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Transformations in public health

In This Issue

Boards of Health: Extinction or Evolution?

Ellen Leahy and Marie Fallon

Once a stalwart presence in America, state health boards have been disbanded in half of the nation's states. In some instances, a revised body was created; in others, nothing replaced them. These traditional boards arose out of major public health reforms that took place more than a century ago. Now, in a new period of public health reform, governance of public health is up for discussion. If it is the case that these boards are no longer the best way to embody states' duties toward public health, governance must evolve to fit today's version of public health.

Early health boards

Today, boards of health are legally designated entities whose members are appointed or elected. They provide advisory functions or governing oversight of public health activities, including assessment, assurance, and policy development, for the protection and promotion of health in their communities. This definition, however, represents an evolution from the nineteenth century health boards that scrambled to respond to epidemic diseases that spread as people migrated to towns and cities with crowded, unsanitary living conditions. Back then boards of health arose out of pure necessity.

In the colonial years, public health was a local matter. Town fathers would institute quarantines, and if an epidemic was disruptive enough, temporary health boards or committees would form. Such was the response in Boston when smallpox struck during the Revolutionary War and in Philadelphia during the infamous yellow fever epidemic of 1793. But when the epidemics subsided, so did the boards. This pattern of frenzy in the face of disease and forgetfulness in its absence reoccurred during the western expansion of the next century.

Permanent health boards

Permanent health boards emerged when the nation's growing cities recognized that the conditions that led to epidemics—urbanization, industrialization, and immigra-

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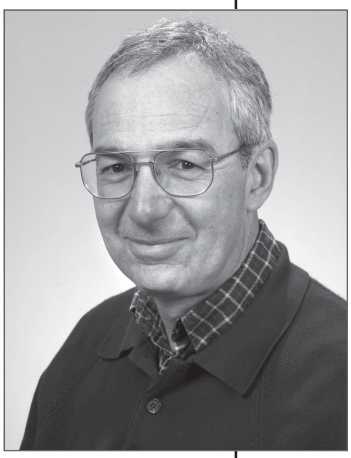
Guest Editorial

Boards of Health Give Citizens a Voice

Dr. Ray M. (Bud) Nicola, MD, Member, King County Board of Health, Washington



Many of us go through several professional incarnations over the course of our careers. It is particularly appropriate to call them incarnations because while we bring to each new position our skills and experience, it is not unusual to later depart a changed person. Our most recent vantage point often deepens our understanding of what is needed to ensure the conditions for the population's health. Being a member of a board of health can do just that.

Two years ago, several close friends encouraged me to apply for a health professional member position on the King County Board of Health in Washington State. While I had spent years as a local health official reporting to the precursor of this very same board, I had never thought I might one day be a board member. Being a member of an active local board of health has given me some insight into the powerful role boards of health can play as we meet today's health challenges.

First organized by doctors to help communities coordinate a response to outbreaks of infectious disease, boards of health in the US have changed as the times have changed. Their scope widened in the sanitation era of public health, and again during the middle and late twentieth century—and now boards of health are in a position of adapting again. Public health has embraced the notion that the social, economic, and environmental determinants of health greatly affect the health of populations and often tragically affect the health of individuals in our communities. Although issues of access, insurance and cost of pharmaceuticals continue to grow, we are continually faced with more common and pervasive causes of ill health: unemployment, poverty, homelessness, decreasing social capital, and an eroding support for government.

At both the state and local level many boards of health have broadened their scope and effectively guide priorities for health in their communities. At the same time, numerous boards of health have been dissolved in the name of efficiency and effectiveness in public health. An inefficient and ineffective board of health is indeed not going to improve health, but boards of health can be very powerful when members understand their role and take participation seriously.

Turning Point's collaborative partnership model beautifully reflects the power in effective boards of health. In Nebraska and Montana for example, Turning Point has worked to help clarify the role of board of health members and has helped to maximize the effect these bodies can have on the health of their populations.

In the end, boards of health embody the most grassroots notions of public health: ensuring that citizens have a strong voice in setting health priorities. If you have an opportunity to go to a board of health meeting, I encourage you to go. Beyond that I encourage you to become a member of a board of health and to run for public office. The health of the public needs you!

tion—were ever-present, requiring permanent solutions. In the latter part of the nineteenth century, America's large eastern cities, teeming with people and pestilence, organized local boards and health departments. Baltimore, Philadelphia, Providence, Cambridge, and Charleston, for example, each formed local health departments before their states did. Massachusetts took the lead in forming the nation's first comprehensive state health board in 1869, followed by California in 1870, and Virginia and Minnesota in 1872.

The effect of these early state health boards was not great. Indeed, it sometimes took the inevitable cost and chaos of statewide epidemics, when they predictably escaped local jurisdictions, to move the states to action. In Montana, for instance, it took a raging smallpox epidemic and pleas for help from local jurisdictions before the legislature formed the nation's forty-second state health board in 1901, more than a decade after statehood.

America's prototypical health board

The foremost example of public health governance arising from local politics is the New York Metropolitan Health Act of 1866. In 1865, burgeoning New York City appeared to be foreordained for cholera. A cholera epidemic in Europe was poised to strike the United States, just as similar epidemics had struck in 1832 and 1849. Despite the devastating lessons of the first two waves of cholera, the city had no effective sanitary administration. What little public health structure existed was under the control of the police department's so-called "health wardens," who had been awarded their jobs through political graft.

A citizens' council that had formed to combat city hall partnered with sanitary reformers and formed a Council of Hygiene. The advancing cholera epidemic lent persuasive power to these reformers as they tried to avoid city hall and go directly to the state legislature in Albany. The resulting New York Metropolitan Health Board was so well-suited to its purpose that it became the template for public health governance for the next century.

The combined elements of the new Metropolitan Board—use of field data, centralized administration of public health police powers, inclusion of experts and citizens, and a structure that sets the board one degree apart from the political establishment—are familiar to us today. The success of this new design was witnessed in the 1866 cholera epidemic, and New York's peer cities quickly adopted the model, with Chicago, Louisville, Indianapolis, and Boston converting in rapid succession over the next decade.

The states followed suit and by the turn of the century, forty of them had adopted boards. The Metropolitan Board served as the prototype for the times, for both state and local boards of health, because, as public health historian Charles Rosenberg observed, "The tools and concepts of an urban, industrial society were beginning to be used in solving this new society's problems." These local and state boards went on to bring a succession of scientific, environmental, medical, and epidemiological advances to efforts to protect the people's health. These methods and board structures were copied in virtually every local jurisdiction. By the end of the 20th century, more than 3,100 active local boards of health existed.

Declining state health boards

In the latter part of the 20th century, state boards began declining in number and in power. Some were relieved of their policy-making powers and relegated to advisory status. Other states dispensed entirely with their state boards, but continued to provide for local

(Continued on page 4.)

[Evolution—continued from p.3]

boards in their statutes. Understanding the forces that led to this decline may be helpful in shaping governance more suitable for today and into the future. Some of the factors that perhaps played a role in the decline of state health boards include: 1) the maturation of comprehensive state health departments, which made the boards seem superfluous; 2) the stark decline in epidemic disease, resulting in less visibility for public health; 3) the increase of necessary restraints upon police powers that accompanied the rise of civil rights in the past fifty years, resulting in a reduced ability to rely on police powers to apply public health constraints; and 4) the ineffectiveness of police powers as a tool to address today's chronic, noncommunicable diseases.

Future public health governance

Although state boards are on the decline, the duties of government for public health are surely not. Effective governance in public health requires that individual members of governing entities within a local jurisdiction understand and exercise personal, board, agency, and other appropriate legal authority; fully appreciate obligations and responsibilities; ensure the availability of adequate resources (including legal, financial, personnel, capital, equipment, and supplies) to perform essential public health services; develop policies to support public health activities and goals; routinely evaluate, monitor, and set goals for improving community health status; and ensure that all relevant stakeholders participate in achieving public health objectives. Such a broad range of complex responsibilities cannot be upheld in the absence of a governing body charged with protecting public health.

Citizens, and private and public coffers, are just as vulnerable to the ravages of preventable disease today as they were when health boards were born out of conditions and diseases that arose more than a century ago.

State boards have served us well, but it is not surprising that, these many years and public health successes later, we find our traditional form of public health governance wanting. As contemporary public health observer Laurie Garrett notes, "[T]he causes of ill-health do not stand still—humanity's very progress changes them." It follows that public health, too, must change. As the public health reformers did in 1866, we need to find public health tools that fit today's times. Although the nature and distribution of disease has changed in the last century, contagion still lurks, and the majority of modern diseases are, in fact, preventable. Citizens, and private and public coffers, are just as vulnerable to the ravages of preventable disease today as they were when health boards were born out of conditions and diseases that arose more than a century ago. Recalling the hard-earned lessons that forged our first boards speaks to the need to evolve public health governance, rather than allow it simply to extinguish.

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Resources

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RWJF Ad Features OK Turning Point

Somewhere,

there's a solution to

the lack of adequate health services in rural communities.

And his name is Neil.

The best way to improve the health of local communities is to let them do it themselves. That's what Neil Hann and others proved when they transformed the public health system in rural Oklahoma. • With the support of The Robert Wood Johnson Foundation's Turning Point program, Hann empowered local communities to make their own public health decisions. In Cherokee County, a state university, a hospital, the county government, and the sovereign Cherokee Nation joined forces to form the nation's first public health trust—which then funded a community health clinic. In Harper County, residents who previously had to drive as far as 75 miles to reach medical services tapped funds from a wide variety of sources to start a local health department. These Turning Point partnerships show how local community involvement can vastly improve community health. And they show that improving the health of small communities can help us all feel better.

The Robert Wood Johnson Foundation confronts many of America's important health and health care issues. That's why we've supported programs like Turning Point and why we expect to make a difference in your lifetime. To learn more, visit www.rwjf.org or call 888-878-0019.

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The Robert Wood Johnson Foundation recently ran this ad in a national media campaign to promote its work in health and health care.

Educating New Boards of Health

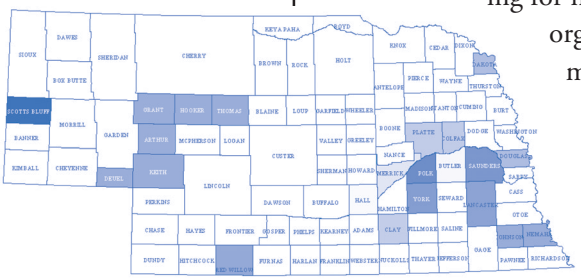
Dave Palm and Marlene Wilken

In September 2001, local health departments covered only 22 of Nebraska's 93 counties. By 2004, 16 new multi-county health departments had been organized covering all Nebraska counties. The formation of these new health departments has created many challenges as well as opportunities to educate and train new board of health members. Because of community spirit and commitment, people regard it as an honor to be appointed to a new board of health. Board membership is a powerful position, since the board, working as a team, will make short- and long-term decisions that affect the health of the community now and into the future.

New boards need training

Currently, 253 appointed persons serve on local boards of health in Nebraska. Each person comes to the position with the best of intentions, that is to serve the community; but it is not unusual for new board members to be confused about board responsibilities and authority. It is important to get the board functioning at an optimum level quickly. Thus, the first challenge becomes team building, as governance cannot happen without a team effort.

Public health leaders recognized the need to provide education and training for new board members early in the developmental stages of organizing multi-county health departments. Board of health members needed to learn the core functions of public health, overall responsibilities delegated to them by statute, and what resources were available to them to answer questions as they prepared plans for their respective public health departments. The Public Health Association of Nebraska (PHAN) and the Office of Public Health in the Department of Health and Human Services organized the early training initiatives covering these subjects.



Nebraska counties (shaded) covered by public health departments in 2001.

Formation of SALBOH

After the initial training efforts, PHAN and the Office of Public Health decided that a long-term, comprehensive approach was needed to meet ongoing challenges. A solution to meet the ongoing demands of the boards was to form a State Association of Local Boards of Health (SALBOH) under the umbrella of the Public Health Association of Nebraska.

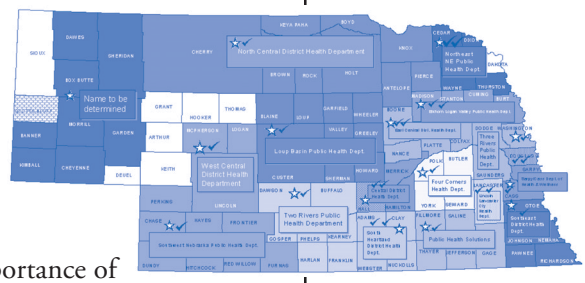
SALBOH held its first meeting in October 2003. At that meeting, both training needs and resources were discussed. Some of the ongoing training needs included roles and responsibilities of local boards of health; legal, fiscal, and liability issues; and environmental responsibilities. Representatives from PHAN identified some of the available training resources, which included a board of health training manual, Web page, a video from the National Association of Local Boards of Health (NALBOH), and other workshop and training opportunities.

Participants also discussed when and where the training workshops could be conducted. Since state law requires county commissioners to be members of the board of health, one suggestion was that SALBOH partner with the Nebraska Association of

County Officials (NACO) and offer training sessions at the NACO district meetings held throughout the state. Another recommendation was to schedule a 20- to 30-minute training program prior to some of the regular board meetings. In these sessions, videos could be used for training and education on the core functions and essential services, board expectations and roles, board management, legal issues, and policy development.

Ongoing support and training

In July 2004, PHAN began organizing regular conference calls for the board of health presidents to provide education on key responsibilities (e.g., statutory requirements, long-range planning, policy setting, evaluation, annual reporting, and the budget). In addition, the calls also provided an opportunity to exchange information on current issues or problems. Some of the key issues that have been discussed are techniques for improving the effectiveness of large boards (i.e., 20 or more), board members acting independently to push their own agendas, and how to reduce the conflict and tension between board members. During the discussions, various suggestions were made that included the importance of developing priorities based on a community needs assessment, creating a workplan and budget based on the priorities, delegating key tasks to committees, and establishing clear operational policies that identify who speaks for the board.



Nebraska counties (shaded) covered by public health departments in 2004.

A grant from Nebraska Health and Human Services System provided funding to PHAN to continue to refine the training needs for local boards of health in the coming year. The Nebraska SALBOH organization is well positioned to provide a leadership role in identifying the training needs for board of health members. Once the needs have been identified, PHAN and the Office of Public Health can use their resources to offer appropriate board education.

Marlene Wilken, RN, PhD, is president of Douglas County Board of Health and co-chair of Nebraska SALBOH. Find more Board of Health information at www.publichealthne.org/id24.htm. Dave Palm is the administrator of the Office of Public Health in Lincoln, Nebraska.

Turning Point and NNPHI Plan Joint Annual Meeting

The National Network of Public Health Institutes and the Turning Point Initiative will hold a joint annual meeting for the first time, May 18-20, 2005, in New Orleans. Together, Turning Point innovators and Public Health Institute leaders will engage in discussions aimed at finding solutions to common public health system challenges across the nation. The conference planning committee is developing sessions on, among other topics, accreditation of state and local health agencies, workforce credentialing, performance standards, advocacy for the public's health, public health systems research, and relationships between governmental public health agencies and public health institutes. Outcomes from this meeting will be shared in the Summer 2005 issue of *Transformations*. If you are interested in learning more, please contact Marleyse Borchard (borchard@u.washington.edu).

Policy Corner

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

Policy Question

Why have boards of health?

Response

Public health is a community affair! For that reason a citizen board of health representing the community is an important and integral part of the local public health system. A citizen board of health provides the link between a community and its official public health agency.

A local board of health's responsibility is to provide oversight for the community's public health programs. This starts with the responsibility of employing a health officer or health commissioner who will lead and manage health department services.

The board of health also serves as an advocate for public health. It can provide important influence in ensuring that adequate resources are available to provide needed public health services.

From their beginning in the late 18th century, local boards of health have been composed of citizens interested in their community's health and well-being. One of the first real boards of health was in Boston, Massachusetts, and chaired by Paul Revere. That board's role was to assist local government in stopping the spread of disease and eliminating pestilence and unsanitary conditions. They were so successful that by the middle of the 19th century the Massachusetts Sanitary Commission report called for the creation of local boards of health for every community. This report later became a guide for public health in the country.

Today, citizen boards of health or advisory boards are equally important to a successful public health agency. They provide the community link for the agency as it addresses the implementation of core functions, essential public health services and emerging health threats. Such a board of residents from the community, when adequately informed, is focused on public health issues and their solutions.

Abandoning, rather than building on, the legacy and resources embodied in a citizen board of health seems foolish and wasteful. Few successful organizations continue to be successful after ignoring their missions. American communities and citizens cannot afford to replace the infrastructure that has been created by the public health establishments in this country. The importance of these conclusions is strengthened when the events of September 11, 2001, are recalled. Public health and safety is most definitely a community affair.

Ned E. Baker, MPH
NALBOH, Past-President and Executive Director
Past Board member and former President, Wood County Board of Health
Bowling Green, Ohio

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

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

Policy Statement: *Are courses whose intent is to train future governmental public health practitioners best taught by those with experience in that field of practice?*

While I agree with Dr. Turnock that good teaching skills are the highest priority, I do believe that public health students should be trained by practitioners. An infectious disease policy analyst appears in housing court to prevent the eviction of a family in which the mother has multidrug-resistant tuberculosis; a health educator manages the problems and costs of an x-ray van that travels the city providing mammograms; an environmental specialist counsels parole officers concerned about infectious diseases—all in a day's work in public health. Theory, research skills, and administrative techniques are important basic knowledge, but until tested in the real work of daily public health challenges, they remain academic. Only practitioners, through sharing their experience with students, can convey the complexities and demands of working simultaneously with the public, the health care system, several levels of government agencies, and budgets. Practitioners can demonstrate the unanticipated difficulties and daily mysteries as well as the triumphs, rewards, and satisfactions of public health practice.

Gail S. Cairns, MA, MPH
Visiting Assistant Professor of Public Health Practice
Graduate School of Public Health, University of Pittsburgh
(formerly with the New York City Department of Health)

New from NACCHO and Turning Point

A one-hour documentary produced by NACCHO, *The Edge of America: Struggling for Health and Justice,* explores how three rural Turning Point communities in Arizona, Montana, and North Carolina struggle to survive injustices such as poverty, inadequate housing, discrimination, ineffective immigration policy, and lack of access to transportation and health care that produce increased morbidity and mortality in their communities.

These stories, told firsthand, demonstrate life experiences of people living on the edge of American society where survival, health, and quality of life present tremendous challenges to individuals, their families, and communities. The vignettes can prompt meaningful discussion and action around these difficult social issues, which transcend their rural context.

The *Edge of America* can be used by health departments, public health practitioners, communities, policy makers, educators, rural health organizations, tribes, and governmental agencies as a valuable tool for dialogue on health and justice issues and as a stepping stone for community action planning and policy development. The themes presented in the film are relevant to urban and rural audiences, as well as to all people challenged by inequities and concerned with the fight for health and justice.

To access a list of questions that can be used for group discussion, visit http://www.naccho.org/general1188.cfm. To order a copy of the documentary, visit http://www.naccho.org/prod183.cfm.

Collaborative Leadership and Local Boards of Health: Putting Words into Practice

Jennifer M. O'Brien

Effective boards of health know that local public health agencies must work with community groups and leaders to be effective in changing the health outcomes of their fellow residents. As a result, local boards of health are well positioned to engage in collaborative leadership within their communities.

Collaborative leadership is a process by which people with different views and perspectives come together, set aside narrow self-interests, and discuss issues openly and supportively in an attempt to find ways to help each other solve a larger problem or achieve broader goals. Some boards of health are naturally adept at this form of leadership. Others need training in new skills and support and encouragement in practicing them.

Collaborative leadership training

In early 2003, the Turning Point Leadership Development National Excellence Collaborative set about developing a curriculum to train public health leaders in collaborative leadership. As a way to implement this innovative project, the collaborative involved both state and national partner organizations, including the National Association of Local Boards of Health (NALBOH), in the development of a set of learning modules on six practices essential for collaborative leadership (*see box*). In addition to the six modules, they developed an introductory module on Fundamental Concepts to introduce the overall collaborative leadership program and its benefits.

Six Collaborative Leadership Practices

1. Developing Trust and Creating Safety
2. Developing Clarity
3. Sharing Power and Influence
4. Assessing the Environment for Collaboration
5. Self Reflection
6. Developing People

The collaborative wanted its partner public health organizations and agencies to work together to describe how these key practices actually function in the community. NALBOH had already worked with other components of the Turning Point program, in particular the Public Health Statute Modernization Collaborative, and had seen that many boards of health already engage in some or all of these practices. In some instances, a single board member may be the "mover and shaker" on the board, able to bring people and groups together on a specific issue. In other cases, some or all local board members work together to achieve success. With more than 20,000 local board of health members in the United States, teaching them about the collaborative leadership practices may be one powerful way to bring about change in health outcomes.

Developing the learning modules

Each national partner developed a specific module. NALBOH's assignment was Assessing the Environment for Collaboration. An instructional design specialist created

the topic-specific curriculum and consulted with each assigned organization to ensure that the learning modules and information were appropriate for public health practice.

Each module incorporates a variety of learning methods (for example, lecture, group activity, visual aids). In the instance of NALBOH's particular module, the thorough training outline leads people through determining if their community is ready for collaborative change. It addresses five learning objectives:

1. Increase understanding of assessing the environment and its relationship to the other five practices
2. Increase conceptual understanding of a systems approach and its relationship to environmental assessment for collaboration
3. Increase awareness of cultural perspectives and how they affect the collaborative process
4. Compare and contrast a variety of environmental assessment tools
5. Create a personal learning plan to increase competency in assessing the environment

Pilot testing the modules

During NALBOH's 2003 Annual Conference, we pilot tested the modules with fifteen board members who attended a special session to provide feedback about the curriculum. Their response was very favorable. Participants said that not only did the program offer information and ways to improve collaboration, but it also reinforced behaviors that were already in place.

Although some boards of health taking part in the pilot test may not have been fully engaged in collaboration, the program showed them when it was possible to undertake collaboration, how to be a collaborative leader, and what they needed to do to be successful.

Many local boards of health are already using the six key collaborative leadership practices to achieve and sustain success. At NALBOH's 2004 Annual Conference in Denver, numerous boards highlighted how they worked collaboratively in their communities to address public health issues ranging from highway safety to passing a mill levy. In each instance, the boards put into action the six collaborative leadership practices and had successful outcomes.

Boards of health do not always use collaborative leadership to achieve their goals. In some instances, they may coordinate efforts or in other cases, rely on a network of groups to address an issue. The overwhelming benefit of these learning modules is to adequately lay the foundation for using collaborative leadership, when warranted, to maximize health outcomes.

Because of their role in the local public health system, local boards of health are the nexus of leadership. Successful boards and board members use collaborative leadership as one tool in their work to improve health outcomes in their communities. NALBOH is pleased to have contributed to the development of this curriculum and to offer it to local boards of health.

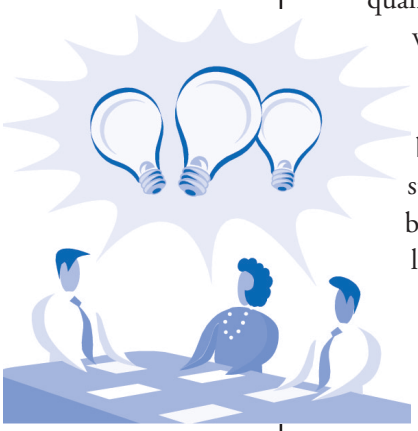
Jennifer M. O'Brien, MPH, MA, is grants manager at the National Association of Local Boards of Health.

Teaming with Local Boards of Health

Judy Garrity and Melanie Reynolds

Montana is a vast agricultural state where cows outnumber humans three to one. The largest of its 56 counties could hold the state of Connecticut with room to spare. If the state's residents were equally distributed from the mountainous western part of the state to the plains in the eastern part of the state, each person would have approximately 103 acres of roaming room. Such spaciousness breeds a populace that is fiercely independent—one that tends to take its cues from the land rather than popular opinion.

Operating and staffing a county health department in Montana can be challenging. Structure and services are as varied as the contours of the land. In the larger population centers, health departments offer a full array of services and can draw qualified professionals from the community. Most rural counties have few services and are staffed by a part-time sanitarian and a part-time nurse.



By law, local boards of health *oversee* their respective health departments across the state. The largest population centers in Montana have active boards that meet monthly, conduct annual strategic planning retreats, and stay abreast of the latest public health concerns. In sparsely populated areas, boards meet quarterly, and summer meetings, if there is a meeting at all, are lightly attended.

In an effort to provide greater consistency among the state's local boards of health, the state Department of Health and Human Services conducted a study to determine the perceived training and education needs of Montana's local boards of health and what other states are doing about board training.

We started with the National Association of Local Boards of Health (NALBOH) to determine priority issues. Next, our consultant conducted interviews with directors of ten statewide associations to determine how they orient, train, communicate with, and assess local boards of health in their respective states. Finally, we conducted interviews with health directors and board of health members in selected Montana counties.

Key findings of the study

Structure

The Centers for Disease Control and Prevention estimates that a population base of 50,000–75,000 is needed to support a health department. Both Nebraska and Idaho have regionalized systems that warrant closer scrutiny.

Information, Education, and Training

Montana Board members want succinct, understandable information that is pertinent to their specific duties. They also want clear guidelines on their roles and responsibilities, as well as ongoing education and skills building. Most were adamant about receiving education and training close to home and endorsed the use of video conferencing to make that happen. Nebraska and Wisconsin provide models for on-

site education and training; and North Carolina provides a model for training board mentors/trainers.

Assessments

Interviews with state directors indicated mixed reviews of the Local Governance Assessment endorsed by NALBOH. (For more information about the assessment, see www.nalboh.org/perfstds/nphpsp.htm.) Local health directors and board members in Montana echoed this mixed reaction. Most respondents found the idea of learning more about public health and about specific board needs appealing, but thought it needed to be balanced with time considerations.

Partnerships

States that were interviewed for this project boast strong partnerships with other entities—most notably the public health association and the association of counties within their respective state. Other partnerships included the state medical and dental associations as well as environmental agencies. Such partnerships underscore the important function served by boards of health and provide the means to maximize the resources for information and education.

The full report has been disseminated to local health directors in Montana with instructions to share the information with their respective boards. We are exploring working with the Northwest Center for Public Health Practice at the University of Washington to develop training modules. Arrangements have also been made to incorporate public health training in the Montana Association of County Commissioners training in the spring of 2005.

Seven Recommendations for Improving Local Board Effectiveness

1. Clearly delineate the pros and cons of Montana's current system versus a regional system.
2. Develop a standard orientation guide at the state level, in concert with local health directors and board of health volunteers.
3. Keep board members informed through regular one-page updates disseminated from the state.
4. Develop a page on the Montana Public Health Training Institute Web site for local board members.
5. Provide statewide education and training to board members.
6. Assess board development.
7. Train current or potential health board members within the context of their professional group.

Change begins with identifying where we have been, where we are now, and where we want to go. Montana's public health professionals want to provide an excellent public health system for *all* residents of Montana. They are determined to find the most effective ways to train, inform, and partner with local boards of health to make that a reality.

Melanie Reynolds is the Montana Turning Point coordinator at the Montana Department of Health and Human Services. Judy Garrity is a consultant.

Illinois Legislation Promotes Planning

Elissa Bassler

On August 20, 2004, Illinois Governor Rod Blagojevich signed the State Health Improvement Plan (SHIP) act. The legislation has provisions that will enhance Illinois Turning Point priorities by strengthening the infrastructure of public/private collaboration in Illinois.

The central goal of the bill is the requirement that Illinois produce a State Health Improvement Plan every four years. According to the legislation, the plan must focus on prevention and be developed using a combination of health status indicators (based on national goals, such as Healthy People 2010) and public health system assessments (such as the National Public Health Performance Standards). The plan must also make recommendations on the contributions and strategies of the public and private sectors in improving health status and the public health system. In addition, the legislation requires specific planning to address racial and ethnic health disparities.

The Illinois State Board of Health is responsible for delivering the plan to the Governor, but the legislation requires that the director of Public Health appoint a planning team made up of public and private/voluntary sector stakeholders, including:

- Directors/representatives of state agencies including the Illinois Department of Public Health and the Illinois Department of Human Services
- Representatives of local health departments
- Representatives of local community health partnerships
- Individuals with expertise who represent a broad array of organizations
- Constituencies engaged in public health improvement and prevention

Institutionalizing state health improvement planning was one of the original strategic priorities in the Illinois Plan for Public Health Systems Change, which was created during the Turning Point planning phase. The Illinois Public Health Futures Institute, which grew out of the original Illinois Turning Point partnership, developed and championed the SHIP legislation.

In addition to the State Health Improvement Plan, the SHIP act changes the composition of the State Board of Health by adding to the existing membership categories two additional private sector public health system members—a representative of the business community and a representative of the nonprofit public interest community.

Elissa Bassler is executive director of Illinois Public Health Futures Institute.

Site Visit

Research!America
www.researchamerica.org

Research!America is a national, not-for-profit, membership-supported, public education and advocacy alliance founded in 1989. Research!America provides a unique, unified link between the people who support research and local, state, and national opinion leaders and decision makers. The public opinion polling, advocacy-based programming, and publications of Research!America bring together the people and ideas that lead to increased support for a strong investment in the nation's health research to prevent disease, disability, and injury and to promote health. Visit Research!America's Web site for advocacy information, press releases, the outcomes of polling data, and more.

RWJF Update

James S. Marks Joins RWJF

James S. Marks, MD, MPH, has recently been named The Robert Wood Johnson Foundation's new senior vice president and director of the Health group. Dr. Marks comes to RWJF from a distinguished career with the Centers for Disease Control and Prevention. Until recently he was director of CDC's National Center for Chronic Disease Prevention and Health Promotion, and he has been integral to CDC's recent transformation and infrastructure redesign.

As a leading expert on disease prevention in this country, Dr. Marks holds numerous national honors, including the U.S. Public Health Service Distinguished Service Award. Also among his many achievements and experiences are his participation in the Swine Flu campaign and in the discovery of Legionnaires' Disease. As the epidemics of obesity and tobacco use have grown into major public health issues, Dr. Marks has been prominent in advancing systematic ways to address these complex threats.

At RWJF, Dr. Marks will be involved particularly in programs to reduce the prevalence of childhood obesity, to expand and improve treatment for alcohol and drug addiction, to improve the public health system's leadership and capacity, and to prevent and alleviate harm caused by tobacco use. He will also work with programs focusing on vulnerable populations.

Dates to Note

March 1-3, 2005. The 19th National Conference on Chronic Disease Prevention and Control; Health Disparities: Progress, Challenges and Opportunities. Atlanta, GA (www.cdc.gov/nccdphp/conference)

May 18-20, 2005. NNPHI/Turning Point National Initiative Joint Annual Meeting. New Orleans, LA (www.nnphi.org, or www.turningpointprogram.org)

July 12-15, 2005. ASTHO/NACCHO Joint Meeting. Boston, MA (www.astho.org, or www.naccho.org)

November 5-9, 2005. APHA Annual Meeting. New Orleans, LA (www.apha.org)

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

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