required, but this phase should be funded in part by applicant fees and other revenues. It is important to attract the full spectrum of local and state public health departments to the accreditation program. As the new organization approaches self-sufficiency, subsidies should be directed more toward applicant fees and costs."

"Incentives. Incentives should be uniformly positive, supporting public health departments in seeking accreditation and achieving high standards. Incentives should support the goal of improving and protecting the health of the public by advancing quality and performance of public health departments. Credibility with government bodies and the public, as well as access to resources for performance improvement, should encourage participation by health departments."

"Program Evaluation. Evaluation is critical in every stage of the development and implementation of an accreditation program. The accrediting entity should encourage research and evaluation to develop the science base for accreditation and systems change in public health."

"Implementation. The details of implementation will be developed by the leaders who take on the challenge of developing the new organization. Implementation will be a multi-year process requiring substantial external support in the development years. Implementation should include rigorous evaluation and process improvements in the accreditation program to make it more successful and cost-effective."

APPENDIX 11

Glossary

Epidemiology: A branch of medical science that deals with the incidence, distribution and control of disease in a population.

Medically underserved populations: Populations with shortages of primary medical care, dental or mental health providers that may be geographic or demographic (low income, Medicaid-eligible populations, cultural and/or linguistic access barriers to primary medical care services).

Social marketing: The systematic application of [marketing](#) along with other concepts and techniques to achieve specific behavioral goals for a social good. Increasingly, social marketing is being described as having 'two parents' - a 'social parent' = social sciences and social policy, and a 'marketing parent' = commercial and public sector marketing approaches.

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