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Transformations in public health

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TurningPoint

Healthy Carolinians: A Successful Integrated Model of Community Health Improvement

Mary Bobbitt-Cooke, Christopher Cooke, Leah Devlin

In 1992, the North Carolina Governor's Task Force for Healthy Carolinians established state health objectives for the year 2000. The Task Force embraced a fundamental system change: communities need to decide what is wrong, how to fix the problems, generate or redirect resources, and implement their own community-devised solutions. Its guiding philosophy was that people are more likely to work toward objectives they helped set for themselves.

The Healthy Carolinians/Healthy People 2000 (now 2010) objectives would serve as targets, but the basic strategy was to create a network of community-based partnerships across North Carolina (NC) that would put decision-making, resources, and accountability where health is created and supported—in the community. This approach turned upside down the idea that the state capital Raleigh or Washington, DC, with their non-local statistics and secondary data, could successfully impose top down solutions to solve community issues relating to chronic disease, mental health, injury, access to health, and health disparities.

The Governor's Task Force, along with the Office of Healthy Carolinians/Health Education (OHC/HE), devised benchmarks to guide the process of achieving the health objectives, based on best practices for community-driven capacity development, including:

- **Community-wide membership** representing diverse agencies, demographics, businesses, elected leaders, and community members
- **Data-driven decisions** resulting from collaborative community assessment
- **Priorities established by the community**
- **Collaborative interventions** and evaluations that include multiple agencies and priority populations

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From the Turning Point National Program Office

Policy—The Final Frontier

Bobbie Berkowitz, Director

Where do the supports for strengthening the public health system begin? At the community level, local health department leaders develop networks with health care, social service, business, education, and faith sectors to provide information that leaders in other sectors need for supporting system changes that enhance public health. These local networks gain power when they create formal agreements to share resources, activities, and accountability for public health improvement. For example, when access to obstetric care disappeared because the only OB leaves town, other providers develop a network to share information about community OB resources. The network leads to a partnership among the community clinic, local hospital, and local public health department. Using their collective talents and space in the hospital, they successfully secure federal funding to expand the community clinic and attract a new OB provider.

At the state level, agreements among organizations and institutions that focus on population and statewide issues can alert the public to risks that threaten the health status of all citizens in a state. For example, when a state health department and hospital association join forces to promote community health improvement, the Chamber of Commerce sees an opportunity to improve the health of the workforce and reduce financial effects of chronic and occupational disease on business.

At the national level, campaigns to draw the public's attention to the value of a strong public health system require collaboration among all organizations that have a stake in health and health care. For example, efforts to launch a social marketing campaign to promote actions that increase physical activity are jointly developed and funded by leading public health membership and research organizations.

The Turning Point initiative has many real life examples of these scenarios. We also have examples of situations where no matter how broad the network or strong the partnership, the lack of a policy agenda reduced the effectiveness of efforts to sustain local, state, or national public health system improvement. Of the three core functions of public health (assessment, policy development, and assurance), policy is most often delegated to the final frontier, the last effort undertaken. Our experience tells us that when we think about the policy agenda early, important supportive elements for public health system improvements evolve.

- Strategies for public health improvement include institutional and governmental policy.
- Policy makers become advocates and members of local, state, and national networks and partnerships.
- Policy makers are part of the team that designs the messages and strategies to support policy change.

The Turning Point initiative is moving forward with a policy agenda that showcases how public health system change improves population health, adds to economic viability, and strengthens and improves public health infrastructure (information systems, organizational structure, and workforce viability and competence).

These system changes are an investment in healthier people. We do not plan to wait for the final frontier!

[continued from p. 1—Healthy Carolinians]

The Governor's Task Force established a certification process for the governor to recognize successful community collaboration. The current certification process includes standards (*see box below*) as well as peer review. Although each community partnership has named itself, the network of community partnerships is called *Healthy Carolinians* (HC). Today, 89 of North Carolina's 100 counties are actively engaged in the Healthy Carolinians process, with 67 certified partnerships. Participation in Healthy Carolinians is voluntary.

When North Carolina became a Turning Point state in 1997, the two local Turning Point partners used their Kellogg funds to establish Healthy Carolinians partnerships and become certified. One of these counties was subsequently awarded the prestigious Thad B. Wester Community of Excellence Award (2000), which recognizes an exceptional community's demonstration of community-based health change.

Standards for Certification as a Healthy Carolinians Community Partnership

1. **Alignment with 2010 Health Objectives.** Partnership must have implemented activities that work toward achieving 2010 objectives.
2. **Reducing Health Disparities.** Action plans/interventions must target populations with health disparities.
3. **Action Plans.** Strategies must have multiple levels of interventions, be effective in achieving health outcomes, and have impact/outcome evaluation plans.
4. **Diverse Membership.** Membership must represent demographics and geographic regions of county, health and human service agencies, businesses, churches, elected officials, and community members.
5. **Leadership.** Leadership must be collaborative.
6. **Community Assessment.** Partnership must demonstrate that it has conducted a community assessment to determine health agenda.
7. **Communication.** Partnership must have a communication plan to report its work.
8. **Support and Commitment of HC members.** Letters of support must demonstrate commitment to HC Partnerships.
9. **Funding.** Partnership should have ongoing financial support and a financial plan to secure additional funding.

Partnerships lead to systems change

At the state level, Turning Point has been an important influence in revitalizing and modernizing several key systems for supporting Healthy Carolinians. The most critical system change that occurred during the first phase of Turning Point was the way in which NC public health implemented community assessment. Community assessment is required for all local health departments (LHDs) and is included in the consolidated contract the state has with each county. Over the past five years, with support from the Turning Point initiative and in conjunction with a State Assessment Initiative grant from CDC, community assessment has been reorganized to support community health more effectively. (*See box on page 4 for a summary of these system changes.*)

These changes in community assessment have enabled communities to move forward with their own health agenda. Today, LHDs have used community assessment findings to advocate successfully for budget expansion at the local level. HC partnerships have used the comprehensive collaborative findings of their community assessment to address their unique priorities. Armed with the findings of community assessment, they have successfully secured funding from foundations and federal and state governments for dental clinics, mobile medical units, safe houses for victims of domestic violence, mobile mammography units providing screening to rural priority populations, prescription programs for older adults, recreation centers, housing, and economic development projects. Over the years, HC partnerships have been awarded more than $17,000,000 to

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[continued from p. 3—Healthy Carolinians]

address their community health issues—funding that has come into their communities on their terms.

Currently, Turning Point is supporting another system change that supports Healthy Carolinians and public health. To broaden the scope of funds that can be made available to support Healthy Carolinians, the Governor's Task Force is establishing a nonprofit organization, Healthy Carolinians, Inc. With nonprofit status, Healthy Carolinians can invite corporate partners to help fund community-based initiatives that target the 2010 health objectives.

Partnerships strengthen policy development

The structure of Healthy Carolinians (the Task Force at the state and the local HC partnerships in 89 of the 100 counties) perfectly positions it to affect state and local policies. And the organization has already laid much of the groundwork for effective policy education.

In 1998 and 1999, OHC/HE provided extensive advocacy training for HC partnerships. This instruction enabled local partnerships to effectively educate their state representatives about Healthy Carolinians and advocate for state funding. For the past four years, the NC General Assembly has appropriated funds to Healthy Carolinians. This funding is remarkable for two reasons.

First, the funds were *not* tied to any specific disease, health risk behavior, or body part. Rather, the General Assembly gave the funds to the HC partnerships stating "… do what is necessary." The General Assembly knew that HC partnerships targeted community-based priorities determined through collaborative community assessment.

Second, North Carolina has been overwhelmed with economic problems with very little money for new initiatives. Since HC partnerships have a steady stream of successes and outcomes to demonstrate their effectiveness, state-level policy makers consider them a good investment.

Other policy successes of Healthy Carolinians are evident at the local level. A short list of some of these successes includes:

- Funding in county budgets for new or expanded programs
- Smoke-free schools and shopping malls

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Changes in North Carolina's Public Health System

	1998	2002
Cycle	Biennial, all 100 counties/LHDs implementing community assessment at the same time.	Counties assigned to a four-year cycle allowing for planning, implementation, and evaluation.
Agency Involvement	State support from State Center for Health Statistics. Local implementation solely the work of the health department.	Multiple state agencies providing data sets and training. Local implementation expanded to include HC partnerships.
Data	Driven by secondary data derived mainly from vital records.	In addition to secondary data, primary data are collected at local level to ensure community input.
Training and Technical Assistance	Biennial training.	Ongoing training.
Off Year	Nothing required.	Annual State-of-the-County's Health reports to provide health updates to the community.
Relationship to 2010 Health Objectives	None.	Community action plans (part of the assessment process) are connected to the 2010 health objectives ensuring that the work of the LHD and HC partnerships are coordinated and aligned.

Turning Point Member Profile

Becky F. Campbell

Becky came to public health leadership from academic nursing. She has always been an active part of her community in Anderson, South Carolina (SC), and is currently the local health director for two county health departments.

Even before Turning Point came to South Carolina, Becky saw a need to involve community groups in public health issues. She was an early participant in the SC Healthy Communities Initiative. The Healthy Communities training in 1995 strengthened a broad-based community coalition, Anderson Partners for a Healthy Community, which has been an independent home for community partnerships for improving health. Becky was a prime mover in Anderson Partners and is currently its chair. When Turning Point came along in 1998, Anderson Partners became one of South Carolina's local partners.

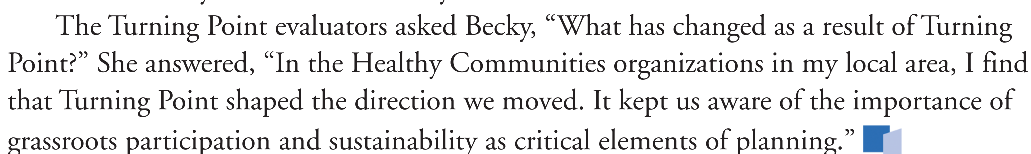
During Becky's years as chair of the state Turning Point Steering Committee, she guided the two-year planning process through research in priority areas, hosted seven statewide teleconferences with expert presentations, and led the consensus process for SC Turning Point's recommendations. In her community, she carried out Turning Point community conversations and involved the media.

Becky was also one of the two SC public health leaders sponsored by Turning Point to attend the 1998-1999 Public Health Leadership Institute (PHLI) at the University of North Carolina at Chapel Hill to assess its process and effect on leadership abilities. Her review led to a decision by the SC Department of Health and Environmental Control to become a part of the PHLI, increasing the community leadership capacity of local health directors and their key staff.

When SC Turning Point received implementation funding, Anderson County responded to an RFP and was awarded a one-year grant to carry out an environmental assessment to complement its health assessment. Becky was key to the process of planning, gathering qualitative and quantitative data, and bringing the community together to determine priorities.

Becky is an active member of SC Turning Point's Implementation Oversight Committee and has provided input on, reviewed, and critiqued materials from the Leadership Development Collaborative. She has brought the message to her local health director peers that there is a better way of doing public health business in communities: seeking community input and direction, defining health broadly, aligning resources, and sharing credit. "Because of Turning Point, I see things differently," Becky said. "I am now on the strangest committees. And just a few days ago, I received a call from a foundation that wanted to give us money, because the foundation had heard that we were about making a difference in the community *with* the community."

The Turning Point evaluators asked Becky, "What has changed as a result of Turning Point?" She answered, "In the Healthy Communities organizations in my local area, I find that Turning Point shaped the direction we moved. It kept us aware of the importance of grassroots participation and sustainability as critical elements of planning."



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

All Policy Is Relationships

Neil E. Hann

Former Speaker of the House Tip O'Neil is famous for saying, "All politics is local." Many past and present politicians have found this to be true. However, I believe this statement can be paraphrased as, "All policy is relationships."

Without question, to influence policy, relationships must be built with policy makers. That is what The Robert Wood Johnson Foundation Connect Project is all about. Simply telling our public health story to policy makers and, in particular, the exciting accomplishments now being realized by Turning Point initiatives all across the country, can have a tremendous effect.

Recently, Larry Olmstead and I had the privilege of attending one of the first Connect training workshops in Washington, DC, conducted by The Robert Wood Johnson Foundation. We were not sure what to expect, but were excited about the opportunity to tell our Turning Point story to the Oklahoma congressional delegation. The training itself was very informative. It showed us how to outline and organize our thoughts and provided a basic structure on our approach to policy makers. The Connect structure allowed us to tell the key points of our initiative effectively in a very limited amount of time.

The basics steps for successful communication

Establish Credibility. As soon as we entered the congressman's or senator's office, Ann Searight from The Robert Wood Johnson Foundation introduced us and cited Turning Point as a very successful initiative.

Outline the Issue. I did this specifically by talking about the Oklahoma Turning Point philosophy of community-based partnerships and how it has transformed the way we conduct the business of public health in Oklahoma. Larry Olmstead then put a human face on the Oklahoma Turning Point initiative by giving examples of local Turning Point successes, highlighting those successes in the districts the congressmen represented.

Suggest How to Work Together. We then discussed how we could work together with the congressman or senator on specific policy issues, including promoting local Turning Point partnerships and establishing business taskforces in existing partnerships.

Recap. We ended by recapping our conversations and leaving materials.

All of our meetings with the Oklahoma Congressional Delegation went extremely well. The staff members were attentive, asked good questions, and seemed very interested in what we were trying to accomplish with Turning Point in Oklahoma. This would have been success enough, but one visit in particular had great results.

Our meeting with the staff person from Senator Inhofe's (OK-R) office, Julie Wareing, went along like the others, but during our recap, Ms. Wareing indicated that she was working on setting up a health summit with Senator Inhofe and Senator Frist (TN-R). She asked if we would be interested in participating as one of the invited panelists. Larry, Ann, and I had to restrain ourselves from jumping out of our seats, but we did manage to say, "Yes!" A few short weeks

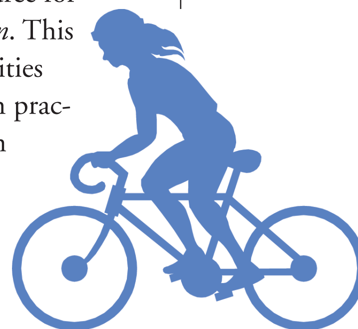
later, Larry participated in the summit, and Turning Point was touted as a key model to help solve our nation's health woes through community-based collaboration, action, and partnership initiatives.

The lesson from all this is that telling our story *can* make a difference and building those relationships with policy makers is not only a good idea, but should be considered an integral part of our work. Some of us have fears about making even minor contact with policy makers, but if we do not tell our story, who will? Telling policy makers about the importance of public health, about the worth of collaboration, and about the success of community health improvement partnerships *is our job* as public health professionals. We protect the public's health, and in order to do that, we need many partners, including our state policy makers and our friends on Capitol Hill in Washington, DC.

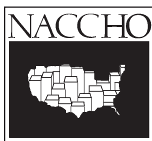
Neil E. Hann, MPH, CHES, is chief of the Community Development Service, Oklahoma State Department of Health.

New Guide Promotes Exercise

The National Center for Biking and Walking has developed a new resource for public health officials, *Increasing Physical Activity Through Community Design*. This guide looks at what it takes to increase physical activity by making communities more bicycle-friendly and walkable. The guide introduces ways public health practitioners and others can increase physical activity through community design and describes seven kinds of projects that can help create more bicycle-friendly and walkable communities. The guide also discusses how these kinds of projects can be funded and presents an array of resources to help with implementation. Download the guide for free at www.bikewalk.org/PubHealth.htm.



For more information contact Gary McFadden, director of operations for the National Center for Biking and Walking, at (202) 463-6622 x106 or gary@bikewalk.org.



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.

University of Washington School of Public Health and Community Medicine

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

Turning Point State Partner Grantee Meeting in Oklahoma City, October 1-3, 2002

The Power of Partnerships to Affect Change

The fall State Partner Grantee Meeting convened in downtown Oklahoma City at the Myriad Convention Center, October 1-3. The meeting started Tuesday night with a reception and poster session at the impressive National Cowboy and Western Heritage Museum. The 20 plus poster topics ranged from New York's focus on capacity building for a stronger public health workforce to Colorado's display of collaborations demonstrating the power of partnerships to affect change.

Enjoying conversation at the opening night poster session and reception.

On Wednesday morning,Wilma Mankiller, author, activist, and former principal chief of the Cherokee Nation, gave the keynote talk on community-based leadership. Ms. Mankiller spoke in a low-key but eloquent way on the characteristics of good leaders and the capacity of the poor for leadership and problem solving. Early in her career, she said, she defined a community as the people who live in a particular place. Over the years her definition has expanded to include communities of practice, for example, professions or activist groups—groups of people who share enough goals to be able to work toward common ends.

Jerry Schultz and Wilma Mankiller.

She listed four key qualities leaders must have.

1. **Compassion**. Leaders have to care about the people they lead.
2. **Focus.** Leaders need a singular focus on what to do rather than trying to do a little bit of everything and, so, getting nothing done.
3. **Optimism**. Leaders need to look at barriers as challenges, not as reasons to give up.
4. **Positive approach**. Leaders can't just recite a litany of problems with no solutions. They have to be forward thinking. She quoted a Mohawk proverb, "It's very hard to see the future with tears in your eyes," and added, "Don't constantly lament the past. Acknowledge it and move on."

Ms. Mankiller went on to talk about solving public health problems. She said she learned about leadership from observing

people, especially poor people, and how they come together to make things happen. She described examples of problems communities she's worked with have defined and solved, from building a community water supply system to nutrition and exercise programs. "There's an untapped capacity for leadership in poor communities," she said, "but you have to trust people's ability to lead and to solve the community's problems."

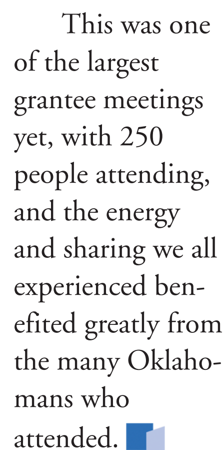
Following Ms. Mankiller's talk, members of the Performance Management Collaborative presented their current work from local, state, and federal points of view. In addition to the description of the model for performance management, collaborative members discussed their goal of developing a performance management field guide.

After lunch the Turning Point evaluators outlined their approach to evaluating the Turning Point program. Major themes reflected in Turning Point evaluations were the development of new structures and systems, the achievement of significant system-level outcomes, and some common challenges. In the afternoon, the group broke into workshops on communications and policy, and constituency building.

Conference participants set out on the Walk for Health.

The day ended with an Oklahoma-sponsored Walk for Health tour that took walkers to the Oklahoma City Memorial and through historical areas of town. The Memorial was immensely moving in its simplicity and its focus on survival and healing.

The meeting concluded on Thursday with breakout sessions on sustainability, using print and broadcast media, Turning Point and bioterrorism preparedness, and building public health infrastructure at the local level.



Participants stand beside the reflecting pool at the Oklahoma City Memorial.

This was one of the largest grantee meetings yet, with 250 people attending, and the energy and sharing we all experienced benefited greatly from the many Oklahomans who attended.

View slide presentations from the meeting online at
http://turningpointprogram.org/Pages/OK_grantee_meeting.html.

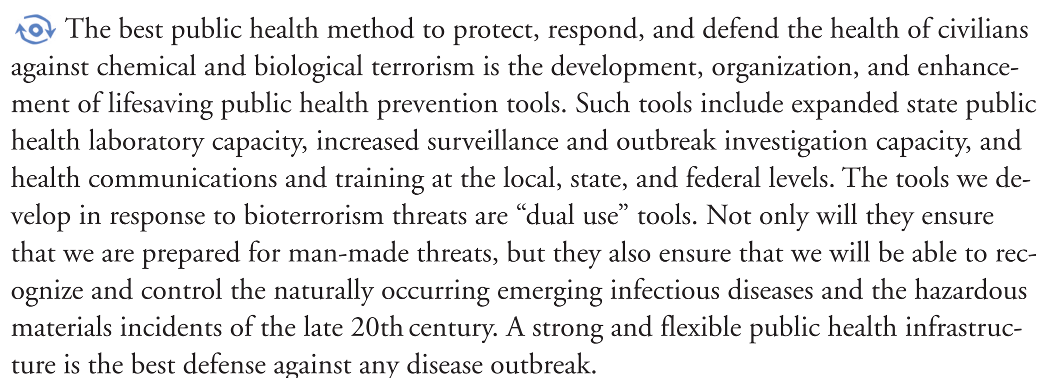
Policy Corner

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

Policy Statement

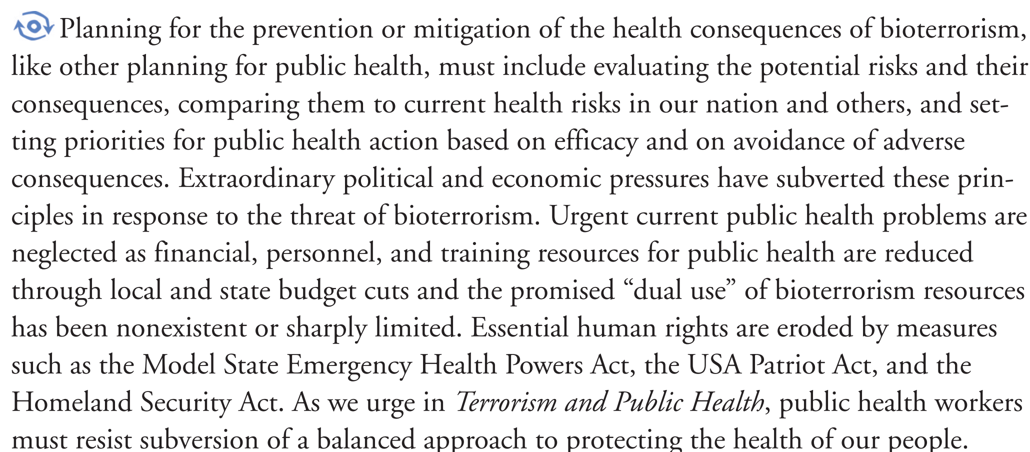
The nation's focus on bioterrorism and bioterrorism prevention funding is undermining the broad mission of public health.

Responses



The best public health method to protect, respond, and defend the health of civilians against chemical and biological terrorism is the development, organization, and enhancement of lifesaving public health prevention tools. Such tools include expanded state public health laboratory capacity, increased surveillance and outbreak investigation capacity, and health communications and training at the local, state, and federal levels. The tools we develop in response to bioterrorism threats are "dual use" tools. Not only will they ensure that we are prepared for man-made threats, but they also ensure that we will be able to recognize and control the naturally occurring emerging infectious diseases and the hazardous materials incidents of the late 20th century. A strong and flexible public health infrastructure is the best defense against any disease outbreak.

Jeffrey Koplan, MD, MPH
Vice President for Academic Health Affairs
Woodruff Health Sciences Center



Planning for the prevention or mitigation of the health consequences of bioterrorism, like other planning for public health, must include evaluating the potential risks and their consequences, comparing them to current health risks in our nation and others, and setting priorities for public health action based on efficacy and on avoidance of adverse consequences. Extraordinary political and economic pressures have subverted these principles in response to the threat of bioterrorism. Urgent current public health problems are neglected as financial, personnel, and training resources for public health are reduced through local and state budget cuts and the promised "dual use" of bioterrorism resources has been nonexistent or sharply limited. Essential human rights are eroded by measures such as the Model State Emergency Health Powers Act, the USA Patriot Act, and the Homeland Security Act. As we urge in *Terrorism and Public Health*, public health workers must resist subversion of a balanced approach to protecting the health of our people.

Victor W. Sidel, MD
Barry S. Levy, MD, MPH
Drs. Sidel and Levy, both past presidents of the American Public Health Association, are co-editors of Terrorism and Public Health*, published in November 2002 by Oxford University Press in cooperation with the American Public Health Association.*

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

Responses to Last Issue's Policy Statement

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

No matter how the BT funding pie is doled out, urban and metropolitan populations will appear to receive the largest pieces. This doesn't mean that rural populations will not be served; nor does it mean that they shouldn't and won't get a fair share. Many features of statewide BT preparedness and response (such as upgrades of laboratory, information, communication, and training) will benefit health jurisdictions both large and small. The issue of equitable distribution of BT resources can be put to rest when and where state and local public health partners plan together for everyone's needs rather than separately for their own.
Bernard Turnock, MD
Community Health Sciences, School of Public Health, University of Illinois, Chicago, IL

The dollars ***cannot*** be distributed evenly. The needs vary from one area of our nation to another, no matter how you may define comparative "area." The biggest deficits, in infrastructure and readiness, are in the geographical communities of less than 100,000; the most likely targets of intentional harm, however, are the large metro areas. If we are smart(er), we fill the fewer gaps in the larger areas, assuring horizontal and vertical integration and begin to construct regional networks that ensure public health activities toward responding—all this with a commitment to complete the construction of the public health system within two years and never let it be ignored again!
Stephanie Bailey, MD, MSHSA
Director of Health, Metro Public Health Department, Nashville, TN

BT funds must provide protection for all citizens of a state, regardless of residence—urban, rural or reservation. If you begin pitting urban vs. rural vs. tribal, you set up an even wider chasm than exists now in rural health care, and we will be forever playing catch up. Native American communities have been fighting this battle for decades—the right to equal health care treatment regardless of residence.
Teresa Wall, MPH
Executive Director, Department of Public Health, Gila River Indian Community, Sacaton, AZ

The real issue is how best to ensure that every community is prepared. In some states, this may indeed result in dollars flowing to all local health departments, large and small. In other states, funds may only flow to the largest metropolitan areas, with the majority of funds remaining under the control of the state health department for its use. Determining how the dollars flow should be determined by preparedness needs within the state and the capabilities of the various public health agencies to meet these needs. All things being equal, having dollars available as close to communities as possible will best ensure that local needs are met. However, all things are not equal. Because public health has been neglected for decades, far too many local health departments will be unable to meet local and statewide preparedness needs. Funding decisions must be driven by honest determinations made by each state's public health community about the capability of a community, large or small, to use funds effectively for community and statewide preparedness.
Ron Bialek, MPP
President, Public Health Foundation, Washington, DC

What Is the Policy Corner?

The Policy Corner is a new feature in which we hope to stimulate thought and dialogue among our readers on important public health policy issues.

We encourage readers to contribute to this discussion by visiting our Web site and submitting their respectful thoughts. In each subsequent issue of *Transformations,* we will summarize the Web discussion on the previous topic.

Deadline for responses to this issue's topic: March 1, 2003.

www.turningpointprogram.org

New York Hospitals See Linked Approach to Community Health and Preparedness Initiatives

Sue Ellen Wagner

Since the September 11, 2001, terrorist attacks, hospital disaster preparedness has taken on a new urgency. Hospitals have always planned for and responded to natural and man-made disasters—plane crashes, severe winter weather, school bus accidents, and floods, to name just a few. However, the scale of the September 11 devastation and our health care providers' pivotal role in providing medical care and relief have changed the way communities and the hospitals themselves view hospitals' role in disaster preparedness and response.

During the spring and summer of 2002, the Healthcare Association of New York State (HANYS) interviewed 11 hospital leaders across New York State, seeking their perspectives on community health and emergency preparedness since September 11. HANYS compiled its findings into *Taking Charge: Health Care Leaders Discuss Preparedness and Community Health*. The document summarizes HANYS's conversations with these hospital and system chief executives and outlines a community health strategy for addressing preparedness.

The lesson health care leaders learned is that no member of a community or a health system can be effective when responding independently in a disaster situation.

In the survey, hospital executives noted that the hospital operating environment since September 11 has been complex. As community expectations have risen and hospitals strive to enhance emergency preparedness, reimbursement rates have remained stagnant, competitive pressures have increased, and the daily stresses faced by hospitals attempting to deliver top quality service to their communities have only intensified. However, HANYS found that most of the hospitals have active community health agendas related to health promotion and prevention efforts, and some are working to integrate their role as emergency responder into a broader community health strategy.

Key survey findings

Key points made by the New York health care leaders in the document include:

Changed expectations. Community expectations of hospitals have changed. In the wake of September 11, communities view hospitals not only as the source of emergency medical care, but also as a refuge from chaos, a fount of knowledge, a channel for information sharing, and a source of comfort.

Need for increased financial support. The chief executives said their paramount concern is how to meet their communities' expanded expectations, given their current capacity and the current fiscal environment. They felt strongly that government at all levels—federal, state, and local—must invest more in health care capacity, communication, and coordination to ensure preparedness. They said that as an integral part of the first line of defense against terrorism, hospitals need significant government financial support to meet the extraordinary challenge of preparing for a wide range of nonnatural disasters.

New hospital roles. Hospitals and health systems recognize that in any large-

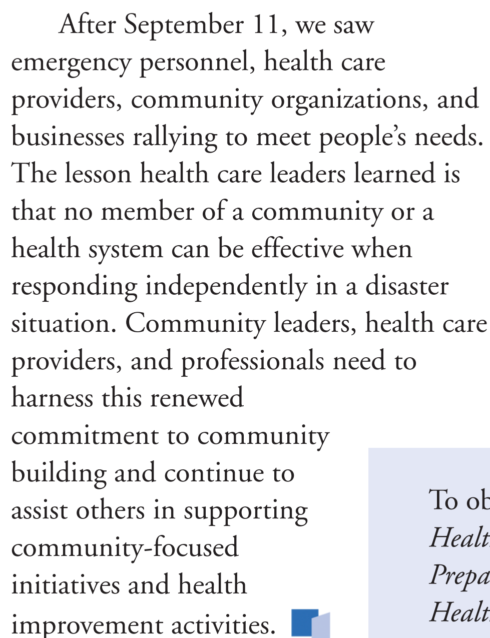
scale disaster, they will have to play a significant role in social and economic recovery, as well as in medical response. Hospitals are actively addressing the many mental health needs of individuals throughout New York City, helping the community deal with feelings of anger, frustration, fear, and helplessness. Hospitals are also integrally involved in the rebuilding and revitalization efforts in lower Manhattan.

Improved coordination and collaboration. Government agencies, emergency personnel, health care providers, and other community organizations need to build an infrastructure of coordination and collaboration to support disaster readiness activities. All the hospital executives that HANYS interviewed confirmed that they have improved coordination and communication both internally and externally, the latter by working with city and county health departments and local emergency response organizations in refining their community response plans. However, several noted that cooperative efforts—even willingness to cooperate—vary widely among local government entities. Dealing with multiple counties and their fragmented approaches has been a challenge for some of the hospital executives, and they are seeking clarity and consistent delineation of roles and responsibilities from government.

Staff development and security. Health care staff constitute a special community whose safety and security needs must be addressed. All of the hospital executives noted their pride in their staffs' dedication and commitment to providing care and service in an emergency situation. Educating staff and allaying their fears about real or potential threats is a critical part of readiness. However, achieving balance between providing community access to care and ensuring staff security is emerging as a difficult challenge.

Economic role of hospitals. Government tends to overlook that hospitals are among the largest employers in many communities. The link between hospitals and their communities' economic viability needs to be better defined by hospitals and recognized by government policy makers.

After September 11, we saw emergency personnel, health care providers, community organizations, and businesses rallying to meet people's needs. The lesson health care leaders learned is that no member of a community or a health system can be effective when responding independently in a disaster situation. Community leaders, health care providers, and professionals need to harness this renewed commitment to community building and continue to assist others in supporting community-focused initiatives and health improvement activities.



Sue Ellen Wagner, MS, is the director of Community Health for HANYS, coordinating the association's community health activities, which include: advocacy, information and education, membership communications, collaboration with civic, national, and state organizations, task forces, and special projects. She can be reached at (518) 431-7600 or by e-mail at swagner@hanys.org.

To obtain a copy of *Taking Charge: Health Care Leaders Discuss Preparedness and Community Health*, please contact HANYS's Corporate Communications and Marketing at (518) 431-7770 or ibush@hanys.org.

HANYS represents more than 550 of New York's not-for-profit and public hospitals, health systems, and continuing care providers. HANYS also offers a host of marketplace solutions designed to help health care providers achieve and sustain financial stability and operational excellence in today's complex environment and tomorrow's emerging markets.

[continued from p. 4 —Healthy Carolinians]

• 1% reduced-fat milk offered in the school system
• Well ordinance regulations for well construction
• Red light violation ticketing cameras at critical road junctions

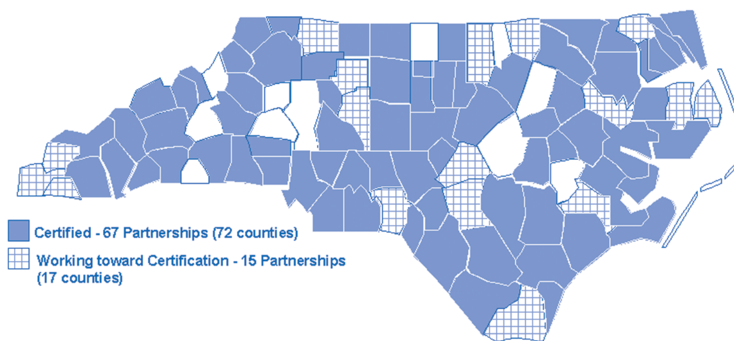
Currently, the Governor's Task Force has established an Access to Health Care committee that is reviewing North Carolina's barriers to adequate medical and dental care, affordable drugs, and so on. This review will include examining existing general statutes, funding issues and priorities, and other systems. The committee membership represents state-level agencies and HC partnerships. The recommendations that come from this committee may need the advocacy strength of the statewide network of local partnerships to effect changes in general statutes and system changes at the local level.

HC enhances local leadership

Turning Point has enhanced the Healthy Carolinians initiative by supporting system changes in community assessment and capacity development. These changes have served as a critical focal point for:

1. Building collaborative partnerships
2. Including community members in decision-making roles
3. Driving budgets and program decisions at the state and local levels
4. Providing needed data to attract additional funding
5. Driving health-related policy changes
6. Building community capacity to mobilize around health issues

Counties with Healthy Carolinians Partnerships



Healthy Carolinians has provided LHDs an opportunity to play a leadership role in community health. Collaborative leadership is a hallmark for successful Healthy Carolinians partnerships. In most HC partnerships, the local health director and the CEO of the local hospital have started the community collaboration by inviting leadership from other government agencies, civic groups, churches, businesses, and elected officials to initiate the development of the partnership. Public health provides the leadership in community assessment and facilitates data gathering and analysis, as well as linking community work to the 2010 health objectives. Through effective facilitation, the LHD uses its HC partnership as a forum, bringing together community programs from all agencies in a spirit of collaboration and coordination. The good news: duplication has been reduced and gaps in services have decreased.

Mary Bobbitt-Cooke is director of the Office of Healthy Carolinians/Health Education; Christopher Cooke is Turning Point project director; and Leah Devlin is acting health director, all are with the North Carolina Department of Health and Human Services.

For more information, contact Mary Bobbitt-Cooke (919-715-0416) or visit the Web site: www.HealthyCarolinians.org.

RESOURCES

Site Visit www.nnphi.org

National Network of Public Health Institutes

Over the past couple years a new breed of public health organization has emerged, committed to improving the public's health through state-of-the-art research, demonstrations, collaborations, evaluations, and training. This new type of organization is the public health institute. (Several have been established as a result of Turning Point public health improvement innovations.) This new multisector entity relies on partnerships and collaborations between federal, state, and local public health agencies, universities, foundations, and other health-related organizations to foster innovations that improve health. Turning Point supported the individual state institutes in exploring the potential benefits of combining efforts in a collaborative network and, with CDC, continues to support the network today. Visit the Web site of the National Network of Public Health Institutes (www.nnphi.org) for more information about their goals, products, clients, and network members.

RWJF Update

RWJF Announces a New President and CEO

Risa Lavisso-Mourey, MD, MBA, has succeeded Steve Schroeder, MD, as president and CEO of the Foundation. Dr Schroeder retired in December 2002. Dr. Lavisso-Mourey joined RWJF as senior vice president and director of the Health Care Group in 2001. Risa has a superb record of accomplishment in academic medicine in her specialty area of geriatrics. She is a member of the Institute of Medicine (IOM) of the National Academy of Sciences and recently served as co-vice chair of the IOM committee on eliminating racial and ethnic disparities. She is a master and former regent of the American College of Physicians and has chaired its ethics and human rights committee. Dr. Lavisso-Mourey served on the board of directors of the American Board of Internal Medicine as well as on the boards of several corporations. Steve Schroeder describes Risa as a "nationally recognized expert in health care policy, in government, and as an independent researcher and analyst. . . . Risa will be a terrific leader for this Foundation as we embark on our next phase of improving health and health care for all Americans."

Dates to Note

February 19-23, 2003. Preventive Medicine 2003. San Diego, CA (www.PreventiveMedicine2003.org)

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

September 9-13, 2003. ASTHO-NACCHO Joint Annual Meeting. Phoenix, AZ (www.astho.org or www.naccho.org)

October 8-10, 2003. Turning Point State Partnership Grantee Meeting. San Diego, CA (www.turningpointprogram.org)

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