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Transformations in public health

In This Issue

The Model State Emergency Health Powers Act

Bud Nicola

Since September 11th there is a new public perception of the importance of the government's responsibility to protect the health, safety, and welfare of its citizens. New and emerging threats to health, such as anthrax, pose serious and immediate dangers to the public's health and lead to a renewed focus on preparedness that includes having appropriate legislative authority in place.

Why a new model law?

There are no health powers named in the constitution of the United States. Primary legal authority for the work of public health sits at the state level. States currently have broad powers spelled out in enabling health statutes that were written at the turn of the century. Although states, and by reference localities, have broad sweeping powers named in existing legislation, little attention is given to the individual protections that have been developed in the U.S. legal system during the course of the twentieth century. Public health law provides the underpinning for public health practice; it defines the interest government has in health as well as government roles in protecting and promoting health. Modern public health practice uses the same principles as those used in the early 1900s. There are many reasons to update the language used in defining the parameters of practice: expanded scientific knowledge in public health; a dramatically changed physical, economic, and social environment; and a new sense of the rights of individuals in society.

A model enabling statute and the Model Act

The Turning Point Public Health Statute Modernization Collaborative has been working on a model state-enabling statute during the past year and a half. An outline of that statute has been fleshed out by the Collaborative and is available for review on the Collaborative's Web site (www.turningpointprogram.org/Pages/phsc_msph_act2.pdf). One section of the model statute focuses on emergency health powers and new and

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From the Turning Point National Program Office

Leadership in Troubling Times

Bobbie Berkowitz, Director

In this issue of *Transformations* we continue to visit the theme of public health preparedness. It's hard to look beyond a topic that remains a top story in most newspapers and continues to be the focus of all public health leaders in the nation.

I, like most of you, have been reading as much as I can on the subject. And there is plenty to read! For example, *Public Health Reports* (Vol. 116, No. 2) devoted its entire issue to the topic. Another excellent resource is the July 2000 issue of the *Journal of Public Health Management and Practice*, Vol. 4, No. 4, whose focus was bioterrorism.

How do we stay the course of Turning Point while awash in the threats of terrorism? As with any topic of such magnitude, public health preparedness has generated both support and criticism from the public, news media, Congress, community leaders, and the public health system itself. Support has come in the form of new appropriations from Congress for bioterrorism preparedness. The news media have voiced criticism for a public health system unprepared for the anthrax attacks in October 2001. The more conservative journalists have questioned public health's mission of social justice in times of terrorism. I encourage each of you to consider the many voices that have responded to the capacity of the public health system to respond to threats such as terrorism. The range of opinions can teach us a great deal about how Turning Point can best contribute to a sound and rational approach to public health preparedness.

I believe that one of our most valuable contributions is through collaborative leadership. Faced with a public health crisis and its aftermath of fear, confusion, and grief, the public seeks a "knowing" voice, the system needs coordination, and problem solving requires the wisdom of science and the skills of a competent workforce. All of this requires leadership that can define, analyze, and respond in a rapid and highly focused way. That is not possible if leaders do not have a systems perspective or a collaborative frame of reference. Turning Point partners have repeatedly told us that a collaborative approach to planning and problem solving using broad-based involvement, an open and credible process, trust, peer problem solving, commitment, hope, and participation is the method to achieve what the public wants and expects from the public health system. Turning Point's intention is a collaborative approach using the expertise of the whole system to build public health capacity.

In the coming months we will be planning for new public health appropriations, faced with pressure from Congress and the media to act quickly in our efforts to become better prepared, and we will be responding to demands from the public that we communicate the risks of bioterrorism in language free of jargon. It is my hope that our commitment to collaboration and leadership will keep us focused on our mission. Our mission has been to create a strong, collaborative, and responsive public health system whose focus is on the promotion and protection of health and the prevention of threats to health. Let's keep that in mind.

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emerging threats to health. After September 11th the Center for Law and the Public's Health at Georgetown and Johns Hopkins University, consultants to the Collaborative, led the team in drafting the Model State Emergency Health Powers Act, with special funding from the Centers for Disease Control, the Solan Foundation for Bioterrorism, and the Milbank Memorial Fund.

The Model Act was drafted in October 2001 in collaboration with the National Governors Association, the National Conference of State Legislatures, the National Association of Attorneys General, the Association of State and Territorial Health Officials, and the National Association of County and City Health Officials.

Since December 2001 more than a dozen states have expressed interest in legislation modeled on elements of the Emergency Health Powers Act. The detailed language of the Act can be found at www.turningpointprogram.org/Pages/phsm_emergency law.pdf.

Overview of the Model Act

Emergency health threats, including bioterrorism and epidemics, require the exercise of the legal powers of government. The Model Act grants emergency powers to state governors and public health authorities and requires the development of a comprehensive plan to provide a coordinated, appropriate response in the event of a public health emergency. The Act facilitates the early detection of a health emergency by authorizing the reporting and collection of data and records and immediate investigation by granting access to an individual's health information under specified circumstances. The Act authorizes state and local health officials to use and appropriate property as necessary; to provide care, treatment, and housing of patients; to destroy contaminated facilities or materials; to provide care, testing, treatment and vaccination of persons who have been exposed to a contagious disease or who are ill; and to separate affected individuals from the population at large to interrupt disease transmission.

In providing these broad sweeping powers for health officials, the Act is reaffirming powers that are currently present for health officials in all states. In addition to reaffirming these broad powers during a time of emergency, the Act requires that the response must respect the dignity and rights of individuals. The exercise of emergency health powers, used for the common good, must be grounded in a thorough scientific understanding of public health threats and disease transmission. The Act provides that, in the event of the exercise of emergency powers, the civil rights, liberties, and needs of infected or exposed people will be protected to the fullest extent possible, consistent with the primary goal of controlling serious health threats.

Planning for a public health emergency

As part of the Model Act the governor will appoint a Public Health Emergency Planning Commission consisting of the directors of the relevant state agencies, a representative group of state legislators, members of the judiciary, and others chosen by the governor. The commission will develop a plan for responding to a public health emergency within six months of appointment, which includes: government notification of and communication with the public; central coordination of responses; location, procurement, and storage of essential materials, including medical supplies, drugs, and so on; training of persons as emergency judges for quarantine; methods of evacuating populations and housing and feeding the evacuees; training of health care providers; vaccination and treatment of exposed and infected persons; tracking the source and outcomes of infected persons; and other necessary measures.

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Measures to detect and track public health emergencies

The Act requires health care providers—including laboratories, coroners, medical examiners, pharmacists, veterinarians, and livestock owners—to report potential dangers to public health in written or electronic form within 24 hours. The Act details identification and interviewing of individuals and examination of facilities or materials when there is suspicion that the public health is endangered.

Declaring a state of public health emergency

The governor may declare a public health emergency after consulting with the public health authority and experts. This declaration activates the disaster response and recovery plans and emergency powers, such as suspension of regulatory statutes for conducting state business. After declaration, the public health authority will coordinate all matters pertaining to the emergency, including special identification for all public health personnel working during the emergency.

Special powers: management of property

The public health authority may close facilities and may decontaminate or destroy materials believed to endanger the public health. The public health authority may procure materials and facilities needed, including health care facilities, control materials, prescribe means for evacuation, and control or limit ingress and egress to any threatened public areas. The Act details the safe disposal of infectious waste and human remains.

Special powers: protection of persons

The public health authority will use every available means to prevent the transmission of infectious disease and ensure that all cases of contagious disease are subject to proper control and treatment. Control and treatment include medical examination and testing, vaccination, treatment, and collection of laboratory specimens. The Act contains extensive details on procedures required for isolation and quarantine. Access to necessary individual health information is permitted. Licensing and appointment of health personnel to assist in the performance of required control and treatment activities is permitted.

Public information regarding public health emergency

The public health authority will inform the people of the state on the declaration of a public health emergency, how to protect themselves during the state of emergency, and the actions taken to control the emergency. In addition, the Act details the tracking of funds, handling of expenses, liabilities, and compensation during the public health emergency.

Next steps

Although bringing public health laws up to date is an important part of protecting the population during public health emergencies, it is also very important to have a public health system that can function during an emergency. A functioning public health system requires a well-trained public health workforce, efficient data systems, sufficient laboratory capacity, and stable, adequate funding. A description of the powers and duties of government required for the practice of public health, as defined in a model enabling statute currently being drafted by the Turning Point Collaborative, will incorporate the Model State Emergency Health Powers Act and will include many other elements. A draft of this model public health law will be available in early 2003.

Bud Nicola is a senior consultant with the Turning Point National Program Office.

Turning Point Member Profile

Natalie Morse

Natalie Morse has more than 20 years of experience in public health at the local, state, and national levels. At the local level, Natalie has worked tirelessly with PATCH (Planned Approach to Community Health), a CDC chronic disease community planning model started in 1987 that serves as the local public health planning entity in the region. She has also worked with the Healthy Community Coalitions on a range of initiatives including several innovative projects. For example, Natalie's current work with a local PATCH coalition is focused on developing community health indicators. Natalie chaired the PATCH work group that has developed local health status and quality of life indicators. She then obtained a grant to help Healthy Communities and PATCH organizations in Franklin, Oxford, and Kennebec counties to plan and report, using a Web-based tool, collaborative activities affecting these indicators. Another recent example is improving dental care access. One strategy she helped develop is to bring dental providers into pediatric primary care settings.

In 1999, Natalie provided leadership to form a community response team in the town of Fairfield, Maine, where a confirmed cancer cluster was identified. She helped local citizens complete a community health assessment and develop a health action plan. She also helped secure funding to hire staff to implement the plan. Natalie is currently assisting this group with grant writing to fund several initiatives.

At the state level, Natalie has been intimately involved in both phases of Turning Point and has committed much of her time and energy to issues related to workforce capacity and public health infrastructure. She also played a key role in the development of the Maine Network of Healthy Communities, an organization comprising coalitions throughout the state that are working to enhance the health of Maine citizens. Natalie has served as chairperson of this network and is the president-elect of the Maine Public Health Association.

At the national level, Natalie has worked extensively with the Turning Point Social Marketing Collaborative. She is also in the process of developing social marketing materials that will be distributed nationally.

Natalie stands out as a leader in Maine's Turning Point initiative because of her hard work and dedication to public health. She is willing to share ideas and explore innovative approaches. She also understands the value of collaboration and is dedicated to strengthening Maine's public health system.

The Maine Turning Point Initiative salutes Natalie for her commitment to public health and healthy communities.

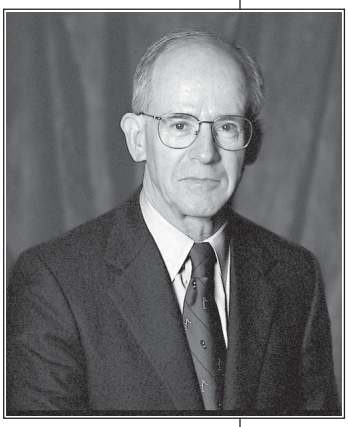
NominateTurning Point members to be profiled in future issues.

NACCHO

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

Public Health: A Personal View

Steven A. Schroeder



In the wake of last fall's anthrax incidents, Americans have rediscovered public health. The Robert Wood Johnson Foundation has a long-standing affinity with this field, which flows from the health component of our mission, but I'd wager that few agree on exactly what public health is or what it ought to be. This uncertainty reflects in part the breadth and complexity of the issues and activities public health encompasses, in part the absence of a strong constituency articulating a clear vision for public health, and in part the fragmentation within the field. If public health is to realize its potential and really improve the health of the public, progress is needed on these and other fronts. I believe The Robert Wood Johnson Foundation can help make that happen.

Definitional ambiguity

To me, public health includes all the determinants of the health of a population, as well as the necessary interventions to improve population health, that lie outside of traditional clinical services. While this conceptual view is broad, I narrow the list of activities I would assign to public health to exclude functions such as those carried out by police and fire departments or in the service of national defense.

The field's breadth makes it hard to provide a terse sound bite of what it is. Let's stick with the example of anthrax. For clinical medicine, the role is straightforward—diagnosis and treatment. For public health, it involves many roles: being able to identify an unusual event at the earliest possible stage (ideally, the index case); assuring fast and accurate laboratory confirmation; triggering rapid reporting at state and national levels; activating appropriate investigation of a possible epidemic; instituting containment where appropriate; communicating effectively, accurately, and frequently with the general public and clinicians; and preparing for possible surges in demand for treatment and testing. So it goes with virtually every public health problem.

Public health is fragmented and lacks a powerful constituency

Compared with clinical disciplines, public health is a less cohesive field. In part, this is because it represents myriad, sometimes unrelated, disciplines—nursing, medicine, maternal and child health, occupational health, environmental sanitation, epidemiology, biostatistics, health economics, law, microbiology, toxicology, engineering, psychology, international health, and many others.

Public health is also fragmented because of the contentious political issues it deals with when discussions about how to improve the health of the public involve matters of social justice, such as race, poverty, income, housing, and jobs. While I agree these are central issues for the society in which we live and worthy of discussion, I also worry that too many well-intended public health colleagues dissipate precious energy and resources in battles they are neither trained nor positioned to win, while neglecting tasks that could make a difference.

Compared with clinical medicine, where we can shake hands with recovering patients and their families, public health's triumphs are often invisible, and thus don't attract a

grateful constituency. Examples include reductions in blood lead levels, fluoridation leading to improved dental health, reductions in drunk-driving deaths, and lowered rates of tobacco consumption. Another quiet triumph of public health is the major decline in deaths from heart disease, attributable mainly to changes in diet, reduced smoking, use of prophylactic aspirin, and, to a lesser extent, improved medical care. Like the cat that doesn't get stuck in a tree, these accomplishments are not considered newsworthy.

Compared with the $1.4 trillion annual spending by the health care industry, public health operates on a much smaller budget (exactly how much is difficult to determine, but the most common estimates are about $70 billion). Because the services public health provides are broadly population-based rather than focused on individuals, they suffer in competition for both private and public dollars.

We have seen what a difference a powerful constituency can make in the example of the move to double the National Institutes of Health budget. Between 1995 and 2002, its budget increased from $11.3 billion to $23 billion, even at a time when many in Congress were pledged to minimizing the role and funding of government. How was this accomplished? Through political pressure mobilized by a powerful coalition that included pharmaceutical manufacturers, academic medicine, the health professions, and disease-oriented interest groups. This coalition sold a compelling vision of improved health through more investment in basic biomedical science by tapping into the personal concerns and stories of families and individuals affected by specific illnesses.

By contrast, public health's power to form a powerful constituency is anemic. It lacks an industry base (in fact, it is sometimes aligned against business in the form of the tobacco, alcohol, fast food, or energy and chemical industries), its academic base is small and fragmented, and it has not been able to mobilize citizen advocacy groups, such as the women's health movement, AIDS activists, or disease-specific organizations, on its behalf.

The inability to rally the influential middle and upper classes to the causes of public health is another limitation. Much of the potential for improved health of Americans lies within the population that tends not to vote, contribute to political campaigns, or subscribe to influential newspapers. Yet, the U.S. will never achieve the health status of other developed nations until it improves the health habits of substantially more of its citizens, especially those who are less fortunate.

Why should we bother about public health?

Much of the important progress made by public health is invisible, like the important gains in sanitation or in purifying water and food. Once in a while, however, events such as the recent anthrax scare serve to remind the general public of its dependence on others for its safety. Now—when even the middle class feels threatened—is the time to bolster infrastructure components, such as the surveillance of disease, the integrity of disaster alert and relief systems, and communications networks.

But for those who are concerned with making this a healthier country, the importance of public health goes far beyond assuring safety. Threats posed by tobacco, alcohol, illicit drugs, obesity, physical inactivity, and environmental toxins simply cannot be addressed by investing more in clinical medicine, basic

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Once in a while, however, events such as the recent anthrax scare serve to remind the general public of its dependence on others for its safety.

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biomedical research, or disease surveillance. They require recognition of the pivotal role of public health and the necessity of strengthening it. This will demand a much greater public understanding of the reality that all populations—not just the poor—are at risk, and that triumphs are not only possible but achievable.

Possible roles for RWJF

There are at least six ways in which we can help to bolster public health in order to fulfill our mission of improving the health of the American people.

First, and perhaps most important, we are strategically situated to serve as a champion for the field. Because of our history and reputation, when we lend our prestige to a field, it is enhanced, as we have demonstrated with care at the end of life.

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A second role for us is infrastructure building. Our Turning Point program, in collaboration with the Kellogg Foundation, has assisted 23 states and almost 100 communities in strategic planning for public health needs. As a result of its emphasis on collaborative partnerships with other community organizations, health agencies participating in Turning Point were better prepared to mobilize resources during the early reports of the anthrax threats.

A third way is to invest in certain public health topics. This is the most developed aspect of our work in public health, especially our decade-long experience in substance abuse. More recently, we have created programs to promote physical activity, and we are now considering programs to combat the epidemic of obesity.

Fourth, we can stimulate scholarship that will point the way for progress in public health. Again, our work in substance abuse provides good examples here, as with the Substance Abuse Policy Research Program and our Tobacco Etiology Research Network. More recently, our support of the Active Living Policy and Environmental Studies Program and of Research!America's efforts to increase funding for prevention research sets the stage for future contributions.

Fifth, we can create institutions that will help to move the field, as we did with the National Center for Tobacco-Free Kids and the National Center on Addiction and Substance Abuse.

Finally, we can build the field by investing in future leaders. Just as many important leadership positions in American health care (and, in fact, in public health) are filled by graduates of The RWJF Clinical Scholars Program, we hope future leaders in public health will be graduates of our Health and Society Scholars Program or prizewinners in our Health of the Public contest.

As you can see, I am a booster of public health, but also a realist. Public health can never achieve the power or constituency of health care. But it possesses enormous untapped potential to improve the health of all Americans. The Robert Wood Johnson Foundation is ideally situated to help make that promise a reality.

This article was adapted from Dr. Schroeder's Message to the Board of Trustees of The Robert Wood Johnson Foundation, January 2002.

Steven A. Schroeder, M.D., is president and C.E.O. of The Robert Wood Johnson Foundation.

National Excellence Collaborative on Information Technology

Creating a Learning Community

Neil E. Hann

The 1988 Institute of Medicine (IOM) report, *The Future of Public Health*, described a public health system in disarray. It identified several areas that needed improvement in order to strengthen the nation's public health infrastructure: adequate funding, leadership development, establishing partnerships with communities and the private sector, and data collection, analysis, and access. Since the 1988 IOM report, some progress in these areas has been made. The Turning Point initiative is founded on the notion that our nation's public health infrastructure can be improved through the collaborative work of partnerships. Leadership development for public health has advanced since 1988 with the establishment of a national Public Health Leadership Institute as well as several regional and state-sponsored leadership institutes.

Unfortunately, information technology in public health has lagged behind in improvement. Technology has made great strides since 1988, but the technological advances have not translated into a standardized system that adequately supports the nation's public health system. Key deficiencies in public health information technology still exist, including:

- An inability of communities and health improvement partnerships to adequately access public health data for identifying priorities and implementing solutions
- A lack of basic information technology infrastructure, particularly at the city and county levels
- A lack of standards for data collection and data archiving

Such deficiencies in the nation's public health information technology infrastructure limit the ability to effectively deliver public health services. Without adequate information technology, public health's ability to assess needs, ensure health improvement, and measure our performance is severely hampered.

For public health to be effective in the 21st century, it is critical that systems be in place that allow easy access to timely and appropriately linked data sources.

Formation of the Collaborative

Recognizing the basic information technology needs for public health, The Robert Wood Johnson Foundation funded the National Excellence Collaborative on Information Technology (infoTech). Oklahoma was chosen as the lead state. Kansas, Maine, Missouri, New Hampshire, and South Carolina are other states in this collaborative. National partners include the Centers for Disease Control and Prevention, ASTHO, NACCHO, and All Kids Count.

When the Collaborative held its first meeting in April 2000, we quickly felt the enormity of the task at hand. Collaborative members discussed at length the nation's public health information technology needs. As the list of items to address grew, we realized that we needed to narrow the focus. Within the array of potential areas to address, three key themes emerged: architecture, community framework, and inventory. Based on these concepts the Collaborative developed its mission statement and goals.

InfoTech Collaborative mission statement

The InfoTech Collaborative of Turning Point will assess, evaluate, and recommend to national policy makers innovative ways to improve the nation's public health infrastruc-

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ture by using information technology to effectively collect, analyze, and disseminate information; by improving data access and community participation for making public health decisions; and by enhancing the performance of the public health system through the use of information technology.

Goals and areas of focus

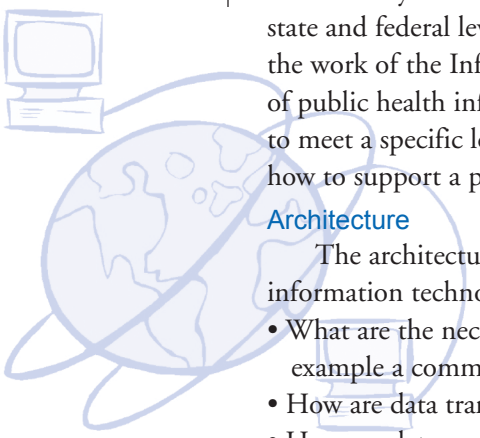
1. Identify community information technology (framework) to support public health improvement.
   - Include end-users and functions to be supported
   - Collection, analysis, and dissemination
   - Identify tools and standards to support
2. Develop guidelines and draft technical and data architecture for public health.
   - Other needs from Turning Point Collaboratives
   - Strategic questions
   - Gap analysis
3. Develop an inventory of current information technology practices to support core functions of assessment, policy development, and assurance.
   - Integrated view/broad determinants
   - Web resources (gateway)
4. Identify funding strategies to support public health information technology.
   - Flexibility across programs
   - Program integration

The model

To address the mission and goals, the InfoTech Collaborative formed into three work groups.

Community Framework

The community framework group helped delineate the idea that the definition of information system needs should be driven from the local perspective. Even those systems at state and federal levels ultimately help improve health at the community level. Therefore, the work of the InfoTech Collaborative will result in the identification and prioritization of public health information system needs at the local level including a description of how to meet a specific local need, how to integrate with state and federal requirements, and how to support a particular public health essential function.



Architecture

The architecture group represents the "nuts and bolts" of developing standards for information technology. They are helping answer several questions, including:

- What are the necessary data elements for specific types of information systems—for example a communicable disease registry?
- How are data transferred/integrated between systems?
- How are data quality and data security maintained and to what minimum standards?

Inventory

Finally, the inventory group is working to create a map of information standards that currently exist at state and local health departments through a comprehensive national survey. The survey will identify what systems are available for particular data sets, how data are stored, levels of access, levels of data integration, and potential uses for data.

Bringing it all together

A key deliverable from the Collaborative will be an online Public Health Information Systems Catalog. The foundation of the catalog will be data collected from the national survey as well as information from the three workgroups. One way to visualize an intersection analysis of this information would be a three-dimensional matrix, as illustrated in Figure 1.

The Public Health Information Systems Catalog will allow users to answer which specific products or solutions (Inventory), are suited for a particular public health setting (Community Framework), and meet required technical standards (Architecture).

Users of the Public Health Information Systems Catalog will be able to approach a search from several different angles. The system will be structured so users could search for a data system that would help meet one of the 10 essential public health services. Or, they could approach it from the viewpoint of supporting a particular health need, such as immunizations. Users could also query the catalog to see what public health data systems support a particular computer operating system.

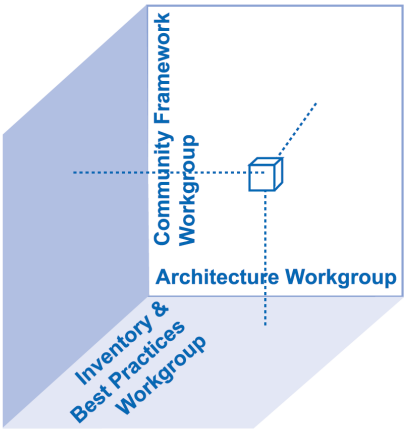


Figure 1. Information Technology Collaborative Workgroup Analysis Matrix

Creating a learning community

The Public Health Information Systems Catalog will be the first step toward creating online learning community around public health information systems. We envision a national resource that will provide the kind of information necessary to answer basic questions about data system resources that can help community health partners prioritize health needs, evaluate the effectiveness of interventions, and measure the performance of health systems. As the online system is further developed, we hope to see an exchange not only of information about data systems, but also of effective public health solutions at the local, state, and federal levels that will contribute to the adoption of information technology standards for public health.

Conclusions

The final question is, Why bother with all this? The InfoTech Collaborative members recognize that everything we do in public health—from assessment to assurance to policy development—is based on the knowledge and insight gained from the careful analysis of health data. For public health to be effective in the 21st century, it is critical that systems be in place that allow easy access to timely and appropriately linked data sources. First though, we have to know what systems are out there. Currently, there is no comprehensive catalog of information systems used to support public health. Our national survey and resulting online searchable Public Health Information Systems Catalog will provide information to help health improvement partners make the right decisions about data systems for their particular needs.

We live in a world with new and emerging threats, yet one with old health problems that still must be solved. This reality has sparked a national recognition of the need to strengthen public health infrastructure. Without question, information technology is a key component of that infrastructure.

Neil Hann, MPH, CHES, is chief of the Office of Community Development, Oklahoma State Department of Health . He has been involved with the Turning Point initiative since its inception.

Reflecting on Turning Point, Post September 11, 2001

Vincent Lafronza, EdD, MS, and Joseph Hawes, MD, MPH

In March 1998, Turning Point's national publication, *Transformations in Public Health,* was unveiled, describing the initiative's intent to strengthen America's public health system through collaboration and partnership building. Specifically, Turning Point was designed to "transform and strengthen the public health infrastructure so that states, communities, and their public health agencies may respond to the challenges to protect and improve the public's health in the 21st century." Less than four years later, on September 11, 2001, we learned precisely what responding to some of the emerging challenges in the 21st century would entail.

Since its inception, Turning Point advocated for coordinated and interdependent partnership activity within and among state and community/tribal public health systems as an essential mechanism of action to transform and strengthen the capacity of our public health systems.

The [person] of reflection discovers Truth; but the one who enjoys it and makes use of its [wondrous] gifts is the [person] of action.

—Benito Pérez Galdós. *El Amigo Manso*, 1882, ch. 39.

Now, after nearly four years of experience including an extensive planning phase and two years of implementing actions framed in public health system improvement plans, thanks to the events of September 11th, we have a glimpse of the new era and its unforeseen challenges for which public health systems of every nation must be prepared. If Turning Point's methodology is sound, experience gained through participation in the initiative should successfully prepare states, tribes, communities, and all participants to work together effectively on *any* issue that affects the public's health and well-being.

Although legal responsibility for protecting the public's health rests with federal, state, tribal, and local powers, the actions that are necessary to ensure adequate health protection and promotion are carried out at the local level. Turning Point teaches us that community-based partnership entities are not interested in assuming the lawful governing responsibilities of protecting the public's health—rather, community-based partnership entities are eager to play a vital role in shaping how the public's health is protected and assured and to influence who participates in these efforts and how interventions are designed and implemented. In the words of the youth members of the Chautauqua New York partnership, "Don't make decisions about us without us." Community-based partners are eager to share information and participate in activities that help improve the ease and efficacy of efforts by those with the legal responsibility for protecting the public's health.

Given nearly four years of partnership formation and collaborative efforts, participating Turning Point sites should be well positioned to ensure effective coordination of information, data, and action among public health partners, the media, policy makers, and the public. Partnerships should be extraordinarily savvy in planning and implementing actions designed to address any issues that affect health, including potential bioterrorism events. As we embark on implementation activities and as we continue our collaborative work, we must now ask, How and to what extent are we fully maximizing Turning Point capacity to address the current challenges to the public's health?

Resolutions for a new era

If we examine the responses of policy makers, the public health workforce, and news personnel to any of the current threats to the public's health, the community is consistently the common thread in terms of information sources and response mobilization. Perhaps the time has come for us to revisit and examine our current notions about how to strengthen public health systems in order to address adequately the challenges of the 21st century. As contributors to this national initiative, perhaps we can collectively explore the following critical questions:

- Given the need for effective community-based response capacity for any health threat, how might we collectively leverage our Turning Point partnership framework to strengthen America's public health systems?
- To what extent is the partnership model effective in bridging gaps between state, tribal, and local public health systems?
- To what extent do Turning Point jurisdictions have increased capacity to protect the public's health?
- Are collaborative efforts well balanced with respect to health protection and health promotion capacities?
- To what extent are resources appropriately placed in all communities to enable public health systems to respond effectively to the challenges of the 21st century?

As we await further evolution of lessons learned from Turning Point activity, we encourage all those engaged in collaborative public health practice to reflect on and reexamine the intent and efficacy of collaborative efforts. Only through reflection and reevaluation will needed changes in direction and practice be made so that America's public health systems are well prepared to meet 21st century challenges to protect the public's health.

Vincent Lafronza, EdD, MS, is program director at NACCHO. Joseph Hawes, MD, MPH, is a NACCHO consultant.

New Public Health Handbook Available

Hot off the press, *The Public Health Competency Handbook* is a user-friendly guide for identifying and developing system, organizational, and workforce competencies. Based on multi-year collaborative research efforts between public health researchers and practitioners in many states and geographic regions, the handbook focuses on practical, field-tested ways to strengthen public health competency and capacity. It includes instruments, exercises, assessment, and learning tools that can be adapted by agencies and organizations to improve their ability to meet the new public health standards.

The Robert Wood Johnson Foundation has funded the distribution of the handbook to 2600 state and local public health agencies, with assistance from ASTHO and NACCHO. For information on ordering a copy of the handbook, call 1-888-864-7720.

The Public Health Competency Handbook: Optimizing Individual and Organizational Performance for the Public's Health, *Jane C. Nelson, Joyce D.K. Essien, Rick Loudermilk, Daniel Cohen. Atlanta, GA: Center for Public Health Practice at the Rollins School of Public Health, 2002. ISBN 0-9718005-0-2.*

Grant-Writing Tips

Writing Informative Project Descriptions

Judith Yarrow

Project descriptions for grants can be compelling or deadly. Here are a few tips for making your project descriptions shine.

Style

- Follow directions. Does the application ask for a one-page summary? Don't write three pages of details.
- Write for your funder. Don't just cut and paste from other grant applications, agency brochures, or annual reports. Understand what funders want and tell it to them using terms like the ones they've used to request the information.
- Be concise, clear, and to the point. Write in plain English. Cut the fluff.

Content

- Follow directions. Does the application ask for XX? Don't tell them CC; tell them XX.
- Define the problem with reasonable dimensions. "Make the community healthier" is too big. Narrow it down: "Improve the immunization rates of minority children in King County."
- Focus on the positive. What you focus on is generally what you get. If the problem is fragmented delivery of immunization programs, don't say "Reduce fragmentation." Instead say "Increase coordination."
- State the problem or need in terms of clients or beneficiaries. If the problem is fragmented delivery of immunization programs, with many minority children not being immunized, focus on the children. Don't say "Reduce fragmentation of immunization programs." Instead say "Increase immunizations of minority children, by coordinating immunization programs." Keep in mind that benefits may extend beyond the direct beneficiaries to include other populations or institutions.
- Provide relevant supporting statements by authorities. Use quotes from well-known people or from beneficiaries of the project. Make sure that quotes demonstrate the benefit of the program. Don't use boilerplate platitudes from government officials.
- Supply credible data to support your statements. Don't say "Parents like our program." Instead say, "Before we initiated the support program only 22 percent of parents returned with their children for follow-up visits. After our support program had been in operation for one year, 72 percent of parents returned for follow-up visits."
- Provide a work plan. Be clear about who is going to do what, by when, and how. Make a grid showing the what, when, where, who, and how of how you plan to achieve your objectives. Use the grid when describing the work plan. If the grant directions permit, you might even include the grid.
- Finally, and most importantly, follow the grant application directions.

Site Visit

The Community Tool Box

http://ctb.ku.edu

This spring Turning Point first cohort states will enter their third year of implementation. It is time to think seriously about sustainability. The Community Tool Box addresses planning for long-term institutionalization. In Chapter 46, some sections worth investigating include:

1. Strategies for the Long-Term Institutionalization of an Initiative: An Overview
2. Strategies for Sustaining the Initiative
3. Promoting Adoption of the Initiative's Mission and Objectives
4. Attracting Support for Specific Programs
5. Marketing the Initiative to Secure Financial Support
6. Sharing Positions and Other Resources
7. Becoming a Line Item in an Existing Budget
8. Incorporating Activities/Services in Organizations with a Similar Mission
9. Obtaining Corporate Resources
10. Tapping into Existing Personnel Resources

You can find the Community Tool Box at http://ctb.ku.edu.

RWJF Update

America, Get Moving: A Call to Action

Given the recent evidence about the importance of physical activity to maintaining good health, the Robert Wood Johnson Foundation has taken steps to provide good, strong leadership in this area. For the first time, RWJF is developing programs aimed at improving the health of Americans through physical activity. This year alone, the Foundation will invest $50 million in national programs that will create activity-friendly communities and physical environments, increase the physical activity levels of adults over 50, and integrate health behavior counseling into routine medical care. Check out the data about physical activity and the programs being sponsored by RWJF at www.rwjf.org. Click Publications, then Advances.

Dates to Note

May 4-7, 2002. Community-Campus Partnerships for Health's 6th Annual Conference: The Partnership as the Leverage Point for Change. Miami (contact: ccph@itsa.ucsf.edu)

July 10-13, 2002. NACCHO Annual Meeting. New Orleans (www.naccho.org)

September 10-13, 2002. ASTHO Annual Meeting. Nashville (www.astho.org)

October 1-3, 2002. Turning Point State Partnership Grantee Meeting. Oklahoma City (www.turningpointprogram.org)

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

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

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