

EXPANDING OUR VISION

Transforming Vital Public Health Systems



Conference Proceedings

October 5 - 6, 2006
Downtown Doubletree Hotel
Omaha, Nebraska

SPONSORED BY
The Office of Public Health
Nebraska Health and Human Services System

Funding for this conference was provided by the Robert Wood Johnson Foundation.

PROCEEDINGS

***EXPANDING OUR VISION:
Transforming Vital Public Health Systems***

October 5-6, 2006
Doubletree Hotel
1616 Dodge Street
Omaha, Nebraska

SPONSORED BY
The Office of Public Health
Nebraska Health and Human Services System

FUNDED BY
The Robert Wood Johnson Foundation

Table of Contents

Introduction	v
Conference Planning Committee and Conference Managers	vi
Keynote Address	1
<i>New Realities of Public Health: Why We Need a Strong Public Health Infrastructure</i> Paul Halverson, Dr.P.H.	
Plenary Addresses	
<i>Building the Public Health Infrastructure: State Lessons Learned and Keys to Success</i>	5
David Palm, Ph.D. Ann Conway, M.A., Ph.D. Jonathan Stewart, M.A., M.H.A. Rota Rosaschi, M.P.A.	
<i>Lessons Learned from Turning Point</i>	14
Betty Bekemeier, M.S.N., M.P.H., R.N.	
<i>Ethical Challenges in Public Health: Applying the Principles of the Public Health Code of Ethics</i>	17
Les Beitsch, M.D., J.D. Terry Brandenburg, M.B.A., M.P.A.	
Luncheon Presentation	21
Public Health in the 21 st Century: It's not your Grandmother's vision, or is it? Richard Raymond, M.D.	
Concurrent Sessions	
<i>Strategies for Workforce Development</i>	25
Tanya Uden-Holman, M.A., Ph.D. Joann Schaefer, M.D. Magda Peck, Sc.D.	
<i>Building Support for Public Health</i>	29
Senator Dennis Byars Senator Maurice Washington Representative Martha McLeod, M.O.E., R.D. Representative Lisa Miller, M.P.H.	
<i>Developing Integrated Public Health Data Systems</i>	34
Joe Kyle, M.P.H. Lisa Tuttle, M.P.H.	
<i>The Role of Collaborative Leadership in Developing a Strong Public Health System</i>	40
Les Beitsch, M.D., J.D.	
<i>A Case Study to Demonstrate the Principles of the Ethical Practice of Public Health</i>	44
Terry Brandenburg, M.B.A., M.P.A.	
<i>Models of Performance Accountability</i>	51
Kathleen Wojciehowski, M.A., J.D. Les Beitsch, M.D., J.D.	
Conference Speaker List	56

These proceedings are based on edited transcripts of audiotapes and PowerPoint presentations prepared by speakers. They were compiled and edited at CityMatCH, Section on Child Health Policy, Department of Pediatrics, University of Nebraska Medical Center, by Marilyn Ingram with assistance from Amy Cotton and students in the UNMC/UNO Masters of Public Health program.

Introduction

This report of proceedings consists of presentations given at the ***Expanding Our Vision: Transforming Vital Public Health Systems*** conference on October 5-6, 2006, in Omaha, Nebraska. The conference was organized by the Office of Public Health, which is part of the Nebraska Health and Human Services System and was funded by the Robert Wood Johnson Foundation. The purpose of the conference was to share best practices from the Turning Point Projects in Nebraska, Maine, New Hampshire, and Nevada that can be used by other states in developing stronger state and local public health systems. The conference included sessions that focused on strengthening the public health infrastructure including strategies for workforce development, building support for public health from policymakers, integrated data systems, collaborative leadership, performance accountability, and application of the Public Health Code of Ethics. There was also a session that was exclusively devoted to the lessons learned from the national Turning Point Project, which involved 21 states and was funded by the Robert Wood Johnson Foundation from 1998 to 2005.

The 250 participants consisted of a diverse group of public health professionals from across the country and included representatives from local and state health departments, academic health centers, community health centers, state legislators, federal officials, and various state associations.

Acknowledgements

I wish to thank the Robert Wood Johnson Foundation for their generous support of the conference. Susan Hassmiller, a senior program officer from the Foundation, has been extremely helpful during the planning process and throughout the entire Nebraska Turning Point Project.

I also want to thank the members of the conference planning committee for their time and effort in developing the agenda and the format for the conference. Additionally, I want to thank Magda Peck, Sc.D., CEO and Senior Advisor for CityMatCH, Professor and Associate Chair for Community Health, and Chief, Section on Child Health Policy, Department of Pediatrics, University of Nebraska Medical Center, and Patrick Simpson, M.P.H., Acting Executive Director, CityMatCH, Section on Child Health Policy, Department of Pediatrics, University of Nebraska Medical Center for their leadership in the development of the proceedings.

Special thanks to Marilyn Ingram from CityMatCH and her team for coordinating and writing the proceedings. Her team consisted of Amy Cotton from CityMatCH, as well as April Fatemi, Joel High, Serena P. Murray, and Adrienne Wemmert, who are

Master of Public Health students from the University of Nebraska Medical Center and University of Nebraska-Omaha.

Finally, I wish to thank my staff for their commitment and outstanding work. Charlene Gondring and Colleen Svoboda were the conference coordinators, and Sue Medinger and Mary Munter provided additional support.

David Palm, Ph.D.
Administrator
Office of Public Health
Department of Regulation and Licensure
Nebraska Health and Human Services System

Conference Planning Committee

Teresa Anderson, R.N., M.S.N.
Executive Director
Central District Health Department
(Nebraska)

Betty Bekemeier, M.S.N., M.P.H., R.N.
Former Deputy Director
Turning Point National Program Office
Lecturer, Health Services
University of Washington School of Public Health &
Community Medicine

Ann Conway, M.A., Ph.D.
Director
Maine Center for Public Health's Area Health
Education Center

David Corbin, Ph.D., FASHA
Professor, Health Education and Public Health
University of Nebraska at Omaha

Bruce Dart, Ph.D.
Health Director
Lincoln-Lancaster County Health Department
(Nebraska)

Kim Engel
Director
Panhandle Public Health District
(Nebraska)

Rita Parris
Executive Director
Public Health Association of Nebraska

Rota Rosaschi, M.P.A.
Executive Director
Nevada Public Health Foundation

Jonathan Stewart, M.A., M.H.A.
Director
New Hampshire Community Health Institute

Conference Managers

Colleen Svoboda, M.P.H.
Program Coordinator
Office of Public Health
Nebraska Health and Human Services System

Charlene Gondring, M.B.A.
Performance Accountability Consultant
Office of Public Health
Nebraska Health and Human Services System

Keynote Address
New Realities of Public Health: Why We Need a Strong Public Health Infrastructure

Paul Halverson, Dr.P.H.
Professor
Department of Health Policy and Management
University of Arkansas for Medical Sciences

It is great to be here in Nebraska! I am pleased to be here and to help set the framework for this exciting conference in public health. This is a great opportunity to pull together a lot of things. I am grateful for the Robert Wood Johnson Foundation (RWJF). Many of the things that we currently enjoy in public health have come, in large part, from their investment.

Today, I would like to talk about the reality of our public health system. There is not enough money to fund what we do in public health without outside help. The public health system certainly includes our governmental public health organizations, but in reality, it is much larger than that and includes important partners like the Robert Wood Johnson Foundation. Their strategic investments have certainly helped us move forward. From my perspective, this is the beginning of a new day in public health; it is a wonderful time of transformation in Nebraska and you have great opportunity before you to create a public health system that will be of great use to the people in your state, well into the future.

I wear two hats in Arkansas. I am both the state health officer and professor of Health Policy Management at the University of Arkansas for Medical Science. We are very integrated and this is important. Today, I come wearing my professor hat. My first point is, if you will allow me a surfing metaphor, "When you are on the wave, ride it!" The "wave" may come in the form of bioterrorism funding or a food born outbreak. Whatever it is, we have to deal with it and we may as well take advantage of the opportunity and make it work for us in public health.

We are faced with many challenges in public health today. We all know about increasing cost. For the last several years, inflation has hovered between 2-3 percent, but medical and health inflation has far outpaced that. The reality is, as health insurance premiums continue to take greater and greater bites out of corporate profits, we will all have to deal with it – both as employees receiving benefits, and as professionals working in a sector that is frequently accused of providing low quality care for a high cost. We are seeing an increase in the number of people with little or no insurance. Disease patterns and risks are changing, as well. We are now dealing with the

concept of pandemic flu, new strains of the avian flu virus, and chronic diseases, as well. In Arkansas, during the last four years, we have had fourteen new cases of Hanson's Disease (leprosy). When was the last time you saw that? I keep reminding my public health colleagues and policymakers that we can't focus on one thing and ignore the others – we must simply add new things to our plate.

Our nation has become increasingly aware of issues concerning security. They look to us to assure them that they are safe from bioterrorism and pandemic flu. The pandemic influenza effort is a great opportunity for us to remind citizens about the importance of what we do in public health, but it also carries a huge responsibility. The public knows that we are getting money to prepare for it and they expect us to be ready. We also need to remind them that they need to be ready -- it is a collective responsibility.

Public health, in general, is misunderstood. Polls suggest that people support it, but understand very little about it. Most people think that public health primarily means taking care of indigent people, protecting the water, and providing birth and death certificates. Fortunately, there is a favorable attitude toward public health. For a long time, public health has been an invisible presence. But as funding gets tighter, the reality is who wants to pay for an invisible service? This has been a problem for public health – trying to get policymakers to understand that they need to make an investment in something that is invisible. We need to do a better job of becoming more visible and help people understand what we do and why we do it.

There has also been a lack of trust toward the government and skepticism regarding the role it should play in protecting us. People don't necessarily want government involved in decisions around smoking and eating, and yet I can show you some very compelling research that suggests public health can make a huge difference if we are involved in the policy development phase around issues like smoking and obesity!

We are also seeing an increasing emphasis on accountability. In the past, our prevailing attitude was, "We are doing things that no one else wants to do, without cutting edge equipment or technology, so please just leave us alone." We can't be that way anymore. In reality, investments have increased, particularly in the area of bioterrorism and preparedness funding, and there will be increasing expectations around accountability. We must change our negative attitude toward accountability. Instead of wondering who is going to be blamed for something, it is important, at this early phase, to be thinking about what we can measure to demonstrate our worth.

The three leading causes of death in the United States are heart disease, cancer and stroke. The actual causes behind these deaths, according to McGinnis and Foege, are tobacco, poor diet/lack of physical activity, and alcohol consumption. It is very difficult to address these chronic diseases and health behaviors; and yet, that is exactly where part of our public health focus needs to be. If we look at the annual deaths related to AIDS, alcohol, illicit drug use and suicide and compare them with the impact of obesity, you can see the magnitude of the challenge before us. I am very pleased to tell you that we have had some success in Arkansas with childhood obesity, so there is hope. The same is true if we look at smoking. I recently looked at a study done in Colorado. A city implemented an ordinance to restrict smoking and the county did not. The reduction in acute myocardial infarction for the city was significant. Increasingly we will see that public health policy decisions like this can make a big difference.

Another new reality has to do with physical fitness. This epidemic of obesity continues to plague us and is probably one of our most significant challenges. No amount of providing access to the health care system will fix this problem. This is not only an access to medical care issue; this has to do with something much more complex – it has much to do with what we do and how well we do it, in terms of our ability to be a catalyst for change.

Another way to look at the success of any health system is to look at how long people are living. What is the average life expectancy? In Japan, the life expectancy for males is 76 years, but in the United States, it is 72. We rank number 25. If we look at McGinnis and Foege's work regarding the actual causes behind these deaths, we see that these deaths are related to behaviors rather than things that are more infectious in nature. Again, these relate to what we do in public health.

In the early 1900s, the leading causes of death in the United States were pneumonia, tuberculosis and diarrhea. Infectious diseases played a major role in what we did in public health. As we think about advances in public health in our country, we need to remind ourselves that some of the greatest advances have occurred because of what we have done in environmental health (e.g. sanitation). We have done some very basic things which have greatly increased the lifespan and reduced morbidity and mortality in our country. Does this mean we should forget about infectious disease? No! In fact, tuberculosis continues to be a significant issue. We still have outbreaks of it primarily in our immigrant population. We must continue to be vigilant in our infectious disease arena, but the point is, as we look at our comparative risk and mortality statistics, we can see a drastic difference when we compare the number of deaths from heart disease, cancer and

stroke to the number of deaths from pneumonia, tuberculosis and diarrhea (although there are still a number of countries where diarrhea is still the leading cause of death).

The World Health Organization (WHO) 2000 report ranked the United States 37th in health care and we continue to fall behind. We have a long way to go. Among the thirteen most economically advanced countries, we rank 13th (last) for low birth weight babies. We were last in neonatal and infant mortality and in potential life lost. We were 10th for age-adjusted mortality, but first in money spent annually per capita on health care. We are paying a lot for health care – are we getting our money's worth?

This has been a theme for the health care system and we need to be careful that, after all is said and done, people aren't asking the same thing about public health. Our health system is a wonderful thing -- if you can access it. It is very expensive and we aren't getting as much from it as we could. We used to think that we would never spend more than 10 percent of our GDP on health care. We now spend almost 15 percent. Our annual increase in health care costs is higher than the inflation rate. People are wondering where the money is going. Hospitals and physicians say the increases aren't going to them, and in fact, the most significant increases are going to the research, development and distribution of prescription drugs.

What is the take-home message? Private investment is beginning to slow and public investment is increasing, although the majority of investments still come from the private sector. According to LuAnne Heinen from the National Business Group on Health, "The bigger the bite healthcare takes out of corporate profits, the higher health care falls on the CEO and CFO priority list." Companies are making decisions to no longer provide insurance and are looking for ways to impact the cost of health, not just in terms of insurance, but in terms of absenteeism, productivity and quality of life. There is a new level of interest in corporate America related to what we do in public health, particularly as it relates to partnering with business to find ways to reduce cost and improve the overall quality of life and the healthiness of the workforce. This is a huge opportunity for those of us in public health and one that we need to be prepared to address.

How can we retool ourselves so that we can be an effective partner? We have made some wonderful advances. In the late 1960s, the Surgeon General's report helped increase our knowledge and understanding of the link between heart disease and smoking. We have made some great strides in that

regard and the actual and expected death rates for coronary heart disease have dropped significantly.

We also need to focus on some of the root causes of these diseases. We have seen a 14 percent increase in number of days that are unhealthy (both physical and mental health status). Soon, we will be asked to be accountable for issues around quality of life in addition to the 18 categorical diseases. We are entering into a new stage where we will no longer be responsible for only one disease at a time. This will force us to look more broadly at what we do in public health. We need to expand our skill set. How do we put it all together to address issues around quality of life and life stages? We need new strategies. Most of the investment in health today goes to people who are dying from complications of disease. Our goal is to keep people from having symptoms and being vulnerable to disease. Ultimately, that is where we are going to see the greatest impact. If we really want to make some important system level changes, we need to shift our focus from finding the person with hypertension to helping our communities to create conditions by which people never become hypertensive.

There are some things we can do collectively to impact the population to reduce vulnerability. Currently, 97 percent of our investment in health goes to health care – most of which happens in the last 60 days of life. But, only 3 percent goes to prevention. We need to think about how we spend the dollars that we currently get so that we can make the case for increasing the investment in prevention. Our health system is in crisis, our challenges are significant, and our work won't get easier. I foresee that our workload will increase and our scope of public health will continue to expand because the demands and expectations by the public will go up.

The relentless emphasis on reducing costs is also a factor. We need to focus on reengineering. In the past, our focus has been on small increases to cover costs; but, when was the last time we sat down and looked at what we really need in order to operate successfully? What can we quit doing? How might we be able to reengineer our process? We will get to that point sooner rather than later because the demands will outstrip our ability to get resources. If we are going to meet the new demands, we are going to have to face the reality of really asking tough questions about reengineering. We will begin to see system consolidation, and if we are going to be smart, we will have to think about what things we might be able to consolidate. If we are going to meet the new challenges, we need to make sure our infrastructure is up to the task. We are facing accelerated change and increasing ambiguity. This is one of the most challenging things for our public health staff today. As leaders in public health, we will have to become, and help our staff become, more

agile. We are in uncharted waters and need to think about how we can hone our thinking skills.

We will begin to see consolidation of specialist roles and we will have greater expectations of generalists. We spent a lot of time developing "silo" systems, and have created enormous artificial barriers to getting our work done. But the reality is, we can't afford that level of specialization and still get the work done. The roles of our generalists (e.g. public health nurses) will continue to expand.

Professional certification is also upon us. The National Board of Public Health has been established, criteria has been developed and delineated, exam questions are being written and in fact, our MPH graduates will be the first candidates to be board certified. Public Health certification is coming, and I think it will come for all of us at some time. Agency accreditation is coming, as well. In public health, we haven't been focused on accreditation and what we do has been open to wide interpretation. Consequently, policymakers have been free to pick and choose what they are going to fund. Accreditation can become a science-based leverage point for us. No one wants to be responsible for their state losing accreditation. The accreditation process can help us justify our legitimate expenses, particularly in the area of infrastructure. But, we need to make sure that we can live up to the level of expectation around capability and capacity.

We need to question basic assumptions and ask ourselves why do we do things a certain way and how could we do things better. We have wonderful opportunities to really impact the health of the public; and yet, we are doing it without a "play book." We are going to have to do it with our existing budget – and that is the challenge. What is the reality? We must look at where we've been, take stock of where we are going, and be willing to incorporate new ideas and make some changes. Begin to think about how we can take what we've learned and make it work for us.

The future of public health will include accountability, comparative data, our infrastructure, performance standards, performance management and accreditation. These are the realities that we are going to face and I think they will transform what we do in public health. We can no longer say "It's good – trust us." We need to begin to say "What is good?" and to begin to prove to ourselves, and to others, that we are accountable.

When we look, for example, at diabetes by states or rates of mammography among African American women in different parts of the country, we see significant variations. How do we cross the quality chasm? The Institute of Medicine (IOM) issued the following statement: "As medical science and technology have advanced at a rapid pace, the

health care system has floundered in its ability to provide consistently high quality care to all Americans. Research reveals a health care system that frequently falls short in its ability to translate knowledge into practice.”

We have many ratings systems in this country and the idea of comparison shopping isn't new. We compare restaurants, airlines, hotels and hospitals. The general public doesn't have adequate knowledge about our health care system, but various groups have been working to make reporting healthcare quality and outcomes a routine feature of the United States healthcare system. But what about what we do in public health? How can we prove what we do?

Increasingly, there are many organizations beyond the government that make-up what we do in Public Health. Can we effectively leverage other partners to help focus on improving and protecting the health of the public and the community? Using the language of the ten essential services of public health can help us find a way in which we can agree and begin to describe to others what we do in public health. Public health infrastructure is critical. The foundation of public health infrastructure is information systems, workforce and organizational capacity. We must have each of these in place to effectively carry out our job in public health. For example, our work in laboratories, epidemic investigations and emerging infections is tied to having appropriately trained staff, working in good facilities with good information systems, and having the organizational capability to carrying out daily functions.

The reality is that while our current public health infrastructure is improving, it is still fragile. The National Association of County and City Health Officials (NACCHO) has done some good work in thinking through some critical issues regarding infrastructure. They put together the *Operational Definition of a Functional Health Department*, which defines what every citizen should be able to expect from its health department, and the *2005 National Profile of Local Health Departments*, which describes infrastructure and where we are at in public health today. A survey of local health department leadership characteristics showed that while there has been an increase in the number of people with actual public health training in our health departments, the number is still surprisingly low. The average score for infrastructure for our largest health departments serving jurisdictions of over 100,000 was 65 percent. If this was a restaurant rating, how comfortable would you feel about eating there?

How can we be accountable in public health? We need to think about developing credible and comparative data. We need to not be afraid of data –

it will put some “heat” on us, but isn't it what we need to compel change? We need benchmarks, scorecards and specific goals. We need to develop a common language and increase our ability to share “best practices,” instead of reinventing the wheel, and we need to better understand the benefits and costs of accountability. It can help us assess our programs and help policymakers understand what they are getting for their investment.

We are moving very quickly toward agreement on the importance and viability of accreditation on a national level. RWJF and the CDC came together with the Association of State and Territorial Health Officers (ASTHO), NACCHO and the American Public Health Association (APHA) for a year-long process to look at whether or not we should move forward with accreditation. ASTHO endorsed the effort and it is only a matter of time until others will follow. We need to get in front of this effort and not try to push against it. It will help us in public health practice.

Who are our partners in public health? Ten years ago we found that approximately 75 percent of public health services were provided by local health departments and the remaining services were provided by non-governmental sources. New data suggests that this number is growing and, in some cases, growing dramatically. Again, we can't just look inside our agencies, but we must engage others in this process. We must adapt to our circumstances. There are going to be increasing demands for accountability and we are going to be asked to do things that we aren't comfortable with; but, I believe that if we are going to be successful in public health, we need to figure out ways in which to grow and thrive in this environment. We are fortunate to have tools available to help us use a performance management approach, thanks to the generous support of RWJF and the work of Turning Point. There is a methodology and discipline of performance management in public health.

I would like to close with a quote from Herophilus, physician to Alexander the Great. “When health is absent, wisdom cannot reveal itself, art cannot manifest, strength cannot fight, wealth becomes useless and intelligence cannot be applied.” I suggest to you: “Come on in – the water's fine.” It is an exciting time to be in public health. This is our opportunity to shine.

Plenary I

Building the Public Health Infrastructure: State Lessons Learned and Keys to Success

David Palm, Ph.D.
Administrator
Office of Public Health
Nebraska Health and Human Services System

Today, I would like to talk about our experience in Nebraska in terms of building the public health infrastructure. I will touch briefly on how things came about, what we did, what changes occurred, the rationale for a regional public health system, and what were some of our success factors and lessons learned.

Why was change needed? Nebraska did not have a lot of public health capacity. We didn't have a very large public health workforce and didn't do a lot with the exception of our four largest health departments. We weren't doing much in policy analysis or assessment, and we weren't doing surveillance or epidemiology investigations. We had very limited fiscal resources and there were certainly no dedicated state funds for public health. There was a lack of consensus about where we were going, and a real lack of understanding about what public health was and where we should be going. We had very limited organizational capacity – 16 local public health departments covering 22 counties (out of 93).

Change began in Nebraska with the establishment of the Turning Point Public Health Plan funded by the Robert Wood Johnson Foundation (RWJF). Turning Point played a huge role in helping us build a public health infrastructure. When we received the grant, we began developing a plan. This plan provided us with a road map for where we wanted to go. It also helped us determine major priorities. We agreed that we couldn't do the things we needed to do in public health unless we had a local public health infrastructure. Turning Point's Public Health Plan was critical.

We created four multi-county Turning Point partnerships. We didn't have a lot of money for implementation, but we attempted to create broad-based coalitions across the state to really think about how we could provide the core functions of public health in areas with unmet needs. Shortly after they were formed, new legislation was passed creating new health departments. We knew that the organizational effort would be huge to get them up and running, but these new coalitions were a tremendous help to us.

The new legislation (May 2001) helped us create 16 new multi-county health departments

across the state. In the rural areas, we had to have 30,000 people and three contiguous counties to form a health district. Of course, in rural Nebraska, if you want to find 30,000 people, you have to have a lot more than three counties...

The funding in Nebraska has been very good. We had 5.6 million dollars from tobacco settlement funds and were able to distribute between \$100,000 - \$150,000 to each local health department for infrastructure development. Additional funds were distributed at about \$2.00 per capita. (If you had a large population, you got more funding.) We also had success in the legislature this past year; another \$1.8 million dollars were appropriated out of state general funds for our local public health departments (about \$100,000 per department).

What was our rationale for using a regional approach and multi-county health departments? We used the regional approach for a variety of reasons. One of the advantages was economies of scale; the cost per unit is less. We were able to avoid duplication of resources (e.g. personnel and information technology). It also created a better opportunity to plan for different types of services and activities (such as emergency preparedness or detecting patterns of disease, which would be very difficult to do on a small county basis), and for leveraging new resources. The regional approach also helped improve the coordination of activities and programs between local departments and the state agency. If we would have had 93 health departments, we would have had to spread our resources way too thin, which probably would have resulted in turf wars. The bottom line was that Nebraska could not afford to support 93 county health departments and would not have been able to find qualified staff.

We had a lot of success factors. Many people contributed to the success of organizing these new local health departments including Dr. Raymond, Nebraska's Chief Medical Officer, who provided terrific leadership, people from the Public Health Association, and individuals from local health departments already in operation. But the most important people, by far, were the core group at the local level who "sold" public health to county commissioners, boards of supervisors, and other health care providers.

While there were some constraints (three contiguous counties and 30,000 people), there was also a lot of choice and autonomy in terms of how the departments were organized and put together. It was up to the counties to determine the structure of their department, who their partners would be, and how they wanted their health department to look.

We built strong partnerships, both vertically and horizontally. The partnerships between the local

health departments and the state agency were critical, but also the partnerships between the local health departments themselves and other partnering organizations. Our health departments have gotten better at seeking input and involving people from the community which has contributed to their success and helped gain more money from the state legislature. I think we have done a commendable job of documenting results and communicating them to the public, but we need to continue to improve in this area.

Another successful factor we employed was meeting with boards of health early on and challenging them to think about the types of people they wanted to hire. We discovered that probably one of the most important things we could do was to hire a coalition-builder -- someone who could really work with a lot of different partners. Over the course of setting up these departments, we found that hiring someone familiar with the area usually made a big difference, as did their ability to handle uncertainty, and being able to use different management styles. If there is a disease outbreak, you need a command and control style. But if you're trying to deal with complex problems like solving obesity or finding strategies to reduce racial/ethnic minority disparities, you need a broad-based coalition, and sometimes you have to be willing to step back and let others take the lead.

Avoiding duplication of services and programs was also critical to our success. The state agency was (and still is) contracting with a number of agencies to provide various clinical preventative services such as immunization, WIC services, etc., and we felt that if departments did this immediately, they would lose their focus and balance. Finally, having a stable, dedicated funding source and the ability to leverage new funds was critical to our success.

What are some of the lessons we learned? We found that it was essential for us to establish trust between local health departments and the state agency because we need each other to succeed. This interdependent relationship has helped us grow and mature. Local health departments build capacity and expertise at different stages, and this means that technical assistance has to be different, as well. Some health departments started very quickly and others lagged behind. It just takes time to do certain things. We initiated a strategic planning initiative between the state and local health departments to figure out how we can delegate and decentralize services. We had to determine the pace and level of capacity and expertise needed to accomplish that. It is an on-going process.

Another lesson we learned was that sometimes it was necessary to think beyond the

established regional borders. Within one department there may be eight or nine counties, but that still may not be sufficient to do all the things that need to be done in emergency preparedness, epidemiology investigations, or studying patterns of disease. Sometimes we have to think beyond our regional health departments. Also, despite delegating some activities and programs, it's important for the state agency to continue monitoring and providing oversight and technical assistance (planning, data analysis, and evaluation), and assuring appropriate training.

It is difficult for new public health departments to immediately find the right balance between health protection and health promotion. Most of our departments were formed in 2002, which was around the time when the bioterrorism grant came to Nebraska and other states. As a result, there was a huge focus on emergency preparedness; and while we need to be good at emergency preparedness, we also need to find a balance so that we can address other public health issues, such as obesity. Another related lesson learned is the realization that workforce training needs for boards and staff are continually changing. We have been extremely fortunate in Nebraska in that we have come up with a lot of resources to do training. For example, we have the new Center for Biopreparedness Education and the Public Health Association has done a terrific job of training. We have the Nebraska Educational Alliance for Public Health Impact (NEAPHI) that has tried to coordinate a lot of the training and we also developed the Great Plains Public Health Leadership Institute. We have a new Masters of Public Health (MPH) program, and a new College of Public Health is on the horizon. We have many exciting training opportunities, but we must remember that training needs vary for our local health departments as we build infrastructure.

I want to stress the importance of personal relationships and collaborative partnerships. If we are going to be successful, it will be because of good partnerships. Also, it is critical for new public health departments to evaluate their performance. We now have some good baseline information for all health departments, and our health departments are going to continue to update this information on a regular basis. We will be able to track how well we are doing in improving the health status of our communities. Some of our health departments have applied the MAPP process (a strategic planning initiative); they have applied the National Public Health Performance Standards, but we still have other things we need to do.

Turning Point provided the opportunity for us to build our public health system. We are deeply grateful to the RWJF for that. Our future success depends on creating a network of community health

partners; developing effective training and educational tools and programs. And, of course, documenting the results and being accountable is also very important. Finally, we have had extraordinary leadership in public health over the last several years in this state. We always need leaders that are willing to share responsibility, accountability and recognition. As long as we have strong leadership, we will continue to move forward. Thank you.

Ann Conway, M.A., Ph.D.
Director
Maine Center for Public Health's Area Health Education Center

Good morning, it is delightful to be here with you today. We have had "a long and winding road" in developing our public health infrastructure in Maine. It has been both interesting and surprising. We have had some bumps in the road but we kept plugging along and have been able to move forward.

There can be misconceptions about a rural state. Therefore, I will discuss the socioeconomics of Maine and the public health community. I will discuss what we hoped Turning Point would do, what happened and what did not happen. I will segue into what contributed to our success, and some of our lessons learned.

Many health challenges in Maine are not that different from those other states experience. We have a relatively high chronic disease rate and frequently refer to the "Three C's" and "Two D's." The common issues and major causes of death are cancer, COPD, cardiovascular disease and diabetes—often with the associated issue of depression. As in other states, we have a relatively high incidence of behavioral risk factors, but through our prevention and clinical efforts, we have been able to reduce smoking rates, particularly among young adults and teenagers. We have issues with substance abuse and overweight and obesity. We have many efforts oriented toward youth overweight, but we are also concerned about overweight and obesity among other segments of the population; if you look at rates of overweight and obesity among people over 65, it is also a very serious issue. Dr. Halverson discussed the utilization of a "life stage approach" this morning and we try to look at people at every stage of life.

We have issues around infectious disease and emergency preparedness, in part because we don't have health departments on the county or local level. We struggle with issues like pandemic flu and how to get the word out. There are also social threats (child and domestic abuse). We are the fourth most rural state in the United States, with a population of one million.

We have the highest median age in the United States (38.6) and are anticipating that it will continue to increase. There are different reasons for that, one of which is that, like other rural states, we have had many economic changes over the past twenty or thirty years. Many of the traditional bases of the economy in Maine have disappeared – farming, fishing, paper mills, textile mills--other manufacturing industries have declined. This has resulted in young people leaving the state. Additionally, we have a large immigration of people over 65 who have moved to Maine to retire. This has implications for what the state looks like demographically and for some political realities. As more affluent people move in, some of the local people are getting "priced-out" because property values are going up.

Maine has a "Yankee ethos" of independence and populism – you just can't tell Mainers what to do. That is the lens through which we view our public health development. Despite a lack of formal infrastructure, we have a strong history of partnerships. Many of the public health advocacy groups have been in existence for the past 20-25 years. In our statewide efforts, we collaborate with people from the clinical realm, voluntary associations, academia, local and state government and foundations. We work together very effectively, both on the statewide level and at the local level.

This partnership ethos has provided us with many victories and successes in public health, particularly in tobacco prevention. We have also had victories in teen pregnancy prevention and infant mortality, and now we're working on youth overweight. We work together on state policy and legal changes, as well as on the municipal level. There is a strong tradition of grassroots efforts and local success in Maine, and because of Turning Point, we are better able to understand what goes on in local communities. We struggle with the trend toward realigning resources, rather than spending more money.

Our Turning Point project was funded by the Robert Wood Johnson Foundation in 1999, along with 20 other states, with the intent to enhance Maine's public health infrastructure. We are grateful for the Turning Point funds. In terms of our public health structure, we have a state health department, the Maine CDC. We do not have county health departments; instead, we have a range of local health organizations. We have two cities with local health departments (Portland and Bangor). We also have a very strong tradition of Healthy Community Coalitions on the local level. In addition, and as a corollary with Turning Point, we have 31 Healthy Maine Partnerships, delineated by hospital service areas, which are local partnerships funded by the state through the tobacco settlement funds.

We were one of the few states to use our tobacco settlement funds to develop a Fund for Healthy Maine, which has helped develop the Healthy Maine Partnerships (HMPs). Legislatively, one of the kickoff points for this was the fact that in the late 90's we had the highest young adult smoking rate in the country. This caught the attention of the legislature. There were some key figures among public health stake holders who encouraged development of a more formal infrastructure to combat that. The HMPs first looked primarily at tobacco prevention, and now they address chronic disease prevention in general.

We were influenced by the Institute of Medicine's (IOM) report (1988), which codified public health. We used, as a guiding philosophy, the Ten Essential Services. When we started Maine Turning Point in the late 1990's, not many stakeholders mentioned the Ten Essential Services, especially at the grassroots level. Now, it's really different! Everyone is talking about them and trying to figure out how to incorporate them into their work.

Maine's Turning Point project had two phases. We had an initial planning grant, followed by an implementation grant. In planning, we had over 200 partners involved in the process. We created work groups to examine issues in Maine, such as the intersections between clinical care and public health, information technology, workforce development and financing issues. These work groups were important because we needed to have a mechanism that allowed us to think together, see where we were, see what was going on nationally and decide how we wanted to change things.

To support the work group analyses, we did a number of surveys inquiring about local and state-level experience, education, and training. We discovered that the workforce largely did not have any advanced training. We also asked: if we were to develop formal education programs, who would come and how could they do it? We found that distance is a huge issue in Maine, as is affordability. We looked at whether employers would pay for tuition reimbursement, etc. Also, if we had people with an MPH, where would they work? If we didn't have much of an infrastructure, where would they get a job? Essentially, we laid the groundwork for the second phase.

In the second phase, we put together a steering committee and proposed strengthening public health infrastructure by making a greater effort to connect local communities with government institutions. This meant developing a sub-state infrastructure. Eventually, the partners came up with a plan to develop a three-tiered public health infrastructure. We had a wide range of stakeholders in this process: Maine CDC, government partners,

and many public health advocates. We had a good relationship with clinicians and the health care community and we had a great deal of community representation. We were able to collaborate with businesses, municipal government, and legislators. In Maine, you work with new cultures as you deal with new partners. Until Turning Point, we had not worked very much with emergency medical services, the police, or the military. So, through Turning Point, we were able to develop some of those partnerships and build on them more significantly than we had in the past.

Through Turning Point, we were able to develop some fairly broad coalitions with new partners which lead to a greater acceptance of sub-state infrastructure. Turning Point legitimized building a sub-state infrastructure, which would have traditionally been viewed as just "adding another layer to bureaucracy," by helping people understand how it might improve systems, increase quality, and limit cost.

When we received the Emergency Preparedness funding, we were able to develop some other aspects of infrastructure, such as the regional resource centers for emergency preparedness, which are allied with health systems throughout the state. We were also able to develop our epidemiologic capacity, which we found lacking during the initial phase of Turning Point. We now have regional epidemiologists around the state which has been a great boon to us.

We were able to develop the Maine Center for Public Health, which functions as a neutral convener for the public health community to bring needed research capacity to the state. It was started in the late 1990s, and it became the institutional home for Turning Point. The Center has a variety of programs, does a fair amount of education and we are an Area Health Education Center (AHEC), one of the few with a public health focus. We also have a Prevention Research Center (PRC) through a Maine-Harvard partnership (Maine's focus is practice and Harvard's is research), which has been focusing on youth overweight for a number of years. We also do public health preparedness and work on chronic disease integration projects.

In Maine, we have also worked on some national initiatives. We participated in the Turning Point national social marketing and information technology collaboratives. Largely because of Turning Point, we have made advancements in health informatics, we are making public health data more accessible, and we have a greater awareness of public health infrastructure and what it means.

Through Turning Point funds, we have been able to strengthen community coalitions. We have a

number of Healthy Maine partnerships and Healthy Community Coalitions around the state. We now have a statewide alliance, the Maine Network of Healthy Communities. We have funded them for organizational development and mentoring

We have made progress in workforce development. Since Turning Point started, we developed an MPH program at the University of New England, College of Osteopathic Medicine and certificate programs at the state university.

In Maine, we tried to develop an infrastructure with three components: community grassroots organizations (local level organizations), regional health agencies and state agencies. The initial proposal didn't go very far in the legislature. At the time we put together the proposal, we had a change in government; and while the new governor was not opposed to our plan, his signature issue was health care and insurance reform. He proposed an extremely ambitious health reform agenda, part of which was Dirigo Health (an effort to expand health insurance coverage making it more affordable and higher in quality). There was not enough legislative buy-in for our proposal because people in the legislature were oriented toward the Dirigo Health proposal. At that same time, the Governor's Office of State Health Policy (GOHPF) was formed to administer Dirigo, though the relationship between that new office, the DHHS, and the Maine CDC was never made clear.

Finally, we did not make a strong enough argument for our proposal. We failed to convince them that public health infrastructure was valuable, feasible, and sustainable. There was significant resistance to 'adding another layer,' and creating "more bureaucracy." Because there are always funding issues around public health, you have to make a really good argument. There were questions about what the infrastructure would look like. We had a good proposal based on the Ten Essential Services, but there were questions to consider about its structure. Should it be governmental? Quasi-governmental? Community-grassroots-based? Should we build an entirely new structure or build on existing programs? Should there be one or multiple models? People didn't understand what public health was, what the outcomes were, and perhaps we didn't really make the best case for how this would help reduce costs and the rates of chronic disease.

With Turning Point, we developed the foundation for an infrastructure and legitimacy for public health. In recent years, Maine has reorganized the DHHS (an arduous process and part of the Governor's reform), and there is an emphasis on service integration, particularly for braiding substance abuse and chronic disease prevention services, which historically, have been "siloed." We also

released a State Health Plan this year, which braids together chronic disease health care interventions and public health. The focus of the plan is quality, outcomes and quantitative data. Finally, the plan led Maine to form a Public Health Work Group to study the issues and come up with an infrastructure development plan by the end of the year. This, based in part on Turning Point's findings, will use community coalitions as the basis of our public health infrastructure. Some Turning Point recommendations concerning workforce, informatics and financing still need to be addressed.

I believe that we need to better integrate ethics into the discussion of public health infrastructure. Many of the choices we face bring up critical ethical concerns. The truth is, we're not going to be able to please everybody. In an era of limited resources, we must think about how to develop a system that is best for the population. What about issues of social justice? Given our limitations, do we fund new labs or community-based prevention? What is the right thing to do?

Patience is one of the basic keys to success; sometimes thorny issues end up turning out well. We need to be empathetic and understanding as we work together at the grassroots level. We must educate each other and not get mired in the negative. Finally, it is very important not to apologize for public health, but to be proud of our work – we're in it for the people of our state and country, for social justice and for meeting the common good.

Jonathan Stewart, M.A., M.H.A.
Director
New Hampshire Community Health Institute

Good morning. The focus of my presentation will be on local public health systems development. I will mention briefly the historical context for New Hampshire, which is very similar to Maine, and talk about recent developments at the state level and how we are moving forward.

New Hampshire has 234 cities and towns; it still has a vestige of colonial history -- if you knew the king you could get a charter for some land and set up a town -- and we still live by that today. Implications of that are that each city and town is statutorily required to have a health officer who, together with the local elected administrative body, constitutes the local health board. What does that actually mean? When we started this process in 1998, only three communities were recognized as actually having what you would consider public health departments at the town or state level; otherwise no county health departments existed. County government in general is less of a factor than the town and state levels of government. Of the 234 health officers, 25 percent are volunteers: the majority of whom are building

inspectors, code enforcement officers, etc. Their average budget is \$1,000, giving you some sense of where we started in 1998. (That is not to demean the efforts of these folks, because it is quite a special person who will be a volunteer health officer!)

In New Hampshire, we have a long history of partnerships as in other states. The state health department contracts at the local level for some services, but often the work is done through community health centers, CAP organizations, and non-governmental organizations. Hospitals are certainly key players in public health in our state as well. We have a strong state health department in New Hampshire serving our 1.3 million people – similar to the size of Omaha. We are not a large state geographically, so the state health department can be pretty involved in actual service delivery on the regional and local level. Also, the Departments of Environmental Services, Education, and Safety play key roles in promoting and protecting the public's health.

When we started the planning process, we tried to be both visionary and practical at the same time. Some of the values we wholeheartedly embraced were the ideas of being inclusive, integrative, and opportunistic. For us, being integrative meant that we emphasized that public health was the collective and shared responsibility of many sectors. We took that to heart, so when we started the planning process, and later went through the implementation process, we focused on building systems and partnerships.

In 2001, New Hampshire began funding four local public health demonstration programs through the Robert Wood Johnson Foundation (RWJF) Turning Point program. We borrowed Dave Palm's RFP and modified it to fit our needs. Right from the beginning, even before the National Public Health Program Standards (NPHPS) were available, we built measurement into our process. We used the Twenty Questions Instrument, which provided a baseline and follow-up. We were able to use that information to develop a presentation, complete with nifty color bar charts, which made it to our governor at a critical time when money was being held up. That little bit of effort helped release a couple million dollars over the next few years that enabled us to continue working in our communities. Since then, all of our partnerships use the National Public Health Performance Standards process, which is a "mind-bending" process when you are involving lots of stakeholders.

As of March 2006, because of the additional funding, we were able to grow from four partnerships to fourteen, which now cover most of the state. At this point, we are up to nineteen All Public Health Hazard Planning regions. These regions form the foundation for an institutionalized and regionally-based

infrastructure for public health, which we will likely take to the legislature to codify.

I want to emphasize that our focus in New Hampshire was on building systems and partnerships and not necessarily on building health departments, although that is certainly desirable, as well. My favorite quote from the Institute of Medicine's (IOM) report *The Future of the Public's Health in the 21st Century* is: "The concept of a public health system describes a complex network of individuals and organizations that have the potential to play critical roles in creating the conditions for health. They can act for health individually, but when they work together toward a health goal, they act as a system, a public health system." I think this statement embodies what we are all about, working together to have an impact. When we don't act together, and in some cases are pulled in separate directions; we don't leverage that potential. In New Hampshire, we articulated the same concept: "An effective local public health system must involve the broad public health interests in a community (e.g. government, health care providers, social service agencies, schools, business, faith community, media) working together to address complex public health issues (New Hampshire Turning Point Initiative, 1999). It was helpful for us to see a national-level endorsement of the kinds of things we were thinking about in New Hampshire.

We defined partnership as individuals with an equal status and a certain amount of independence, but also with formal obligations that are implicit or explicit to one another. In New Hampshire, we are trying to lend definition to partnership and address the following questions: What are the obligations between various entities? What are the commitments you have made? What is the point of accountability? What compromises are made (what are you giving and what are you sharing)? If you are a part of the system and we are partners, what is my obligation to you? Do we have equal status? If you are in governmental public health, does that mean you have a supervisory role over me? Will you measure my performance or are we in this as equal partners? In New Hampshire, our public health partnerships basically work through a cycle of assessment, implementation and evaluation. We did a lot of performance and community health assessment and developed a public health improvement plan.

One thing I'd like to emphasize is that we don't have a public health network in New Hampshire without the local governmental entity. Sometimes that is a point of criticism because, if the funding goes to a non-governmental based partnership, it sounds like it isn't "public health" but rather "community health." But, if the local governmental entity is not effectively at that table, you don't really have a system and it's not possible to have a strong network.

Some good things happened as a result of Turning Point in terms of workforce development. When we started, we didn't have an MPH program in the state; now, we have two: one at the University of New Hampshire (UNH) and one at Dartmouth. We have a practice-based Institute for Local Public Health Practice that is housed at the Manchester Health Department (our largest city). The Community & Public Health Development Section was developed within the health department to work collaboratively with community partners to provide training, capacity development, and technical assistance. Finally, we developed the New Hampshire Public Health Network.

Turning Point highlighted the fact that New Hampshire was one of only two states which had not developed a health agenda for Healthy People 2010. Through Turning Point, we were able to get plans for Healthy People 2010 going. This had a practical impact and strengthened our efforts because it increased the demand for data by our community groups so they could measure the impact of their efforts. Finally, there is a law from fifty or sixty years ago which allows New Hampshire's many land grants to join together and form health districts. No one has ever done it because of a variety of issues such as resources, local control, etc., but the law is there, and will likely be the basis for leverage to codify the planning regions and have them become health districts.

Our work has been evaluated by an independent evaluation through the efforts of the RWJF. They evaluated three states (New Hampshire, Oklahoma, and Nebraska) and compared them to three other states not involved in Turning Point. They found that there were significant improvements in local public health infrastructure in all three states. One of the most significant changes they discovered was that the Turning Point states built longer-lasting partnerships and Turning Point served as a structure/rationale for developing these partnerships. Their methodology included surveys and interviews with state and local public health leaders. We were delighted to find out that our efforts resulted in improvement when independently evaluated.

The idea that we are all in this together, building rationales and accountability in a system, is a concept; but, it is also a strategy. It fits well with New Hampshire's history of public-private partnerships and community-based approaches to problem-solving, and engages a diverse array of public health assets. If you will recall, Dr. Halverson talked about the investments that are in the medical care system versus the public health system. If you can effectively engage the health care sector in public health and create an understanding of public health work by people who don't call themselves "public health people" but do "public health work," you

can leverage that part of the pie for public health. Also, when you gather these people together for a performance assessment and they start to realize that some of the pie is missing because we don't have the capacity we need at the local level, suddenly, we have allies who are willing to say "We need more resources, because a budget of \$1,000 for health in our town isn't acceptable." Building that conversation and understanding is part of our strategy for systems development and change.

One of the challenges we face involves people who don't consider themselves public health people. However, when they realize where they fit in the system, it can be very empowering for them and give meaning to what they do. Building a system is "macro-level stuff," but you still have to have some accomplishments and stay focused on priorities. Also, we had to manage the challenge of balancing state and local priorities, which included the need for greater local government involvement and resources.

Some basic areas for improvement include codifying, explaining, and making explicit the relationships among partners. What does it mean to have a memorandum of agreement between a town and a hospital for a health improvement plan? How can we hold ourselves accountable to one another?

In the past year, we decided it was time to set up performance measurement systems and do assessment at the state level in combination with our local colleagues. We completed the NPHPS State Level Instrument and convened a Public Health Improvement Action Plan Advisory Committee (PHIAP) to study the assessment findings and identify priorities. From there, we formed work groups in the following key areas: inform & educate; monitor health status; mobilize community partnerships; policies and plans; workforce development; and public health communications). We now have the system up and operating at many different levels. Not everyone is always on the same page at the same time, or even agrees in the direction we're going; but in general, this process has been very exciting and we have made positive improvements.

Rota Rosaschi, M.P.A.
Executive Director
Nevada Public Health Foundation

Good Morning! Nevada is 110,000 square miles and the seventh largest state. It takes about five hours to drive from east to west, and about eight hours to go north to south. We have two major highways, Interstate 80 and Highway 50. Highway 50 is also known as "the loneliest road in Nevada" because there are parts of rural Nevada where you can drive for hours and never see anyone else. We also have a highway known as the Extraterrestrial Highway (located at the junction on Nevada 93 (north) and

Nevada 375 (west) near Alamo, NV), which passes infamous Area 51.

Nevada is the fastest growing state in the United States (the 2005 census estimates we now have 2.4 million people) and has been the fastest growing state for the past 19 years. Clark County (home of Las Vegas) is our largest county with 1.7 million of those 2.4 million people, and it's growing at about 5,000 people per month. This growth has put some real hardships on the whole public health infrastructure in the Clark County area. Carson City, also the state's capital city, is the smallest county (168 square miles and 56,062 people). State gambling taxes accounts for 34.1 percent of the state's general fund tax revenues; Nevada is known as the "Gambling Capital of the United States." In 1960, there were 16,067 slots machines in Nevada, but by 1999 there were 205,726 slot machines – one for every 10 residents, and this number does not include all the new slot machines that were added when the big mega resorts, such as the Bellagio and the Wynn, came a couple of years later. Nevada is also the largest gold producing state in the nation, second only to South Africa.

What were some of our major accomplishments with our Turning Point project? One major accomplishment was the development of the Carson City Health Department. Previously, we only had two health departments, one in Clark County and one in Washoe County (the Reno area). During the Turning Point Project, we were very much involved in setting up the Carson City local health department.

Another accomplishment was having our former Executive Director (Dr. Mary Guinan) sit on Congressman Gibbon's health advisory committee. She was able to help influence policy decisions. We also partnered with Utah's Department of Public Health to develop the Great Basin Public Health Leadership Institute. This is huge for us because now we are able to help prepare public health leaders. The third class of this Institute will graduate in 2007. We helped to reconstitute the Nevada's Public Health Association, which is a statewide public health advocacy group. Also important for us was holding the first ever Public Health Forum this year (2006), and sponsoring a chronic disease conference this past April in northern Nevada to address obesity and other chronic disease related issues.

Our goal for the Public Health Forum was to have ongoing meetings among Nevada's seventeen public health officers to collaboratively work together to address problems of mutual concern. This was the first time public health officers from around the state ever met together at the same time. Another goal of the forum was to create an opportunity where the public health officers and interested public health partners could set up an ongoing forum to develop a

single voice and message for Nevada citizens and government officials to communicate with legislators/public policymakers to help bring about change and needed funding. Currently, there is little recognition of what is going on in public health. One thing we keep hearing is there is no consensus on a definition of public health. No matter who you talk to, everyone has a different definition. It is important for us to have that unified voice, particularly as we prepare for the 2007 legislative session. The third and last goal was to communicate best practices among public health officers and public health partners in terms of administration and self-governance. Because of the size and distance of the state, it is very difficult to understand the different strengths and weaknesses that exist in the various counties.

All state health officers, representatives from the two schools of public health, public health advocates and many other public health partners were invited to the Public Health Forum. We tried to invite people from all different sectors so they could come to one place and start talking. The forum was facilitated by a University of Nevada, Reno (UNR) School of Public Health lecturer and she chose to use a positive change model called "Appreciative Inquiry." Instead of looking at what was not working in Nevada, we looked at things that were working correctly or things that could be improved upon. We started with the basic assumption that every organization had something that worked right – things that give it life when it is effective, successful and connected.

We started by looking at some of Nevada's public health indicators. We noticed we were not number one for anything good on the list. Some of our successes included the prevalence of asthma (we ranked #7) and the prevalence of obesity (we ranked #11). We decided we could work from some of those factors. We also had to look at some of the factors where we were not doing as well. We were at the bottom of the nation in immunizations. Nevada use to be much better in our immunization status, so we have to determine what caused us to slip in the national rankings. We ranked #48 for the prevalence of high cholesterol and #46 for percentage of population with no source of health care coverage. We realize we have a lot of work to do in these public health areas.

One of the public health challenges we face in Nevada is the rapid growth of the state. Especially hard hit are the communities of Las Vegas and Reno. Other challenges include: decreasing funding in the face of increasing demands, access to health care for uninsured individuals, chronic disease burdens, poor life style choices, high rates of teen pregnancy, drug and alcohol abuse, tobacco use, and gambling addiction. We also have high rates for injury from

automobile accidents, suicide, and domestic violence. Other challenges we face are communicable disease prevention and control and the demand that public health preparedness places on our resources. Further challenges include marketing and maintaining public health, and finally, the impact on air, water and environmental quality due to the rapid growth of our population.

The Public Health Forum was well received. Attendees realized the importance of having public health meetings to discuss these issues. Public health officers and public health partners were already looking for partnerships and ways to share information. They were interested in hearing what their fellow public health officers had to say concerning the challenges facing their portion of the state. They wanted to figure out how to work together and improve outcomes.

The facilitator, working from a positive aspect, was able to unite participants in the common goal of creating a healthier Nevada and working together to figure out how to accomplish this goal. The process started with a series of questions. "How will future generations know Nevada was making progress in improving the health of our state? How will we go about doing this (what does the ideal partnership/collaboration look like)?" and "Who will make it happen given the fact that we have the fastest growing population and our infrastructure is being stretched?" It was important for the forum attendees to talk about their partnerships and look within their communities for answers.

The inaugural forum was a success and a decision was made to hold another meeting. It was also decided to focus on a few issues so we would not get overwhelmed and to make sure our rural partners were included as well. We agreed that it was important for us to define "public health," have a unified message, and prepare for our 2007 legislature. Finally, we wanted to be sure we identified all the right stakeholders so they could be involved in the discussions and the message to the legislature would be united. To prepare for the next meeting, we discussed what was needed to include the voices of rural and frontier public health leaders, their needs and concerns. We discussed how to help small counties prepare for "rural readiness" by helping them learn how to tell their stories using data available from the State Health Division and meeting face-to-face with their public health officers and other major players.

Finally, it was decided that since the Nevada Public Health Foundation is a neutral entity, it would be best to have them help bring the stakeholders together. The Foundation would facilitate stakeholder discussions, help accomplish "rural readiness" activities, become the "parent" organizer for all future

forums, and be the "voice" to the 2007 legislature. Thank you for your time and attention.

Plenary II

Lessons Learned from Turning Point

Betty Bekemeier, M.S.N., M.P.H., R.N.
Former Deputy Director
Turning Point National Program Office

Thanks for inviting me to come and share the news from Turning Point. At Turning Point, we, too, are "riding a wave," a fitting metaphor alluded to by Dr. Halverson; and if you will allow me another metaphor, as in white-water kayaking, we must not only look at what is immediately in front of us, but what lies ahead, as well. This is true for our public health efforts; because in public health, it is important that we plan for our next line of action and think about how to prepare for it. We work so hard on a day-to-day basis; it is easy to get caught up in the everyday, nitty-gritty tasks that we do in our community agencies. It is hard to stop, look around, take in the big picture and plan ahead. Turning Point has been instrumental in creating the opportunity to look ahead and plan for the future and in creating a culture in which this can happen.

The Turning Point Initiative is a joint venture of the Robert Wood Johnson Foundation and the W. K. Kellogg Foundation to protect and improve the public's health by transforming the resources and strategies of the public health system with the involvement of key stakeholders. The purpose of Turning Point is to improve and transform the public health infrastructure through collaborative models, build relationships and create a planning environment for public health improvement, improve population health outcomes, and impact health policy.

The initial model of innovative systems and cross-sector change began with an idea something like "letting 1,000 flowers bloom and see what happens." Over the years, the Turning Point states worked with and learned from each other and we at the Turning Point National Program Office supported and assisted the 21 states involved in Turning Point and five National Excellence Collaboratives. Ultimately, we looked at the collective experiences of those 21 states to see what worked and what didn't, so that we could all learn from their cumulative experiences, see what issues had to be addressed throughout the process, and identify how to help adapt existing models for improved system development.

There are two parts of Turning Point. One part was the specific funding for states to set individual infrastructure improvement goals and then to implement the individual state public health improvement plans (many of them started in 2000). The second part was about the national multi-state

collaboratives around areas of national significance to public health. The five Turning Point collaboratives worked on social marketing, information technology, promoting and developing collaborative leadership, performance management, and public health statute modernization. This talk will focus on the work of the states and not specifically on the collaboratives.

Promoting public health system innovation and change has been accomplished through cross-sector partnerships throughout Turning Point states. The Nebraska experience is a good example that highlights innovative changes in the public health infrastructure. Nebraska decided to focus its energies on increasing the number of counties covered by local public health agencies. In 2000, near the beginning of Turning Point, there were only 22 out of 93 counties with local public health agencies. With the help of Turning Point, their Steering Committee, including some key legislators, developed a Public Health Improvement Plan to cover every county by a local health department, leveraged additional funding and put Tobacco dollars to work.

As Turning Point grew nationally in visibility, calls came in from around the nation to the National Program Office. People from non-Turning Point states asked us "What lessons have been learned?" and "What actually improves public health infrastructure?" At that time, we at Turning Point didn't know the specifics of what promoted public health system improvement. Our aggregate experiences had given us some information, but to provide more concrete guidance to our peers, we developed several research projects asking critical questions to determine what lessons were learned and what was needed for continual innovation and improvement in public health systems. Through research and development, Turning Point, with funding from RWJF, was able to examine and disseminate the experiences of various states and articulate the lessons learned by presenting and publishing related papers.

I will tell you about four of the studies we conducted. The first one was "Partnership for system change: Elements of success." Our specific research questions were: "What themes and key elements are associated with state level partnerships developed through the Turning Point Initiative? and, "How do these compare with the partnerships that are documented in the literature?" The purpose of this study was to: describe key elements and themes concerning state level partnerships developed for the purpose of systems change, compare those key elements to what has been described in the literature, and develop a more comprehensive understanding of partnerships needed for systems change.

The data were gathered through site visit reports, online documentation from state Turning

Point leaders, and interviews and focus groups with other key members. A number of our results seemed to confirm or expand upon what was already known about how partnerships work. The data were clustered into three areas: structure and process, working in and across existing systems, and leveraging change.

We found that "relationships are key" and although it sounds trite, this has been a big "take away message" of Turning Point for the last ten years. A number of elements were found to be important in forming and maintaining relationships such as: clear structure and decision-making and working in and across existing systems. There have been a number of places where strong, respectful, collaborative relationships between state and local agencies have been established as a result of Turning Point efforts, as well as places where Turning Point states have worked with local people in communities to build local agencies that did not exist previously.

One of the benefits of working at the state level through Turning Point was the proximity to policy development and budgetary decision-making. However, being close to power can also have a downside. Proximity to power and the political arena where policies are being developed, and having a close local/state relationship when political changes are happening, can make you vulnerable to the conflict between needs and possibility (what you'd like to do and what can actually be done once those changes are made). In other words, when changes occur in the legislature, the landscape of possibility also changes. Our state partners have experimented with a variety of ways to cope with those political upheavals. Choosing projects wisely, as well as developing strong relationships, seems to have helped maximize success during periods of transition.

As Dave Palm mentioned earlier today, high-level support and leadership helps with legitimacy, recognition, and visibility. In Nebraska, you had the support of Dr. Richard Raymond at the state level. However, the vision of Turning Point is clearly not one that can be imposed from above. Collaborative leadership is more about facilitating change. When we talk about leveraging change, we mean having folks inside state agencies collaborating with different groups in the community and with people from different agencies. Engaging in the partnership process seems to transform the activities of state health agencies in a way that a more directive approach might not be able to. Systems change involves the structure and policies of agencies and understanding the people who work in them and their relationships with the communities they serve.

The results both confirm and extend what has been written about collaboration and coalitions:

collaborative partnerships are possible on the state level and can be used as a strategy for making system changes and influencing planning and policy development. Building trusting relationships with partners is really necessary and so is paying attention to activities that promote large-scale organizational change. One Turning Point leader described his experience as follows: "Trust was developed from involving so many different partners...people got wrapped up in the process. It was exciting -- especially with so many partners involved...we were confronting embedded systems."

Our second study addressed preparedness and systems change. In 2002, the federal government responded to bioterrorism threats by calling for states to develop emergency preparedness plans. We asked, "How did Turning Point participants describe the relationship between their Turning Point efforts and their states' ability to respond effectively to this federal request?" We posed open-ended and semi-structured questions to participants about the extent to which their partnership members, models of shared decision-making, and previously developed Turning Point state plans and recommendations contributed to the development of an effective preparedness response plan (in terms of the federal proposal in their state). The interview data were analyzed and patterns were identified, using qualitative data analysis software.

Our strongest finding was that Turning Point "set the stage" for emergency preparedness planning, enabling a more effective bioterrorism preparedness proposal. A common language had been developed, at least partially, and governmental and public health professionals began to understand each other's language and work. They were able to use their newly developed skills in comprehensive planning and effectively use the collaborative model. Partners were able to participate more fully and effectively in preparedness planning. The bottom line was that it paid off to have participated in Turning Point. Again, as in our research about collaboration and coalition-building, trust was a key factor for success. This quote really says it all for me, "Not having trusting relationships built up-front, before the situation where a pot of money is on the table, is a recipe for ugliness. Trust works toward collaboration."

The third study looked at Public Health Institutes (PHIs) as administrative vehicles for Turning Point and public health system change. PHIs are multi-sector entities able to function as a convener to improve health status and foster innovations in health systems. We are beginning to see non-profit public health organizations cropping up around the United States, and while not every state has one, those without are thinking about developing them. As activity moved from state health departments to PHIs, or as state health departments

partnered with PHIs, we had questions about the extent to which these relationships played a role in public health system innovations in these Turning Point states.

We wanted to know what organizational characteristics of PHIs were advantageous in partnering with the public health system. There are 22 established PHIs in the United States, and ten more in emerging stages at the time of that study. In states with Turning Point projects and established or emerging institutes, we asked about the relationship between the PHI, the Turning Point project, and the state health agency. We found that PHIs had many advantages including greater freedom and flexibility in pursuing alternative grants and funding sources outside of governmental agencies. Also, PHIs offered a more flexible organizational structure in terms of staff, programs and policies, and provided a more compatible home for work to be done in the rare instances where the state agency was neither interested nor helpful. PHIs also functioned as neutral conveners and were less often perceived to be driven by organizational self-interest like state health departments are often viewed when promoting public health, though PHIs were not necessarily “neutral” regarding policy. PHIs worked to be compatible rather than competitive and assisted with advocacy.

Some challenges were also found with PHI partnering. While PHIs offer the opportunity to pursue different grants, the reality is that “alternative funding streams” lack certainty. A second challenge was increased distance from policy development. Moving from the state health department to a Public Health Institute meant that there was less access to policy making and government. Despite these challenges, we found that the work of developing PHIs was worth the effort.

Finally, we were interested in how much money was leveraged for public health infrastructure in Turning Point states. All 21 states were asked to participate in this final study and we received full participation from 17 of the Turning Point states. Our research questions were: “What was the magnitude of resources that these states leveraged for public health system improvement?” and “What were the factors promoting success in leveraging resources?” Surveys were completed for quantitative data collection regarding the magnitude of funds and we conducted follow-up interviews to elicit further information on how states were able to leverage funds.

A total of about \$130 million was described as having been leveraged by the plans and activities related to Turning Point for improving the public health infrastructure in the 17 participating Turning Point states. More than 30 million dollars of this total came from outside the Turning Point grantees and

was provided by their partners. Turning Point grantees participating in this study received \$12.7 million in funds from RWJF, and then leveraged additional funds within their own agencies (\$79.6 million) at more than six times what they had been awarded. States also estimated that their own grantee agencies contributed 96,000 hours of staff time outside of those hours budgeted for in their grants. The states felt that had they had not been in partnership with Turning Point or in a position of public health systems transformation; these leveraged funds wouldn't have been allocated. Since these funds were often difficult to distinguish from other funds, the states were particularly asked to err on the side of conservative estimates. As a result, it could be that these numbers are even an underestimate.

The most important factor that promoted success was the development of a comprehensive plan along with partnerships to leverage resources. “Leadership, money, and timing” were catalysts for “making the case” for public health system improvement. Comprehensive planning was crucial and states not involved in that process reported less leveraged funding. Additionally, strong partnerships and the cultivation of influential public health champions eased the planning process. Cross-sector, institutional partnerships and planning were also positively affected by good timing, as was the case when tobacco funds were allocated, and they had a suitably long length of time given them from RWJF during their grant periods.

We learned that when many sectors are eager and able to work toward improvement, the public health system can be improved. These improvements can be sustained through the institutionalization of cross-sector public health partnerships, and resources for public health systems can be leveraged and sustained through multiple sectors. In a word, “relationships are key,” particularly when they are deliberate and we work to foster them.

Findings from the studies helped contribute to the broad model of collaboration and public health system improvement. Out of the public health improvement plans that each state developed, there were a number of common infrastructure issues that were chosen to be worked on as groups of states in “national excellence collaboratives.” Another set of results from our studies are available in a CD-ROM package and tools have been developed to assist in infrastructure development and improvement. These tools are available at: www.turningpointprogram.org. We hope that they will help to further disseminate the lessons we've all learned from Turning Point. Thank you.

Plenary III

Ethical Challenges in Public Health: Applying the Principles of the Public Health Code of Ethics

Les Beitsch, M.D., J.D.
Professor of Health Policy and
Director, Center for Medicine and Public Health
Florida State University College of Medicine

(The ideas presented in this segment were developed by Ruth Gaare Bernheim, J.D., M.P.H., and presented by Dr. Beitsch in her absence.)

Good Morning. Much was said yesterday about engaging the community and trying to do things in public health that reflected the will of our constituents and partners. This provides a very nice lead-in and framework for what we are going to talk about today.

There is a difference between law and ethics, even public health law. We talk about the positive law, which is the law that is written or codified. We also talk about morals and ethics. Sometimes, those things are in the positive or written law, but not always. Today, we will talk about using ethics, particularly the Public Health Code of Ethics as a framework for how we might begin to tackle some very difficult public health issues and problems and how to justify to our constituents, partners and communities the things we do.

Every time you make a decision, you incorporate a bunch of concepts. You may not consciously consider the legal, political, economic or ethical issues, but you draw from all of them. Researchers in this area have found that public health professionals take a very serious approach to the ethics of an issue. There is an art in how to apply various ethical codes and in particular, the Public Health Code of Ethics.

For a moment, let us consider that you are the public health director of a local public health agency. You have just finished the MCH Block Grant Needs Assessment for your community and found that two of the dentists that accept Medicaid are retiring within the next week or two leaving you with only one dentist who will accept Medicaid. You don't have the type of dental resources that you need, but suddenly, McDonald's calls and says they would be delighted to give you \$100,000 to put together a new dental program for your community, but they want their logo on all your materials and your website. What are you going to do?

When contemplating these kinds of issues, the first thing to do is to look at the law. What is the law? Generally, it is written in the form of case law, statutes, administrative rules or code. To a certain

extent, it provides limitations on the authority that people have.

On the other hand, when looking at an ethical or moral framework, it is a little bit less of a formal institution and a little more diffuse. Where law tends to be a general set of rules to be applied in a general way, ethics are really directed toward how we might use them in an individual case like the scenario I just set out before you. In the legal world, there is a very set process for how we do things, and sometimes that process actually determines the result. An ethical analysis, however, is much more analytical, applying principles, but not with a consistent framework and the answer is not so obvious.

The legal standard, for most of the things that apply in public health, comes from the standpoint of a reasonable person. You ask yourself "What would a reasonable person do in this particular setting?" Whereas in ethics, your requirement is to justify to an audience of reasonable folks why you chose to do what you did.

As local public health directors, you think about some of the differences between the universe of medicine and the universe of public health. This helps us frame some of the issues we face. Physicians see one patient at a time, whereas in public health, we are constantly reminded that we have responsibility for an entire community. As physicians, we focus on treatment, and as public health practitioners, we focus on prevention. In medicine, we rely heavily on the bio-medical approach, whereas in public health, science, epidemiology and prevention are important.

Medicine is governed not only by laws and science, but by the Hippocratic Oath and other oaths that health professionals take. In Public Health, we have a newly evolving Public Health Code of Ethics as well as a series of laws to help guide us. In the 1970s, hospitals formed hospital ethics committees to grapple with difficult ethical decisions about life and death (e.g. Karen Quinlan). Public health ethics committees are much less formalized, but still have just as many important decisions to think through.

Norms and roles are an evolving kind of construct that are negotiated out in the public sphere. You, as the public health director, are justifying to your community the actions you have taken. It is a very transparent role in contrast with the role of a physician or nurse whose interactions are conducted individually and confidentially. You may have to publicly negotiate a proper legal or ethical framework. Sometimes law may have some moral issues imbedded in it, (e.g., murder in the Ten Commandments.) Often as those norms evolve, they become part of the code.

We heard several times yesterday about the importance of relationships in moving forward collaboratively. One of the important things about following an ethical code is building trust. The Public Health Code of Ethics is relatively new. It began as a project of the Public Health Leadership Society in 2000. The process was very transparent and involved the widest possible group of stakeholders. This Public Health Code of Ethics has now been adopted by a huge number of the collaborating organizations. The document is a “living” document, much like a constitution or a preamble.

Let me highlight a couple of things from the Public Health Code of Ethics. Let’s think back to the dental example I mentioned earlier. The Code states “Public health policies, programs, and priorities should be developed and evaluated through processes that ensure an opportunity for input from community members.” At least one of the answers or considerations might be “What does the community want?” Another consideration is “What is in their best interest? Again, the Code states “Public health should advocate and work for the empowerment of disenfranchised community members, aiming to ensure that the basic resources and conditions necessary for health are accessible to all.” This is an argument for setting up a clinic. Finally, the Code states “Public health institutions should provide communities with the information they have that is needed for decisions on policies or programs and should obtain the community’s consent for their implementation.” It is not only your decision, but it is a community decision, and the right answer for Lincoln may not be the right answer for Omaha.

Finally, how do you use this Code? Decisions based on Public Health Epidemiology aren’t always going to be the best answer by themselves. In medicine and in Public Health, there is an art as well as science that should be taken into account. Even though we may have authority under law to accomplish certain things, it may not be the best course of action to fully utilize those tools available. For example, are there less restrictive alternatives? This comes up a lot in and around HIV/AIDS and tuberculosis. We are thinking a lot about quarantine and isolation issues right now.

Processes are also important. In the legal world, process is crucial and sometimes the process may determine the outcome. When we talk about ethics, having a process and following the process can help you come to the right conclusion. Using ethics can help you justify the decisions you make. Whether you choose to open that clinic with McDonald’s or choose not to, based upon your community input, you will have sufficient grounds for doing either based upon the ethical analysis. Again, it is following the deliberate process with the input of key community members, constituents, and partners.

How do we utilize the Code and how can we incorporate it into our structure and into the management decisions we make as administrators and directors of local health departments? The Code can help us determine when we have enough evidence to move forward and when research should become practice. It can help you determine how much information is necessary to present to your community in a crisis so they have sufficient information to help you formulate a proper decision.

We can draw inspiration from the Code when we look at a public health problem. For example, you are trying to decide how much information you need to present to your community so they have the necessary information to help you formulate a proper decision. The Code can help you address questions such as, “When is something research and when is it practice?” and “When do you have enough evidence to move forward?” It can help you address issues surrounding disease surveillance and outbreak, data and community information and evaluating public health responses. Thank you for this opportunity to raise these questions.

Terry Brandenburg, M.B.A., M.P.A.
Health Commissioner
West Allis Health Department
(Wisconsin)

Today, I would like to look at the Public Health Code of Ethics and see how we can incorporate it into our day-to-day public health practice. First, let’s talk about Public Policy. When we talk about public health policy, it transcends organizations and entities. We are certainly talking about the elected officials, but our agencies are also creating public health policy in terms of how we operate and prioritize internally. We triage depending on our resources. We are really good at public health practice with our years of training, epidemiology, disease investigation skills and our work in community planning assessment, but unfortunately, when it come to creating policy, what often happens is our public health practice or science rules the day.

I am from the Milwaukee area. In 1993, we experienced the largest waterborne disease outbreak in history. *Cryptosporidium* infected over 400,000 people over a period of several months and my community had about a 40 percent infection rate. It was a typical public health crisis – we went into the “war room,” brought in the mayors and scattered about using our science skills. Sanitarians went into restaurants and ordered food to be tossed. Unfortunately, some places of business had to close down because their water supply was infected. We did things that, to this day, may be questioned legally because we had a one-dimensional response to a wide-scale emergency.

What is on the table drives policy; however, there are legal considerations that come into play. This isn't a foreign topic to us; we have been enforcing Public Health Laws for well over two centuries in this country and many of us have years of experience in that regard. We are very good at the legal basis of it, but some instances occur that make us question our policies. For example, in the fall of 2001, episodes with Anthrax occurred in Florida, New York and Washington. Those states scurried to look at their statutes to see what statutory authority they had to deal with the crisis. Did they really have the ability to do what needed to be done in this situation? Subsequently, many states adopted an emergency health powers act to shore that up.

I would like to relate another example of how the law plays into public health. Several years ago in the Milwaukee area, we were the epicenter for a monkey pox outbreak. It was a foreign virus to the United States. Gambian rats were imported to Texas and sold for pets. In the pet store, they were commingled with Prairie dogs. The prairie dogs were then shipped to Wisconsin pet shops where people bought them for pets. The monkey pox early rashes presented like smallpox. This caused great consternation for several hours. When the pets got sick, the owners took them to their veterinarians, which caused the veterinarians and staff to become infected. Consequently we found ourselves issuing isolation orders. This wasn't the typical isolation we do with tuberculosis patients or food handlers with salmonella or shigella. We had to hold these people and isolate them until we saw how this disease would progress. Once again, when it comes to public health policy, this is an area where we have to put on our "science hats" and "legal hats" and start to take action. Were they the best actions? Fortunately, it was quite limited.

What is missing from our public health, science, and legal skills? Ethical dimensions must be brought into our decision making process on a daily basis. When we make public policy decisions, whether we are part of a board, the director, or a program director, we need to put this Code on the table to give us direction. It will force us to consider ethical issues in our planning process. This is the best use of this tool you could have. The Code of Ethics won't give you the answers, but it will pose a number of questions. When attending a recent conference, the question of evacuating the Katrina victims came up and the question was posed, "Will this Code tell you what to do?" The answer is no, but it will prompt you to consider things in that decision making process.

The Public Health Code of Ethics is in full alignment with the ten essential services of public health. If you adopt this Code, you are in essence committing yourself to performing the ten essential

services. Lets look at how to use the Code in a past public policy event. Many of you will recall the Smallpox pre-event vaccination program. It was a federal initiative that rolled out with varying degrees of success. When faced with a major crisis, we can use the Code to set up a matrix for planning purposes to ask questions like "Are we doing our best at communicating with our stake holders?" and "Are there issues concerning disparities?" You can use the Code retrospectively to determine "Was there sufficient information available regarding adverse effects?" or "Was there full disclosure of information?"

The Code can also help up direct resources. Should we look at the ethical dimensions of taking huge sums from one program to support another program? It can also help us with issues of confidentiality. Should we have a national registry of those who went through the vaccination series? How much information and conversation was a part of that decision? How much of your time is currently being spent on pandemic flu planning? Public health ethics are extensive and require much thought. But, if we take the time upfront to use public health ethics as well as our science and legal skills, we can come up with a good plan and policies.

We know there will be some big issues coming up for public health officials and isolation is one of them. This issue may come early in a pandemic phase for at least a period of time. What do we do with the infected passenger on a flight coming into Omaha? Presumably, you will be dealing with this issue ahead of time. Once again, the Code can help you in your preplanning. We will also have to deal with the issue of quarantine early in a pandemic phase. In our country, our game plan has been to delay disease until "the cavalry" arrives with the vaccine, but we may need to implement isolation and quarantine.

Community containment is another area that will need to be addressed. Communities and states will have to make decisions about things like whether a movie house is going to remain open or whether a certain fall football season is going to go on in Nebraska. We can't just wear our "epidemiology hat" when making decisions that are going to affect our citizens. Once again, how would you go about addressing these issues?

We also have to think about prioritization. How will you communicate to your community about your vaccination policy? If you only have enough vaccine for 10 percent of your population, how do you decide who will get the vaccine? How will you communicate that to your community without being sacked? What process are you going to use to lay out your proprieties? The reality is, we may be handed federal or state priorities in terms of how we are to use the vaccine, but how are we going to

communicate that successfully to our communities? These are very difficult decisions. We have a limited supply of antivirals and many states around the country are trying to decide whether or not to purchase more and what protocols to use for their delivery. These are huge decisions and if I were in the planning phase, I would try to have the Code on the table to help us make these decisions.

Luncheon Address
Public Health in the 21st Century: It's Not Your Grandmother's Vision, or Is It?

Richard Raymond, M.D.
Under Secretary for Food Safety
Food Safety and Inspection Service
United States Department of Agriculture

It is great to be here today with good friends who helped build the public health infrastructure here in Nebraska. So far today, we have heard about the importance of building partnerships, coalitions and collaborations, but it is also important to have a legislature and administration that understands public health. When our state got the tobacco settlement money, we could have built roads, but we were fortunate to have a Governor, Lieutenant Governor and legislators that were sensitive to public health issues.

I am delighted to see Dr. Garry McKee here today. The president appointed Dr. McKee to be the administrator for the Food Safety and Inspection Service and he began the push to bring public health into that agency. He gave us a foundation and I am trying to continue to build on his legacy at the United States Department of Agriculture (USDA).

Dr. Paul Halverson brought up the issue of ranking this morning. There is some concern over accrediting health departments because some will rank highest and some will rank lowest. Dr. Halverson suggested that both agencies will have problems and I agree with him. The legislature for the health department who is ranked first will say "We must be spending too much money - isn't average good enough in public health?" On the other hand, the legislature for the one who is ranked lowest may say "You're doing such a bad job, why are we giving you any money?" There is danger either way and it is true in my job as well. When you ate your lunch today, you didn't know what plant your meat was processed in. You didn't know if it was the best, cleanest, plant in the country or the worst. There are currently 6,000 of those establishments out there and we are instituting a system to rank those establishments. It isn't going to be easy, but we have to develop a system to rank plants using recalled food products, test for salmonella, E-coli, and Listeria, and report non-compliance. We will discuss the system during four days of public meetings; everyone will have a chance to speak. When meat is recalled, we will be able to list the grocery stores where it was sold. Currently, we simply recall meat, but the average person with hamburger in their refrigerator doesn't know if they bought it from a store that had contaminated meat.

Dave Palm asked me to talk about my remembrances of what we did as we were transforming the public health system in Nebraska. This morning, Dave (Palm) outlined our rationale for taking a regional approach to plan for, and respond to, public health emergencies, detect patterns of disease, and leverage new resources. I would like to add that I can't imagine trying to work with 93 health department directors to try and figure out what to do with bioterrorism dollars. That would have been a nightmare. It is much easier to dispense money when you are talking to 19 health directors instead of 93, and dividing money into 93 pots just isn't worth it. We had to figure out a smarter way of doing things and taking a regional approach worked for us.

In Nebraska, we get a fair amount of money per capita for the Preventive Health and Health Services (PHHS) Block Grant in comparison with some other states. With the support and collaboration of our health departments, we stopped the sixteen PHHS Block Grants that went to the old existing county health departments based on old historical data, and we put the money into one big pot and set it up so that our health departments could compete for it. Based on their populations, they could compete for up to three grants. Each application was scored on an individual basis. It was a bit unfair the first year because health departments were learning how to write the applications, but they learned and it was a way we could work in this small state with this small amount of infrastructure.

Dave said that it is difficult for new health departments to find the right balance between health promotion and health protection. I would also add that finding the balance between disease prevention and health promotion is challenging, as well. Dave stated that workforce training needs for boards and staff are continually changing, but I would challenge that. Are they really changing? One hundred years ago they were teaching boards of health how to institute quarantine. Today, we are talking to boards of health about how to institute quarantine.

Lastly, Dave stated "Personal relationships and collaborative partnerships are the cornerstone of a successful public health system." I couldn't agree more. If you don't have collaboration, you don't have anything. One of the things that made Nebraska great was the fact that we didn't have very many health directors, and when we asked them to do something, they were open to trying it. One of the first meetings I attended was the Robert Wood Johnson Foundation (RWJF) Turning Point Advisory Committee meeting. They had been working together for a couple of years and were about to make public their plan for transforming the public health system in Nebraska. As they went through the final draft, they got hung-up over the language in the document and

did not move forward until they reached consensus. Collaboration is essential!

Dave also talked about the extraordinary leadership we have had in public health and that we must continue to have enlightened leaders who are willing to share responsibility, accountability, and recognition. I would like to add that I think “share” is the key word in that sentence. We did not take personal credit for our accomplishments. We went to the legislature and public meetings together. We shared our successes and our failures and helped each other out when something didn’t go right.

In the beginning, we had small “county health departments.” They were demonstration projects that provided home health care as their primary function. Federal dollars were made available for these health departments because home health care enabled Medicaid and Medicare patients to get out of the hospital and be treated at home which helped the government save money. For the most part, these health departments were staffed by nurses and home health aids with a very limited knowledge of public health.

In the 1980’s the monies for these programs dried up and counties became responsible for funding them. They didn’t want to use tax levies, so they relied on grants to fund their programs. As grants became available, the grants would determine what activities were carried out. Services performed had nothing to do with the needs of the counties, but had everything to do with what monies were available. If money was available for lead screening, immunizations, or blood pressure screening for senior citizens – that what they did, using the staff they had in place. They also relied on Preventive Health Block Grants.

A lot of collaborative effort and some funding preceded the actual formation of the Nebraska Health and Human Services System (NHHSS). Bits of money left over from the PHHS Block Grants were used to start a local board of health training manual and fund the local health director workshop training programs. The Nebraska state legislation also created the Health Care Cash Fund. Five million dollars were available annually to fund public health projects. It was a competitive funding source and any health organization in the state could bid for it. Through those funds we were able to fund a social marketing program, a public health workforce training program and public health nurses training program.

Part of transforming our public health systems included collaborating with the University of Nebraska Medical Center (UNMC) and the University of Nebraska, Omaha (UNO) to implement the University’s first Masters of Public Health Program. The Nebraska Rural Health Association and UNMC

collaborated on the Public Health Leadership Program and the Public Health Workforce Development Group helped us determine our needs and figure out what sort of degrees should be provided from the MPH program. The Public Health Association of Nebraska (PHAN) reorganized around the same time in order to strengthen their work in public health and lobbying, as well. They created and implemented public health training courses designed for specific audiences, including: physicians, dentists (in collaboration with the HHSS Office of Dental Health), local boards of health and local health directors.

We encountered some bumps in the road along the way. During the process, we discovered a lack of knowledge concerning public health. There was also a lack of trust from people who felt our proposal was too good to be true. They were concerned about losing funding, but we got some of our senators to reassure them. We had to answer questions about why it was necessary to change our systems and address several “what if” scenarios. Small health departments were concerned about losing autonomy and wanted to protect their jobs. There were community action agencies and other organizations rendering services that didn’t want to fall out of the picture either. We had to try and make sure that everyone understood that the new health departments weren’t going to start giving immunizations or take over the WIC program the next day, but instead, were going to work with them and perhaps even give them money to do more things based on the needs of the multi-county health department.

In determining regions, we had to address the issue of travel distance. Many people thought we should follow the Centers for Disease Control and Prevention’s (CDC’s) guidelines and use 50,000 as the population base for a health district. But for Nebraska, a health district of 50,000 in the western part of the state was geographically impossible, so we compromised and settled for 30,000.

We spent the summer of 2001 trying to build health districts. The multi-county health agencies previously formed by the RWJF grant kept us positive and inspired us to move forward. Things turned around significantly after 9/11. Suddenly, everyone realized that we were vulnerable to attack. Anthrax attacks and the mail box bomber also brought things close to home. People began to realize that they were vulnerable, even in their own little towns and this helped things to come together.

Bioterrorism preparedness also helped strengthen our public health system. We got a CDC Bioterrorism Preparedness Grant and were able to give money to the new health departments to set up a health alert network. We put either a bioterrorism

coordinator or emergency response coordinator in each health department and made sure each health department had access to an epidemiologist. In doing all this, we strengthened our state's infrastructure.

Lastly, we coordinated one of the most successful smallpox vaccination programs in the country. This program functioned at a level that had never been seen in this state before. We sent out four immunization teams and had the directors from each of these health districts present at the immunization sites. Local health directors and their staffs lined up the site, did the publicity, recruited the volunteers, and did all the logistical work. Each week, our teams would operate four clinics in a geographical part of the state and come back to Lincoln for the weekend. They would go out again on Sunday night, read the results, move to the next location, and do it all over again. It was a cooperative effort between emergency management, health departments, state people, and health care providers.

We ran into one little hitch. Our coordinator from CDC liked our plan, but was afraid someone might try to jeopardize our supply of vaccine. They wouldn't ship the vaccine until we had a plan in place to protect it. We contacted the highway patrol and negotiated a solution. They provided us with a state patrol escort and we provided them with protective equipment in case they had to handle hazardous materials. This is an example of the kind of teamwork we had in Nebraska.

Public health has a lot of ethical conflicts. How many times have we fought mandatory immunizations? We struggle with questions like: "Does the measles, mumps, and rubella (MMR) vaccine cause autism?" "Should we get rid of it?" and "Is there too much mercury in the flu vaccine for kids?" It is not a simple question of "vaccine is good – get it!" We are currently grappling with the question: "Should the human papillomavirus (HPV) immunization be mandatory for children in Kindergarten in order to prevent sexually transmitted diseases in them when they are teenagers? That is a tough sell. Infectious disease reporting used to be fairly simple, but HIV/AIDS turned the whole system upside down. It's not as simple as it used to be. Other ethical questions include: "Should there be seatbelt and motorcycle helmet laws?" We know they save lives, but people like to be independent. "Should tobacco be allowed to be sold in this country and to kids?" We know that kids are going to experiment, but should we be paternalistic for the good of all? Do we want the autonomy to decide one's own practices? Things haven't changed all that much from the 20th to the 21st Century. Quarantine and isolation laws were fought a hundred years ago and we are still dealing with them. The numbers may have changed, but many of the issues remain the same

and boards of health have to have much of the same education.

In conclusion, I would like to give a brief overview of public health in this country during the last one hundred years. In 1900, the average life expectancy was forty-five years and the leading causes of death were: tuberculosis, cholera, dysentery, enteritis, smallpox, pneumonia/ influenza and diphtheria. One of the contributors to these deaths was immigration. People came from Eastern Europe to work in the beef slaughter plants in Omaha and Chicago. They lived in very crowded living quarters and did not have adequate health care because they were poor and spoke limited English. They lived in close proximity with animals. War was another contributing factor; men living in camps that were over-crowded.

In 1906, the Meat Inspection Act was passed which set up food safety inspection practices for all meat, poultry and egg products in this country, which enabled us to trade internationally. The Food and Drug Administration (FDA) was created as well and they got produce, dairy products and anything else that the USDA didn't oversee by law. Health Departments were formed as well. The country needed an agency with authority to quarantine and cleanup sanitation in order to prevent the spread of disease. That is why they were formed. The discovery of antibiotics in 1929 helped prevent deaths from pneumonia and vaccination programs helped prevent tetanus and diphtheria. In 1955, the Salk vaccine was licensed by the FDA and kids were mass immunized. We couldn't do that today because we have too many legal and personal rights restrictions. Everything changed in the middle of the century. We didn't know it, but that is when everything changed. In 1955, Roy Crock opened the first McDonalds restaurant, and the Civil Rights Act passed in 1957. The law said we could no longer impede on individual rights.

Today, the life expectancy rate is 75 years and the current leading causes of death include: heart disease, stroke, chronic obstructive pulmonary disease (COPD), cancer, diabetes and HIV/AIDS. But, we have also seen the resurrection of old diseases. In 1999, Nebraska had a rubella epidemic. We had more than 80 cases and two children were born with congenital rubella syndrome – something I thought I would never see. We've also had measles and mumps epidemics and a rise in tuberculosis deaths.

We have faced some new challenges along the way, as well. We had to deal with anthrax in 2002. We never thought we would see anthrax used as a weapon. In 2003, we were notified that SARS (Severe Acute Respiratory Syndrome) had hit Canada and we sent a message to all our health

departments and health care providers through our health alert system providing them with information to answer questions and address concerns. We couldn't have done it this way before 9/11. Canada had to deal with issues concerning quarantine and isolation and I was scared to death that we would have to address quarantine and isolation here in Nebraska. When I was the health officer, we had to address infectious diseases. West Nile Virus hit Nebraska in 2004. Over 2,500 people were infected and we had over fifty deaths in this state. We also faced influenza vaccine shortages – things were not a whole lot different as we advised people to stay home when they were sick, cover their coughs and wash their hands. Currently, we spend a lot of time talking about High Path Avian Influenza, which we haven't even seen in this country, and we recently we had to deal with an outbreak of E.coli in spinach.

Why are we seeing this resurgence of infectious diseases in the first six years of this century that look a lot like 1900? We still have immigration issues-- people are living in overcrowded living quarters, who have difficulty with the language and can't afford health care. We are still dealing with wars and international threats, food processing practices, and we now have international travel and trade issues. We are worried that we will have to deal with High Path Avian Influenza, either by migratory birds or by jet.

How different are today's public health issues and departments when compared with those of our grandparents? I don't think they are really all that different. Big government versus freedom of choice is still a big issue as well as the reappearance of old diseases and emerging new diseases. Obesity is an issue that needs to be addressed, but it's difficult to do so. The public's emphasis isn't on obesity; it is on protecting us from infectious diseases. We need new antibiotics that will kill germs like penicillin used to. So what do we do at the health department? We tell them cover your mouth when you cough and wash your hands frequently – just like our mothers and grandmothers used to tell us. Once again, we have to deal with issues around quarantine and isolation. We are starting to screen passengers on international flights. I submit to you, it isn't a whole lot different from a hundred years ago when we screened immigrants and put them in isolation. But thankfully, we have the infrastructure to deal effectively with these issues.

Concurrent Session Strategies for Workforce Development

Tanya Uden-Holman, M.A., Ph.D.
Associate Dean for Education and Student Affairs
Associate Professor (Clinical), Department of
Health Management and Policy
Deputy Director
Institute for Public Health Practice
Director, Institute for Quality Healthcare
College of Public Health
The University of Iowa

(Dr. Uden-Holman presented on behalf of Christopher G. Atchison, MPA, who developed the PowerPoint presentation.)

I would like to begin by talking about why is it important to understand today's public health workforce. In the May 1999 issue of *Public Health Management and Practice*, Kristine Gebbie stated: "The challenges facing public health today are enormous and require a workforce in governmental, voluntary, and interested private health agencies that is skilled not only in the technology of public health but also in its philosophy and framework." We are facing many new challenges in public health today and it is critical that the public health workforce has the skills necessary to respond.

In a recent national survey by *Research!America*, individuals agreed that they benefit from many of the activities that public health agencies and professionals carry out. Yet, in the same survey, public health was not identified as a high priority. This is one of the challenges that public health faces—how do we get the general public to understand the importance of public health and how public health services positively impact their lives.

Although we know having a competent public health workforce is critical, there are barriers we face in reaching this goal. First of all, we must understand who is included in the public health workforce; we do not currently have a complete inventory. In addition, we do not have a national consensus on public health competencies or curricula, nor do we have an integrated system for life-long learning. Finally, we need to ensure there are adequate incentives for individuals to participate in training and continuing education and a coherent policy strategy for funding our workforce.

To successfully develop the public health workforce, we must first assure a broader understanding of the purpose of public health, purpose being the key word. We must establish a consistent systems approach for public health practice and ensure that the workforce is accountable. To establish a public health system, we need to come together and develop an ecological

strategy and utilize a practice model (e.g., The Ten Essential Services). We must develop the competencies of our workforce and be able to measure and demonstrate the results (Public Health Performance Standards). Finally, we need to move toward accreditation to recognize excellence.

Currently, there is a "disconnect" between medicine and public health in our health system. In medicine, the focus is on the individual; and in public health, the focus is on the population. So how do we integrate the two systems? We can improve health by coordinating services for individuals and we can improve access by establishing frameworks to provide care. If we apply a population perspective to the practice of medicine, we can make it more cost effective and improve the quality of care; and, we can use clinical practice to identify and address community health problems. Together, we can strengthen health promotion and health protection through community campaigns and collaborate around policy, training, and research. Collaboration is absolutely critical to our efforts!

Another key component of workforce development is competencies, or what do you need to know to be able to carry out your job? Traditionally, we have focused on the five core areas of public health (especially in MPH programs): biostatistics, epidemiology, social and behavioral sciences, environmental sciences, and health services management. The Council on Linkages Between Academia and Public Health Practice identified public health competencies in eight domains: analytic and assessment skills; policy development and program planning skills; communication skills; cultural competency skills; community dimensions of practice skills; basic public health sciences skills; financial planning and management skills; and leadership and systems thinking skills.

Acknowledging the importance of competencies to workforce development, the Institute for Public Health Practice (IPHP) in the College of Public Health has been working with local public health agencies to develop public health practice-based competencies. IPHP is also working with specific disciplines, such as environmental health and the laboratory on competency sets.

In order to bring the different pieces of the puzzle together that are necessary to strengthen the public health workforce, Iowa is utilizing the *Prepare Iowa* Learning Management System. The Prepare Iowa LMS, which is jointly sponsored by the College's Preparedness Center and the Iowa Department of Public Health, is a Web-based system developed by the University of Illinois-Chicago and is designed to ensure efficient delivery and management of assessment and training. As noted in the corner of

the slide, the URL is www.prepareiowa.com. Prepare Iowa is similar to the learning management system used in Nebraska – *TrainingFinder Real-time Affiliate Integrated Network (TRAIN)*.

Prepare Iowa is a “one-stop shop” which allows individuals to assess their own competency skills in areas like leadership and frontline management, core public health and public health bioterrorism. This self-assessment tool gives individuals a chance to get a feeling for where they are and to identify gaps or knowledge deficits. Programs and classes are recommended to help overcome the gaps identified. In addition, a course catalog and conference registration function are available through *Prepare Iowa* as well as a calendar of events.

When developing courses, our staff works closely with the practice community about what they need to meet their training needs. They advised us that long academic courses were not going to “cut it.” They suggested shorter, self-paced, interactive programs that are available 24 hours a day, seven days a week, and are truly relevant to their practice. We worked closely with the state and local public health departments to pilot test the on-line courses with the target audience before releasing them. We also utilize a course rating system (using stars similar to Amazon.com) so that students can get an idea of whether or not the course was liked. In summary, we have found *Prepare Iowa* to be an important tool in helping us strengthen the public health workforce in Iowa. Thank you.

Joann Schaefer, M.D.
**Regulation & Licensure Director/
Chief Medical Officer
Nebraska Health and Human Services System**

Today, I would like to talk about the interface between physicians and public health. How do we involve physicians in public health? First of all, I would like to share from the physician’s perspective. Please don’t get me wrong – I love my job and make a good income, but when I graduated from medical school, I had about \$170,000 in student loans. Like many other young physicians, during residency, I deferred payment on those loans, but the interest continued to compound. I watched my non-medical friends buy cars and homes and start families and invest in college and retirement funds, while I continued to invest in my training. When I finally finished, I had a huge amount of debt and was already in my early thirties and had a young family, a home to buy and a car to replace.

My point is, it is hard to attract physicians into public health when the income offered won’t cover the amount of debt they owe and the normal

expenses of life. Also, public health requires even more training and education. Natural public health partners are family practice physicians and academics, but we can’t ignore the reality that our private practice partners have their own infrastructure to take care of. Academicians are driven by grant funds and tenure. Wanting to do good for the community won’t help them reach tenure or pay the bills. We also need to recognize that some physicians may have a less than positive relationship with their State Health Department because of disciplinary actions or view the State only in the disciplinary role.

How do we address these issues? First of all, we need to engage students at the undergraduate level. I was fortunate to have been a part of a good pre-med program. We need to introduce the concept of public health and community involvement early on. We also need to reach out to the frustrated physician. It is a win-win situation for physicians to know what the community is doing around issues that they care about like obesity in children. The physician that shows a high level of interest in a public health issue like obesity will be your champion. One of our biggest selling points is that they already practice public health every day, but at the individual level. We need to find out what they are passionate about and use it! Finally, we must remember that the physicians treat the individual. It is hard at times for them to endorse something when they can’t see the benefit for their individual patients.

Magda Peck, Sc.D.
**CEO and Senior Advisor, CityMatCH
Professor and Associate Chair for Community
Health and Chief, Section on Child Health Policy
Department of Pediatrics
University of Nebraska Medical Center**

I was asked to talk about what types of training opportunities are needed to assure a competent workforce in public health. The demand for a competent workforce is so much greater than the supply. This has been true for a long time, but now, with all the local health agencies, particularly in Nebraska, the demand is even greater – particularly in the governmental sector of public health. How do we insure that the traditional and non-traditional public health workers have the necessary skills and competencies to do the job?

I would like to suggest some strategies. We know that public health does three things: we offer assessment, assurance and policy development. We’ve identified again and again a series of ten services that public health is about. But today, I want to recognize that one of our services is to assure a competent public health and personal healthcare workforce. I think it is interesting that we are responsible for both, but we do not have control over both. How do we make this happen overall? We have

tried to figure out how we can move from providing services to implementing the set of competencies that have been identified by the Institute of Medicine.

There are new areas that we must pay attention to, as well. A new comprehensive set of competencies has been established by the Association of Schools of Public Health (ASPH) that will address these particular issues. Until we get beyond the core stuff, we probably aren't going to be able to solve the complex problems that we face today in public health.

When we talk about how we are going to assure a competent public health workforce, the usual stuff that comes up is education, training, assessment, licensure, quality improvement, life-long learning and the question about management and leadership development. I think one of the keys to accomplishing a competence workforce is to challenge ourselves to identify "What is the unit of change?" Training, education and workforce development is a means, not an end. We need to ask ourselves what is the theory of change of how that is going to happen?

If we offer you a particular course, you have the opportunity to change. While personal change is necessary, it is not sufficient. We must think in terms of a systems change - how do we connect wonderful, well-trained individuals with other people in such a way that it leads to change in how we do business in public health and in our related worlds. Our primary focus has been individual training, but there hasn't been room within our organizations for us to reward individual training and no time allotted for us to integrate what we have learned into our daily work. For the 21st century, I challenge us to think beyond this. Leadership training has to happen at the individual, organizational and trans-organizational level.

How can we make learning experiences different from any other capacity building, workforce development training? We need to really think about how to train multiple people at a time and to create organizational support, context and rewards for being able to be units and individuals of change. We are wasting extraordinary amounts of resources by pumping people full of new information, but not creating a work environment that rewards them for what they have learned. This is not a good return on our investment. If we are going to think about new ways to develop our workforce, we need to think about how to align the individual with their unit or team so that change can happen within their organization. External support from the community can also move us toward systems change. I challenge us here in this region not to do business in the same way, because we will get the same result.

Second, we need to think about the education pipeline. We have been hearing about the "graying" of the public health workforce. It is essential that we do succession planning upfront and now. We need to groom those who come behind us. Where is our relationship with K-12 in public health education? In the development of our new College of Public Health, we will work with the University of Nebraska, Kearney Campus because they train most of the teachers in the state of Nebraska. We must think creatively. How can we better align ourselves with what is already occurring within the education pipeline? We need to be present early and often.

We also need to address the issue of re-entry. When I attended Harvard, I discovered that most of the people in the MPH program were in their 30-50s, or mid-career. They had taken a year off to get their degree and were rewarded with a lot of support. The point is, people are trying to re-enter or shift careers and we need to be there waiting for them.

How can we make opportunities available for people who are either isolated or out of the mainstream of public health, so that they can transition in with a lot of support? We must create manageable steps, pathways and milestones. If I am one of three employees in a new local health agency – the concept of an MPH is so far beyond my reach. How can I get there? If we can create smaller packages such as certificates or short courses that come with rewards and give me recognition on my CV or within my agency, then we can make it more attainable. If I can complete a certificate within an MPH program, I may think "Well – maybe I can go on for more..." We must make it manageable. We can't sit in our ivory towers and say you've got to leap up to an MPH, put it beyond their reach, and then judge them for not having it; this is unfair and we are setting ourselves up for failure. How do we look at continuing education or certification and how do we tailor it, particularly for communities of color, our tribal communities and those for whom the usual opportunities are out of reach because of their geography or gender?

Last, I think we have some lessons to be learned from what we have already done here in Nebraska. I am hugely proud to have been part of the start of the first MPH program at the University of Nebraska. We had a lot of support from Creighton and other Universities in the region to help us get going. In fact, an MPH program relates in many ways to different parts of the Essential Public Health Services around research, education, assurance and empowerment. We designed our goals in such a way to be very practice oriented and to insure a competent workforce overall. I think an ecological approach or way of problem solving is critical. If we recognize the multiple tiers out there and the

complex public health issues, we can find ways to meet folks at every level and work together. And, if we have an ecological model, as it is recommended by the IOM, we can teach it in junior high, high school, college and in graduate school. We will have a common way of defining what the problem is.

We have just kicked off the second year of our Great Plains Public Health Leadership Institute – a one year program for leadership development. We asked our scholars to identify the most significant challenges they face and we tailored our curriculum to fit their needs. One issue that has resonated with our scholars is about understanding political landscape and political advocacy. In fact, when we asked our scholars to do a self-assessment of their mastery of the leadership competencies (a subset of the National Competencies in Public Health), this was the lowest rated area. Our public health leaders in this region do not feel confident about understanding the political landscape or knowing how to manage and navigate through high political stakes. It is critical that we know how to manage and use power for change. By being able to design curriculum utilizing the power structure in this region, our scholars will grow in leadership competency.

Finally, through CityMat**CH**, we have been able to develop the Data Institute. This national program is about translating data to action for effective leadership and uses a team-based approach. We work with cities around the country that put together learning leadership teams from their communities and learn how to translate data into action. We have been doing this for eight years and have trained about 75 teams from cities around the country. We have a strong evaluation base and we know this really works. When you learn in teams, the composition of the team is critical. By bringing together a team with different strengths—data, program and policy--you can have more effective transformation within your organization; and by decision-making and practice being more evidenced based, public health practice succeeds.

If we think about relevance and quality from the individual to the group to be trained, using adult learning and evidence-based approaches, we may, in fact, be able to transform the workforce into one that will be durable, sustainable and replaceable over time.

Concurrent Session ***Building Support for Public Health***

The Honorable Dennis Byars
State Senator
Nebraska Senate, District 30

Have you ever tried to explain what public health really is? It's amazing to me – if people get sick at a restaurant from food poisoning, they don't associate it with public health. I think Dr. Richard Raymond's presentation was right on target - as we learn about building public support for public health, we have to educate. Probably each one of us here can tell stories about how public health, or the lack of it, has affected our constituency. When we first started really and truly looking at an effective public health system in Nebraska, we didn't have much knowledge. We had so-called health departments within counties across the state, but other than a few truly functional public health departments, primarily in the metropolitan areas, we didn't know what public health was.

How do you build support for public health? You have to build coalitions, you have to educate, and you have to build relationships. If you don't go away with anything else today, I want you to think in terms of building relationships, starting with your county and township boards or councils. In Nebraska, we have 93 counties, and many of them are in rural areas. When we started in 2001, there were a ton of these counties without any public health representation, so we decided to do something about that. I wish I could tell you that I just had this brilliant idea all of a sudden – that I woke up one morning and decided, "I know how to build a public health infrastructure in Nebraska!" Guess what? If I told you that, I'd be lying to you. Any public official worth their salt will tell you the same thing. We learned about these issues and how to present them by you (public health professionals) educating us.

Never ever assume that those of us who make public policy understand your issues. We usually don't know enough to really represent you and it is up to you to educate us. That's what happened in Nebraska. The ones with the expertise need to teach the politicians who make public policy decisions. It takes time and effort to build the necessary relationships. We built support, one senator at a time, and put enough money into the pot to build an infrastructure that would represent all 93 counties in Nebraska. We built relationships. We called on Senators in their home districts and visited with them. This is pretty hard for some people to do, because they put public officials on a pedestal and are afraid. But believe me, don't defeat yourself unnecessarily; you don't have to be afraid of them. Change is going to happen – you have to decide if

you are you going to let it happen to you or make it happen.

To build support for public health or any other kind of public policy, you must first build relationships. It is like courting; you have to build a relationship with the people who make the policy. If you don't do that, policies will never change, there will be no new funding sources, and existing funding sources will be in jeopardy. But, if you build relationships one "date" at a time, you can be successful. In order to do this, you have to make it a priority. We did this with our governor this year. We visited him to ask for an additional \$100,000 for each of our public health departments. Coincidentally, he had a visitor from Washington and they were talking about avian flu. We were able to explain how our public health departments might play a role should we have an outbreak, and he decided to support our request for funding.

It is also important to build coalitions and make friends with partners. We discovered that we weren't really reaching out to our hospitals, medical associations, or health care providers that have a tremendous lobbying influence within our legislature. I can't emphasize enough the importance making friends and building relationships.

What should you do after meeting with your senator/representative? Be sure to thank him/her. Few people actually thank the people making public policy. They want something, but won't take the time to thank them. We notice the people who make the effort to say thank you. This doesn't mean we will agree with everything you said, nor should we, but it does show that you appreciated the time we spent with you.

What should you do next? Invite representatives into your public health department. Talk to them about what you do. If you have a special gathering in your community, make sure you invite your representative and ask him/her to give a few remarks – politicians love to make remarks! Again, be sure to thank them for their time and effort. Make an appointment with them at their office (not when they are in session) and take the time to meet with their staff. Don't wait to build a relationship until they are under the pressure, trying to get things done and have 5,000 people on their doorstep. You want to build that relationship before you get to the point of asking for their vote or to increase revenues.

Finally, show respect. It is important to show you have respect for them and continue to build a relationship that will last. Never underestimate the importance of being courteous, polite, and showing respect. You need to talk with policymakers before you need them to actually do something for you. Even if they don't agree with you, it is key to

remember that the vote today is only one of many. There will be other votes and you want your relationship to last. Do it one vote at a time, and build one relationship at a time. Don't use the excuse you don't have time. If you don't do it, it is not going to get done. Build coalitions and help each other and you will be tremendously successful.

**The Honorable Maurice E. Washington
State Senator
Nevada Legislature, District 2**

I am from the great state of Nevada and have been serving in the Nevada Senate for the past last twelve years. I am the Chairman for the Committee on Human Resources and Education, and have also chaired the Internal Study Committee on Health Care in addition to serving on other committees, as well.

In our state, we are in a unique position because we are experiencing rapid growth. Clark County is growing at a rate of 5,000 people per month. If you divided our state in half from north to south, the south would be the fastest growing state in the union, followed by Arizona, followed by the Northern half of Nevada. Currently, most states are losing their rural populations, but we are gaining population in both our rural and urban areas. Because of our explosive growth, we are facing tremendous challenges.

Our legislature has to take a look at all the facets that are taxing and pulling on Nevada's infrastructure. Recently, people have asked me what I think will be the primary issues for our next session (we have a biannual session and only serve 120 days, so the issues are fairly taxing). I think the primary issues will be:

- Education: We spend a large portion of our general funds on education.
- Transportation: Our transportation issues are huge. We must try and keep up with the needs generated by rapid growth in major metropolitan areas, but also maintain our highways to support commerce and trade.
- Public Safety: Like everyone else, we are faced with ballooning public safety issues – we need to increase the size of our fire departments, police force, etc.
- Managing resources: About 80 percent of Nevada is owned by the federal government and we are a land-locked state. Consequently, we do a lot of land swaps with the federal government. Water is another complex issue we have to deal with. It is very precious in Nevada and is becoming even more so as we continue to grow.
- Health care: It is important that we develop an infrastructure that will meet the on-going needs of our diverse population and changing economy.

Currently, our unemployment rate is less than 3 percent and jobs are available in every sector. We have a lot of high-tech companies that are relocating in Nevada, so our communications industry is booming, as well.

Health care plays a very important role in the ongoing demands of our changing economy and growing communities. Before moving into a community, people want to know what kind of health care delivery system is in place. We had to take a serious look at our health care industry. Bill 342 required the internal study committee to look at our health care delivery system statewide. We tried to figure out how we were going to grasp such a huge task. Like Senator Byars said, we aren't the experts. We are legislators and our job is to affect policy and, hopefully, put the right policy in place--the one that pays the biggest benefits and serve the most people. Sometimes we make mistakes, but we rely on you folks to help us. Our Committee looked at the following areas:

- The University system: How can we address workforce issues?
- Hospital facilities: How can we enhance our hospitals and develop a research center?
- Health insurance coverage: How are we going to work with insurance companies and provide for the uninsured?
- Pharmaceuticals: We have to try and figure out coverage. (We had the Senior Rx Program in Nevada before Medicare Part D.)
- Technology: Like most states, we are waiting for the federal government to determine what the standards will be concerning technology. How can we protect our patients' right to privacy?
- The public health arena: How are we going to put this health care delivery system together?

We looked at chronic diseases, health disparities, tobacco use, wellness issues, obesity, and more. We took the time to really immerse ourselves in the issues so that we could clearly articulate the issues and present them on behalf of the public health community at our next legislative session. If we want to maintain the lifestyle that we have become accustomed to, and have the health delivery system that we are looking for, we can't be reactionary – we must be proactive. We put together a plan to be implemented over the next ten years to serve as a foundation for our health care delivery system. We will ask for \$5 million in funding to address public health issues. These issues won't go away and we will have to deal with them as our population increases and ages. We have to make sure our public health delivery system can deal with any problem facing our State.

In conclusion, I want to echo what Senator Byars said about the importance of building

relationships. We met with all the stakeholders, listened to them, took their best ideas and practices and tried to come up with a responsible plan for the State of Nevada to address health care needs over the next ten years. We looked at each component in light of the big picture and tried to build a health care delivery system that includes public health.

**Representative Martha McLeod, M.O.E., R.D.
District 2
New Hampshire House of Representatives
Executive Director
North Country Health Consortium, Inc.**

I represent communities in rural northern New Hampshire near the White Mountain National Forest. I think of myself as a rural legislator. I am just finishing my first term in the legislature. Because we have two-year terms in New Hampshire, we have a short amount of time to get things done. I will speak from that perspective, but I also will speak from a background in public health. I worked as a public health nutritionist in the WIC program at both the local and state level, and ran an Area Health Education Center (AHEC) in northern New Hampshire. Currently, I run the North Country Health Consortium, which is a rural health network.

In New Hampshire, we are a citizen's legislature. There are 400 House members and 24 Senators. I'm a little fish in a huge pond, so it was important for me to find my area of expertise or area of concentration. Our rural area is losing population, unlike Nevada, and people are losing their jobs. Our forest and manufacturing-based employment market is in a state of transition. Our biggest industry is becoming outdoor recreation and tourism. There isn't as much opportunity for our young people as there once was and we are losing them to areas with more opportunities. I am interested in the economy and the role it plays in the education system, the health care system, and all the sectors that are part of the rural economy. I chose to serve on the House Commerce Committee to represent the interests of the North Country businesses and because it is where health insurance legislation is addressed. Our uninsured rates are going up (we have an aging population with poorer health status).

Today, I would like to suggest a few strategies for getting public health on the agenda of the legislatures in your state. First of all, you need to understand the structure of the legislature in your state and how it works. In our state, senators have to serve on several committees because there aren't many of them and there is a lot of work to be done. In the House, we have divided ourselves into about twenty Committees. Because we do not have any formal public health infrastructure, public health bills can come to almost every Committee. If you have the same scenario in your legislature, I recommend that

you look at where bills have gone in the past so you will have an idea of where your bill might go for a public hearing. Then, you can find out who the legislators are on those committees and start to learn something about them.

It is essential to build good relationships and credibility with your legislators. They want to pass good bills without unintended consequences. Make sure you also build relationships with the departments that provide information and data for your bill and make sure you have the support of your Governor's office, as well. Be sure to treat people with respect! Remember, today's opponent might be tomorrow's supporter. Even if you disagree over a bill, be sure to treat people respectfully. Let them know you are there to help them, give them information and work with them on future issues.

Next, strategize! You can't just bring your bill to a legislator and expect it to go anywhere. You must understand the fiscal climate and the past history of the legislation. If you don't know that, your bill may die for any number of reasons (bad work, bad feelings, etc.). If you know these things ahead of time, you can develop a strategy to move your bill forward. Another strategy is to bring your bill to the House and Senate at the same time. This allows you to educate both bodies at the same time, so when they reach "crossover," both the House and Senate are already aware of the issue and can build on their work and move the issue forward. This is the strategy we used to pass our most significant health insurance bill. If your issue is very complicated, you may want to think about it in incremental steps. Maybe the issue is too big to take to the legislature all at once. Develop logical steps so that you can educate people successfully or consider bringing the issue to the legislature in several smaller bills.

Be willing to compromise. If you think it's "my way or the highway," it will most likely be the highway; so put some serious thought into the amendments that are proposed. Legislators aren't going to pass a bill they think will have unintended consequences even if they like the idea behind it. Be realistic about your issue.

Develop persuasive messages. Think about what your state is known for and what the culture is like, and then frame your message in the context of your state's culture. For example, if your state is all about community, tell your legislature how your cause builds, enhances, responds to, or supports community. We also love to hear about public-private partnerships. Show how your cause creates a public-private partnership. Think about some incentives for private industries to join hands with you and do something for the good of the public. I imagine your state, like New Hampshire, is concerned with fiscal responsibility. We don't have broad based taxes or

income taxes, and there is only so much you can do in government without a revenue source to fund services. So, ask yourselves, how will this cause maximize efficiency? Is this issue cost effective, and what will be the return on the investment for the public?

I encourage you to attend committee meetings and legislative events. Come, listen and learn how your representatives work together. I love to see people in the back of the committee room. As we get to know and trust them, we start looking to them when we need help with something. Creating a forum for your legislative partners in their community can be mutually beneficial, as well. Finally, provide technical assistance and develop a communications plan. Reach out to the media with human-interest stories as well as focusing on lobbying efforts. Working on public perception is a very important part of the process.

Why is there so much resistance to passing public health legislation? New Hampshire is a very independent state. Our state motto is “live free or die” and our independent legislature often perceives laws and regulations as burdens. And since this is our culture, we must proceed slowly to move beyond this mindset. Another barrier has to do with enforcement. A number of public health bills are difficult to enforce. We have to consider individual rights and restricting those rights in any way can be seen as starting down a very “slippery slope.” Powerful lobbying goes on all the time – they are heard because they are present; you need to be there so you can be heard, as well. You also need to be aware of the changes that could result from your legislation. If your state’s economy relies on something you want to change, you must be aware of it and get industry on board. Finally, it is important to educate the public. Public health science may be well ahead of the public’s knowledge on the topic. You will want to educate the public and the legislators and help get them up to speed on the subject.

Representative Lisa Miller, M.P.H.
Maine House of Representatives, District 52
Senior Program Officer
The Bingham Program

Good afternoon. Like Representative McLeod, I am a representative for a rural area, as well. I am also trained in public health. The summary of my talk today is “seize the day!” I will talk about a few events in my state that show how we mobilized to support public health.

In general, legislators don’t know much about public health, but this is rapidly changing. Because we are faced with spiraling health care costs, more and more legislatures are focusing on prevention. We have to deal with the health insurance crisis,

exploding Medicaid costs that are eating up more and more dollars from state budgets, and pandemic flu and bioterrorism/emergency preparedness issues. Because all these issues have fallen in the laps of state legislatures, they have brought public health front and center and provided us with some great opportunities.

I would like to talk about three profound opportunities that came to us in Maine in the form of tobacco settlement funds, the Dirigo Health Reform Act (it was the centerpiece of our governor’s administration and was largely an insurance product, but had other elements to it, as well), and the arrival of the emergency preparedness funds.

We received \$40 million in tobacco settlement funds. The Maine Coalition on Smoking or Health already had a fifteen year history and they were very successful. Maine has been one of the leaders in the country for regulating smoking. When we got the tobacco settlement money, we had to set some policy goals. We had to ask ourselves the following questions:

- How will we keep this money from going into roads and bridges?
- How will we capture all of it for health?
- How can we keep from dumping all of it into Medicaid budget shortfalls?
- How can we use it to not only to prevent smoking, but to focus on other preventive issues, as well?

Our coalition expanded, and with the help of a broad range of partners, it pulled off a number of policy successes. The coalition decided that we should not designate the funds for smoking only, but should weave in other public health programs that are prevention-oriented and related to smoking, such as drugs for the elderly and early childhood visits, to try and keep families who are at high risk for smoking on the “up-and-up” so their children can live in a smoke-free environment. We had eight wide-ranging prevention issues rolled into our tobacco settlement plans; and as a result, we had a very broad coalition which gave us a large constituency (in the thousands) that we could contact for lobbying purposes.

This new coalition, called the Friends of the Fund for a Healthy Maine, worked like clockwork to effectively and efficiently distribute funds. They were successful because they did strategic research. They polled the public to see where they were at and hired a policy analyst who knew not only the “ins and outs” of state government and legislative policy, but could analyze the budget and understood how the Appropriations Committee worked. The coalition used a very sophisticated communication/ media process, using lots of press conferences, press releases and letters to the editor. They worked with editorial

boards, which resulted in favorable editorials. The coalition provided grassroots education. They used e-mail to help facilitate activation. It took a lot of coordination, but it worked.

I would like to emphasize the importance of legislator education and advocacy. First, you need to provide basic information to your legislator concerning the issues in your bill. Unlike our Senator friends, we have neither the staff nor the time to go dig up the information necessary to advocate for your bill. Secondly, you need to identify “champions” or influential people who might be willing to support your effort and educate them like mad! You need to give them the right tools and information for them to be public health champions.

The Dirigo Reform Act was the biggest health initiative to hit Maine in years. It was the Governor’s signature initiative and at its core was a new medical insurance plan for the uninsured. At the time, those of us in public health were trying to figure out how to “jump on the train.” The Governor’s first rollout of the initiative was very health care cost-oriented, and didn’t contain anything about improving the public’s health. However, it did call for a new “state health plan.” We were able to revise the first draft of the state health plan and make the primary goal “making Maine the healthiest state in the Union.” It took a lot of work and lobbying (face to face interaction), but the state health plan became an organizing tool for us and we were able to build into it a whole new planning process to develop public health infrastructure in Maine. The Turning Point project also helped us by building a platform for developing public health infrastructure. We were able to build on that platform with the new Public Health Work Group that is part of the state health plan.

In closing, I would like to talk briefly about emergency preparedness in Maine. We aren’t doing very well. Emergency preparedness is very “siloeed” and public health is barely part of it. In the Legislature, jurisdiction for emergency preparedness is being fought over by the Criminal Justice and Public Safety and Health and Human Service Committees. Because there is no broad-based supportive coalition to help keep things calm, they are battling over where the money should go. Unfortunately, this has gone in a direction that none of us wanted because there was inadequate planning and little effort to build trusting relationships; without trust, things can get ugly. This is an example of what happens without adequate planning and investment. We have done a lot of things right in Maine, but we have also learned some lessons along the way about how not to do things.

Concurrent Session

Developing Integrated Public Health Data Systems

Joe Kyle, M.P.H.
Director, Office of Performance Management
South Carolina Department of Health and
Environmental Control

It is a great privilege for me to be here today. As my title suggests, I am not really a data integration specialist – I am more of a data consumer and will be presenting from that perspective. I would like to share with you some of the things we have going on in South Carolina including our SCAN GIS website.

What is the rationale for developing integrated public health data systems? First of all, we are increasingly resource-challenged; this means that we have to work smarter and do more with less money. Second, technology is rapidly changing and becoming more powerful. The potential for the tools at our disposal are increasing every day. My first computer had a 20 megabytes hard drive. Now, I can carry around 2 gigabytes of information in a flash drive the size of my pinky. It is phenomenal what has happened in only a few years. Third, we are operating in an age of accountability. We want to know what works, what doesn't, and why? We must justify our existence and demonstrate that we are being effective and efficient. As a result of this, there is a greater need for evaluation. What are our processes? Are we doing a good job? What is the impact of our efforts, and ultimately, what are the health status changes and improvements that we are all striving to accomplish? Fifth, what are our customer's expectations? Finally, the bottom line is that integrated data systems have a greater opportunity to affect the common good.

What are the benefits of integrated data systems? These systems help make us smarter and hopefully give us better insights, desired outcomes and results. They help us prioritize and redirect some of the resources that we have at our disposal, although at my state health department, the data and our priorities don't always line up. But hopefully, some of the discretionary funds we have at our disposal can be redirected based on what the integrated data is telling us should be our focus. Finally, they make us more efficient.

In South Carolina, we have faced many challenges and opportunities as we have developed our integrated data systems. In my state health agency, for example, we have very old systems (Legacy/mainframe). We are transitioning to late 20th Century technology, but we still have the tried and true currier system, faxes, etc. We have many stovepipe data systems, but we are beginning to

overcome these through several different programmatic and surveillance systems including our client encounter data base (CARES). CHES IR (Carolina's Health, Electronic Surveillance System) will also help our reportable disease systems. Vital events are being transferred to an electronic birth certificate and death reporting system.

In today's world, reporting to grantors presents both an opportunity as well as a challenge. Programs that receive federal funds can now report many of their accomplishments via the internet. It is very customer friendly and efficient; however, the incentive that the program once had to integrate their data with other programs isn't as important as it once was.

Finally, we must effectively demonstrate the link between our resources and our efforts (personnel, workforce development, payroll, budgets, expenditures, etc.).

MAPP has suggested some data categories for us to consider using as we develop an integrated data system: demographics, socioeconomic, health resource availability, quality of life, behavioral health factors, environmental health, social and mental health, maternal/child, death, illness and injury, infectious diseases, and sentinel events. These categories require us to collect multi-agency data and we have to ask the question "Does all this data exist and who has it?"

When we think about community health assessment work at the local level and try to utilize data in an integrative way to address issues, it is extremely challenging. My agency, which is statewide, has some of the recommended data, (e.g. behavioral risk factor data) but not everything that MAPP is calling for. Consequently, it makes it difficult to address some issues.

Another important consideration when talking about an integrated data system is the tremendous short-term upfront costs in staff time, capital, and cash disbursements. Ultimately, we hope to have long-term benefits, but certainly that short term cost has to be taken into account. We also have to face the possibility that creating this kind of system will be expensive whether or not it is successful. There are plenty of stories out there about failed attempts at doing something like this, and once you spend those resources, they are gone.

I think it's also important to think about combining broad systems data with the process and impact data. For example, at the state level, I can tell you what the unintended pregnancy rate is in our state because we do the Pregnancy Risk Assessment Monitoring System (PRAMS) (a statewide survey of women who have delivered a

baby in our state). We have a statewide percent, but I am not able to tell you the percent for the 110,000 women we see in our family planning clinics. So, when a legislator asks me “What is the impact of your family planning program in terms of preventing unintended pregnancy?” it is a difficult question to answer because I only have state level data and it isn’t linked back to the women in our family planning clinics. More and more, we will be asked those kinds of questions, and we have found that success breeds more demands including demands for more robust and timely data for smaller geographic areas and more specific variables of interest. How do we anticipate these needs when building a system? We also bump into privacy issues and small number variable concerns and are confronted with turf and power issues. “I have the data and you don’t—and what are you going to do for me to entice me to share my data?”

Let’s look at a performance measure out of our state performance management system related to newborn home visits. Our goal is for 90 percent of all Medicaid newborns to receive a newborn home visit within 72 hours of hospital discharge. Here are some of the things we want to know: 1) Did it take place? 2) By when? and 3) Who did it? What is the source of this kind of information? One way to look at it would be to look at Medicaid Claims Data (a retrospective approach). It can be broken up by county, region, state or provider specific data systems, but first, you have to obtain the Medicaid claims data. After the newborn home visit is completed, we want to know was their a referral for, and receipt of, a well-child visit as a result of that newborn home visit? That is a specific impact outcome that we want. We also want to know was there a referral for, and receipt of, family planning services, and was it provided by the Health Department of someone else? Was there a referral for, and receipt of, WIC services? We may be able to get this information from our own internal data systems CARES, but if we don’t have enough information and linked electronic systems, we will have to pull a sample of charts which is very labor intensive. Sometimes, we may have to pull in Medicaid claims, as well, if it is a family planning provider who is not a health department provider.

When we look at creating a system, we have to think about who our customers will be. Different groups have different mind sets, skill sets, agendas, competencies and interests. We may be dealing with researchers, community and advocacy groups, the media, public officials, and public health community members, all wanting different information.

From the public health perspective (based on the Core Public Health Competencies) we are looking for people who will be able to determine the appropriate uses and limitations of the data. They

must be able to select and define variables, identify relevant and appropriate data, attach meaning to it and make relevant inferences. They must also be able to determine risks and benefits, and be able to recognize how the data illuminates ethical, political, and scientific issues. In essence we are looking for Renaissance men and women to work in data. They must be philosophers, epidemiologists, researchers, biostatisticians, politicians, economists, scientists, and “regular Janes and Joes” so they can communicate with the common person. We need team players who can help us translate the data into understandable English and help us bridge the gap between technology and the community.

In South Carolina, we combined several approaches to develop our systems. We linked data through unique identifiers utilizing the Office of Research and Statistics (ORS). ORS is unique in the sense that by law, all governmental agencies at the state level are required to give them their data. They are a data depository and have all the data from the Department of Education, Department of Social Services, Department of Mental Health and all the various health departments, as well. They are able to take all the different data sets and link them together so they can answer the types of questions we posed earlier regarding newborn home visits.

In my health agency, we built a modular system from the ground up called Client Automated Record and Encounter System (CARES). On another data challenge, we blended the Electronic Birth Certificate (EBC), Newborn screening, and birth defects surveillance data; and finally, we have also created the South Carolina Community Assessment Network (SCAN).

In my state, we are vertically integrated which mean that whether we work for the county, state, or region, we all work for the same organization. We have 46 county health departments and 90+ clinic sites, but we are all part of the same system. I mention this to give you an idea of the volume of what we are dealing with in developing our single statewide system. CARES has over 4.5 million records and can be accessed from anywhere in the state. It is morphing into an electronic medical record because it combines all encounters we have had with specific individuals. It is web-based, reliable, and HIPAA compliant. CARES has helped increase productivity because it allows clinicians to more quickly access health information concerning their clients.

Currently, our health departments across the state can access a single client record which will provide them with demographic information and allow them to schedule appointments and manage records. We can look at the percent of appointments being kept, and the amount of down time at clinics

(productivity tool). We are currently rolling in the WIC and Immunization modules and soon will be adding the adult health (including STD and family planning) and children's health module. The foundation for our system is the demographic module and the additional programmatic modules go on top. We also have a data cube which allows us to select variables and generate reports. Before this, when our MCH Title V program was asked what percent of newborns were screened for metabolic conditions, we couldn't answer them with 100 percent accuracy because their data system wasn't linked to the birth system. Now we will be able to develop aggregate reports with truer denominators and be able to get client-specific data off the electronic birth certificate for follow-up. So, if there is an issue that needs to be addressed, we are able to do a much better job of follow-up because we have more accurate and timely data.

Other challenges include disagreements over which system is best, and control issues regarding how the data is managed. They aren't insurmountable, but are certainly challenging.

If you would like more information or would like to see what our SCAN system looks like, you can visit <http://scangis.dhec.sc.gov/scan>.

Lisa Tuttle, M.P.H.
Director, Office of Public Health Informatics
Department of Health and Human Services
Maine Center for Disease Control and Prevention

One of my objectives today is to talk about the rationale behind building a comprehensive data system for our State Health Department in Maine. Our desire was to collect quality information and apply it to drive evidence-based public health. We were fortunate to have a Director and Senior Management Team that had a vision for an integrated public health information system – they asked early on, years before our plan for Public Health Informatics was developed, how to overcome traditional limitations on integrating data in order to inform public health performance. The Integrated Public Health Information System (IPHIS) project has since “morphed” into an even larger effort that we now call the Office of Public Health Informatics because we are focused not only on developing technical systems to do information business, but also on implementing informatics standards – from data and interoperability standards to project management and policies.

We discovered that once you begin to look at the effective use of information and invest in the tools and processes necessary to do informatics successfully, it brings a whole bunch of conundrums to the fore (e.g. what are you currently doing around data quality, what kinds of data analysis standards

are you using, and are they consistent throughout your organization?). This is the charge before our newly formed Office of Public Health Informatics.

As we worked to develop IPHIS, one of our biggest challenges in Maine was [lack of] vision and freeing up staff to think about the future. We struggled, like most other health departments, with our “siloed” data systems, driven historically by funding and structural limitations. We were unable to easily produce comprehensive population-based reports and analyses from our existing data systems. In order for us to practice evidence-based, data driven public health, our program directors and managers had to rely on printouts, floppy discs, CDs, etc., to put together information about our populations. We collected all kinds of data, (e.g. demographics, etc.), but we had no consistent reporting formats to aid us in identifying the work we needed to do. Our business processes needed a lot of attention because of the “clunky” way that data was managed in our organizations. We had never really looked at how we were doing business around information and thought about how we could do it better.

We soon discovered that as we started building and implementing IPHIS; we really had to do our homework because we didn't want to build an expensive system that “replicated 1960 processes.” We wanted our system to make the work easier and help us do it better, and there was a push also coming from our colleagues in the Maine Public Health Community. As Ann Conway said earlier today, the Turning Point Project sparked a desire among community members, public health partners, stakeholders and planners, to develop a tool that would give them the data they needed from the State, and they solidified that desire into a rough functional design. Like many other large state agencies, we collected all kinds of information in our organization, but rarely gave it back to anybody in a meaningful way – partly because our processes were so inefficient. We didn't know how to make sense of it all ourselves, and we were not alone nationally – even the federal CDC is collecting reams of information that aren't being used to drive improvements in public health.

Part of our rationale for building an integrated data system is that we are ethically bound to do our work well. According to the Public Health Code of Ethics, “public health should seek the information needed to implement effective policies and programs that protect and promote health” and “public health institutions should provide communities with the information they have that is needed for decisions on policies or programs and should obtain the community's consent for the implementation.” We have a responsibility to underpin our work with information that is valid and reliable and to feed it

back to our communities in such a way that it infuses interventions. Competent use of information is critical to our ethical responsibility as public health professionals.

The world of public health informatics that has emerged over the past seven or so years is very exciting – and the thinkers that have led us down this path have provided tools that are the missing piece in the way we've tried to put public health data together, like the Public Health Conceptual Data Model that underpins our IPHIS system. This new discipline is also producing core informatics competencies for public health professionals. The Public Health Data Standards Consortium defines public health informatics as "...the systematic application of information and computer science and technology to public health practices, research and learning." "It is the efficient and effective organization and management of data, information and knowledge generated and used by public health professionals to fulfill the core functions of public health: assessment, policy and assurance."

We are currently developing a technical intersection with our local Regional Health Information Organization (RHIO). Many communities across the nation are making similar efforts to create an electronic health data exchange with data medical records, etc. Our RHIO in Maine is poised to be one of the first statewide efforts in the country. MCDC was one of the lucky recipients of a Robert Wood Johnson Foundation (RWJF) Info-Links grant to bring together public health and health care data electronically. RWJF has been very important to our projects at MCDC, as has the Public Health Informatics Institute. RWJF/PHI funded an early business case analysis for us before we started to build our Integrated Public Health Information System (IPHIS)

Building integrated data systems is a very, very risky field. There have been many colossal failures, and typically, public health professionals are not schooled to manage the various aspects of these projects. I think it is easy in information technology to get in over your head because projects are statistically more likely to fail than to succeed; and even the ones that succeed are only likely to meet only some of their functional requirements and go way over budget. However, in Maine, it is important to move forward because of our structural and systemic challenges as a state. Maine has vast geographic areas between towns and cities and some very minimally populated areas with few formal services. We have only two local health departments, so our State Department of Health (MCDC) must rely on connectivity and the efficient use of remote business tools. We must continue to work on developing an infrastructure that can meet our

population health needs and this demands that we learn how to use informatics successfully.

So how can we increase the chances of success? First of all, we must have a competent workforce. As public health managers and directors, we need to know how to work in this discipline, how to build quality systems, how to define our functional requirements, how to reanalyze and refine our business processes and how to deal with information technology vendors who make a lot of wonderful promises, but may not be able to deliver. We must also learn how to do this in the challenging environment of the public sector.

Our State Legislature recently conducted an audit on large state informatics implementations, which revealed, as one would expect, a variety of concerns including: unacceptable levels of unmitigated project risk, insufficient staffing, concerns about security policies and standards, and low levels of information technology management skills resident in State staff. The audit reinforced that the State needed to take informatics management seriously, and highlighted the risks of building IPHIS in the State infrastructure. It is certainly challenging -- I do not have direct control of my technical resources on the IPHIS project. I'm sure this is probably the case for many of you. I have a matrix management relationship to the IT project manager, who is building the IPHIS project, and the State Office of Information Technology (OIT) supervises the technical resources and controls the technical aspects of the infrastructure such as networking, procurement, etc. Typically, satisfaction with OIT services has been a concern, so one role of the OPHI is to create and refine a customer service partnership with OIT in order to meet our public health functional requirements. I recently asked Dave Ross from the Public Health Informatics Institute for guidance on the challenge of working with OIT; he gave me extremely valuable insight, which we are trying to operationalize in OPHI: Limited resources and the ability to control them can create tension, but regardless of who controls the technical resources, take the high road and keep focused on the delivery of your public health requirements. He encouraged using that as the primary point of evaluation with our OIT. This also reinforces how critically important it is for us in public health to define effective functional business requirements and demand that technology providers meet them.

Our vision for IPHIS is to build a solid infrastructure to receive, generate, and safeguard quality public health data. Ultimately, we want to, in some way, integrate and/or coordinate all of our existing data systems. We focused on building a scalable system that would meet the national data exchange standards and is capable of integrating with multiple subsystems and external partner

systems. Our vision included tools for comprehensive population-based analysis, planning and assessment, early detection, response and alerting. We have a common business portal front-end that addresses security, authentication, communication and information sharing, and we implemented the National Electronic Disease Surveillance System (NEDSS) as a core component of IPHIS. We are the first state that went live with NEDSS with the electronic Lab reporting capacity turned on. The IPHIS central data repository was built on the public health conceptual data model with non-person centric data marts built around it (e.g. environmental health data). Our vision integrated the Health Alert Network system for partner communications and alerting and although the first system we built failed after rigorous security audits, we have been able to salvage a stand alone piece of that system for basic alerting and redundant communications functionality. Our vision is still to integrate our new Health Alert Network (HAN) into the common front end and to implement more innovative uses of the alerting. Our White Pages Health Partner Directory is a centralized list of all of our public health partners with which we do public health business. Finally, we are in the process of rolling our Subsystem Data Integration. We are integrating data from the immunization registry – all three of the public health lab systems, clinical, forensics, and environmental. We also mapped in some census and Behavioral Risk Factor Surveillance System information.

The capacity to exchange information and communicate with staff through our portal as we go live is phenomenal, and will be new business for us. We will be able to post information and share it across the board so that we can get past the traditional limits of information sharing in our organization. For example, people in MCH can have immediate information on key activities in infectious disease. The IPHIS portal presents a whole new world of possibilities for us that we really need to strategically think through.

We have assessed some legacy systems for integration, and hope to integrate them in the next phase and broaden the information in the CDR. We built an oracle data base for the data from the Maine Health Data Organization (MHDO) (our State hospital utilization data) and hope to integrate it into IPHIS to increase efficiency. We will work with MHDO to iron out the politics and the appropriateness of how to do this, but it offers significant improvements in our business processes; for example, one benefit is that MHDO has strict confidentiality requirements on their data and we can manage some of the data agreements through the IPHIS security model and role based security. We can also use the IPHIS functionality to manage data updates and occasional recalls which now take a lot of staff time.

In building IPHIS, we had to bring many different disciplines together from across the organization. This was challenging because we don't all speak the same language. Ultimately, we want to integrate all of our critical systems, but to plan for this, we have to start at the beginning with the definition of our terms, including systems – What do we even mean by “system?” What do we mean by “integration?” Many programs have gone through the process and designed access data bases. If we are to integrate our systems, then we must agree on common definitions. When we held our initial design sessions with our IPHIS vendor, they were very challenging because our terms meant different things to different people. For example, there was not even a common understanding of what “reporting” meant – some people thought it was a published document, some thought it was a transmission of information to federal CDC, etc. This was very illuminating to me. We had to bring together people from all the divisions within the Maine CDC to come up with a common meaning for “reporting.”

We are designing our White Pages to track complex relationships with our public health partners, meaning we need to track multiple persons across multiple physical sites and organizations (e.g., we want to be able to track a public health nurse who works in more than one setting.)

In the InfoLinks grant, Connecting Maine, our largest external partner in this project is HealthInfoNet (Maine's developing Regional Health Information Organization (RHIO). Funded by the RWJF InfoLinks Program, our goals are to: 1) to strengthen the relationship between public health and health care informatics 2) create a functional requirements document for the technical intersection between IPHIS and the HealthInfoNet, (For example, how will public health policies need to change once we move into the private sector (doctors) and start talking about sharing data?) 3) provide assessment and recommendations for Policy Implications, and 4) develop a Public Health Data Prototype that can be leveraged during the HealthInfoNet pilot phase.

The functional requirements for exchange of public health data from the RHIO focus on three scenarios and use-cases for data exchange: 1) Data shared with public health from HealthInfoNet that are already mandated by law and we are already collecting, 2) Data that may be authorized for collection under certain circumstances, and 3) Data that may help detect aberrations or syndromes. So far, the drafted requirements include the ability to create and collect pseudo identification numbers from the RHIO, but if we need to go back in and get identified data in a category authorized by law, we will have the “break the glass” functionality necessary to track down individuals for further investigation.

The data prototype was developed to address the question of what would a model data prototype look like if public health could get all the data that we wanted?" Our sources would include major hospital systems, electronic medical records, etc. We would compile these data into a data system that could provide us with an individual profile or, in the aggregate, a community data profile. We hope the prototype can be used for planning data collection and system development over time, and help focus on improving business processes between sectors of society where electronic connectivity may not be feasible (e.g., the shelter system).

Here is an example of a simple county-based report we are developing out of IPHIS. For a state health department with no previous capacity to do electronic reporting, this is phenomenal for us, even though it may look like a small step forward. We have ambitious plans for the future including tools assessment and report generation, but we will also be faced with some challenges. Technological challenges are some of the risks we've already faced and will likely continue to face. As I mentioned earlier, IPHIS was delayed for months because our proposed single sign-on technology failed to work after months of research by the vendor. It proved to ultimately have a technical incompatibility unbeknownst to even the source vendor. Whenever possible now, I increasingly prefer to go with "tried and true" technology, instead of relying on something new that looks great and is exciting but may not work ultimately – this is a typical challenge of implementing information technology tools. Other challenges include our need for technical resources and staff to make this system successful and sustainable which may mean "making the case" with diverse partners and State leadership, and educating them about what public health is and why it needs to be a priority of the State CIO's office.

Concurrent Session

The Role of Collaborative Leadership in Developing a Strong Public Health System

Les Beitsch, M.D., J.D.
Professor of Health Policy and
Director, Center for Medicine and Public Health
Florida State University College of Medicine

What do I know about leadership? I have had a few leadership positions and I'm still recovering from them... Basically, leaders know when to lead, when to follow and when to share power. We have to learn how to share power to be successful in today's world. There is a paradox of power--if I empower others, my power actually grows. When others seek me (or my organization) out as a partner, the influence of the public health agency, public health institute, hospital or any public health system partner actually grows.

We all know that there are many forms and models of leadership. The hierarchical model is a vertical model, where heads of agencies or other formal leaders are sought out for guidance on how to accomplish something. However, leaders may or may not have a formal role within an organization, but they exercise extraordinary power. They are the "wise ones" we go to for assistance.

Collaborative leadership is different from the hierarchical model. Collaborative leadership has a horizontal orientation. There are organizations that collaborate well, and others that are not nearly as successful. Unfortunately, public health often fits into the latter category. Collaborative leaders – the individual with a designated role within a hierarchy – must not only manage and maintain change within their own agency, but also collaborate across organizational lines. There are times when collaboration is absolutely the best way to accomplish something, and times when it is the worst possible way to go. When is collaboration a bad idea? You should not collaborate during a time of crisis (audience example: when the building is on fire). We have a command system—the military--to handle crisis situations; there are times we don't want to even think about collaborating. There are different types of leadership styles, competencies and skills you need to use depending on the situation and what you are trying to accomplish. If the only tool you have is a hammer, than everything looks like a nail. It is important to know when it is appropriate to collaborate.

It has been very exciting for me to hear about how the Turning Point states (New Hampshire, Nevada, Nebraska, and Maine), have built collaborative relationships and worked so hard to build the public health infrastructure in their states.

However, I wonder if the states that have strong governmental public health agencies really understand the value and importance of system partners, since they don't need them as much. I'm curious about how effective Turning Point was in the states that have much stronger public health infrastructures.

I would like to suggest a few "rules" or strategies for changing our public health infrastructure. First, public health must build vocal constituencies. I think most of you are already pretty good at that, but let's look at a couple of examples. National Institutes of Health (NIH) made a serious effort to double their budget in five years and they were successful. But, have you heard about anyone making an effort to double the budget for CDC? What about HIV/AIDS? There is a lot going on right now in HIV/AIDS and their constituents are effective advocates and play a huge role in setting policy! What about moms and children? Block grants do not have clearly established constituencies. Overall, in public health, we haven't built up the energy necessary to increase funding and save lives through prevention efforts and strategies.

In the past, people in public health seemed to think that when they participated in a successful project or initiative, the credit belonged to their partnering organization(s); however, they were quick to accept the responsibility for failed initiatives. After much reflection, I decided that this is dumb! People don't want to form partnerships with individuals or organizations that aren't successful. If all the credit goes to somebody else, public health organizations, agencies and systems aren't going to be seen as strong and viable partners. While most of the credit can go to someone else, public health organizations need to take some of the credit, too.

My next rule is "No Whining!" I think we have developed public health whining into an art form. We complain about the fact that we don't have enough infrastructure, funding, or legislative support. No one wants to partner with somebody who can't get anything done and whines about not having enough of this or that... People want to partner with someone who is proactive, wants to accomplish something, and knows how to get things done.

People talk about the death of public health, but from what I have seen, it is alive and well. It has been over a hundred years since the U.S. Supreme Court ruled that local and state public health agencies have substantial and significant authority to regulate things like quarantine (Jacobsen versus Massachusetts). Everyone says state Medicaid programs are broke. There was a time when education programs were the biggest budget item in every state. Now, the biggest budget item is Medicaid and it's continuing to grow. How are we going to

change that? Public health has prevention to offer, and that may be the only viable cost saving alternative, along with health promotion. In addition, preparedness remains at the forefront. While we do not want to celebrate tragedy, every time there is a public health calamity, it is an opportunity to explain what public health is and why it is important. I thought the public health community did a very good job during Hurricanes Katrina and Rita, but they didn't get any media attention or credit for their successes. No one knows that during Hurricane Katrina public health "went right" when lots of things went wrong.

Sometimes, we need to be more aggressive and invite ourselves to the table. Don't be shy! Collaboration requires a high level of involvement and engagement among organizations. However, that is not typically what we have. More often, we have networking relationships – someone may tell you about a grant opportunity and share information concerning a key contact. Sometimes we function as coordinators; we may share information and do some things together that resonate with us, but seldom cooperate to the point of sharing resources. Why don't we get to this point? Because public health organizations have so few resources, we aren't about to share what little we have. However, when we talk about collaborating, we are talking about something that enhances capacity for us all, is mutually beneficial and serves a common purpose.

If you are a leader within an organization, you must lead both vertically and horizontally. You are responsible for managing your organization and assisting with the management of other organizations. I find it interesting that there is conflicting evidence concerning whether or not collaboration is actually effective and leads to change in health status and health outcomes. I submit to you that true collaboration is effective and when it appears not to be, the collaborative effort is actually somewhere between networking and collaboration. I think the results are more impressive when there is genuine collaboration.

To be a successful collaborative leader, you must first be aware of what has already taken place within your community. There is typically a history, or baseline, and leadership already in place. You must also plan your collaborative effort carefully. We heard earlier today from both our legislators and Turning Point partners about the importance of careful planning. You must think about measurable goals and outcomes. You need long term goals and a process that will demonstrate how your project will have a positive impact on the health and wellbeing of your community (e.g., a meaningful law was passed concerning tobacco use or people are actually wearing seatbelts).

Collaborative leaders must be able to build constituencies. You may have a great idea, but you have to figure out how to build a constituency to support it and come up with a process to move your effort forward. In public health, we want our efforts to be evidenced-based (doing things that we know work). To facilitate the process, we must work continuously to build relationships and respect among partners. We must also have clearly defined roles so that each partner understands his/her role and what resources they are contributing; without this understanding, things won't go well.

Consensus around purpose and goals is also important. Activities or processes are much more likely to succeed if you agree on where you are going and how you are going to get there. To assure early success, you must agree upon concrete tasks that reflect recognized goals. Goals need to be attainable, but not so easily attainable that they don't demonstrate important changes in your system. Any transitional projects must connect with the long term vision, and projects must represent significant system change. Clear communication and a supportive environment are also vital to the process. Incentives help achieve desired ends. Certainly grants can be incentives, but sometimes, the simply knowing that you are doing the right thing for the public's health is incentive enough.

How do we engage the community and get important stakeholders (not the usual suspects) to buy-in to the project? Successful collaboration requires champions and buy-in from established leaders. Without some of the expected leaders taking ownership, you won't be successful. Turning Point is a great example of bringing folks to the table and engaging them in the project.

Collaborative synergy has been defined as the "merging of partners to produce a whole that exceeds [the] sum of individual parts" (Weiss, et al). Organizations that have harnessed collaborative synergy are able to accomplish great things. Collaborative leadership can bring novel ideas and innovation to the table and bridge cultural gaps (both with people and organizations). We have heard some great examples at this conference about collaboration and innovation. I love the idea of "braiding" services--everyone puts their resources together for the benefit of the community. When partners commit resources, though they may not necessarily be the same amount or same kind (money, data, facilities, or staff members), the fact that all partners make some kind of commitment is often a key factor for success. Programs like this can be more integrative, comprehensive and foster closer relationships with the community.

It has been said that those of us in public health do not collaborate well. There are inherent

structural limitations in bureaucracies. “Multi-sector collaborations require bureaucratic organizations to share decision-making and resources with other agencies or with non-profit community groups-and ‘sharing resources’ goes deeply against the grain of most organizations” (Padgett et al). In Nebraska, you are fortunate because your local health departments haven’t been around long enough to become entrenched. Entrenched thinking can derail efforts. Other limitations are categorical funding and frequent shifts in direction. Changes in leadership and cuts in funding can have a serious impact on collaborative efforts.

Winston Churchill said, “It has been said that democracy is the worst form of government except all the others that have been tried,” and this may be true for collaboration, as well. We have heard several times today about the amount of time that must be invested for collaboration to be successful. It may not be the most attractive option, but it may be the best one. Collaboration is not a panacea for poorly functioning organizations; you have to have your own house in order to be a good partner. You also have to have a successful track record, know where your resources are coming from, and have a culture of

partnership and collaboration. Additionally, you want to form partnerships with organizations that complement your strengths or, in some way, compensate for your weaknesses. Look for nimble, flexible relationships, which may be outside of your entrenched bureaucracy (a private organization).

Shared vision is the prerequisite for success and success is determined by measuring appropriately what is appropriate to measure. Dedicated resources are crucial and you must also have staff members with assigned responsibilities. Each partner’s role must be clearly defined, and while partners govern the effort, the lead agency must manage it. It is also important to remember that sharing power grows power. Collaborative leaders can be developed, but more importantly, we need to teach organizations how to collaborate – particularly public health agencies where leadership and governance can change regularly. Teaching organizations to collaborate may be at least as important as having good collaborative leadership. When partnerships and collaborations are successful, there is momentum and a palpable energy that raises the level of performance.

Principles of the Ethical Practice of Public Health

1. Public health should address principally the fundamental causes of disease and requirements for health, aiming to prevent adverse health outcomes.
2. Public health should achieve community health in a way that respects the rights of individuals in the community.
3. Public health policies, programs, and priorities should be developed and evaluated through processes that ensure an opportunity for input from community members.
4. Public health should advocate and work for the empowerment of disenfranchised community members, aiming to ensure that the basic resources and conditions necessary for health are accessible to all.
5. Public health should seek the information needed to implement effective policies and programs that protect and promote health.
6. Public health institutions should provide communities with the information they have that is needed for decisions on policies or programs and should obtain the community's consent for their implementation.
7. Public health institutions should act in a timely manner on the information they have within the resources and the mandate given to them by the public.
8. Public health programs and policies should incorporate a variety of approaches that anticipate and respect diverse values, beliefs, and cultures in the community.
9. Public health programs and policies should be implemented in a manner that most enhances the physical and social environment.
10. Public health institutions should protect the confidentiality of information that can bring harm to an individual or community if made public. Exceptions must be justified on the basis of the high likelihood of significant harm to the individual or others.
11. Public health institutions should ensure the professional competence of their employees.
12. Public health institutions and their employees should engage in collaborations and affiliations in ways that build the public's trust and the institution's effectiveness.

Public Health Leadership Society

www.phls.org

© 2002

Reprinted with permission.

Ethical Issues Surrounding Pandemic Flu Planning

Issues around Flu Pandemic Preparation	Principles of the Ethical Practice of Public Health											
	1	2	3	4	5	6	7	8	9	10	11	12
Isolation and Quarantine												
Vaccine Priority												
Antivirals												
Community Containment												

Concurrent Session *A Case Study to Demonstrate the Principles of the Ethical Practice of Public Health*

INTERACTIVE SESSION

Terry Brandenburg, M.B.A., M.P.A.
Health Commissioner
West Allis Health Department
(Wisconsin)

During the course of this session, we will fill out the matrix: ***Ethical Issues Surrounding Pandemic Flu Planning*** and use it to demonstrate how to incorporate the Public Health Code of Ethics into practice. This will be an informal discussion of issues and perspectives that need to be brought out when disaster planning begins.

The media has focused on this issue with headlines like “killer flu to strike America.” Because of all the media hype, there are many misconceptions out there that probably work to our disadvantage. Public health professionals have the dubious task of coming up with good, sound public health policy and planning while rumors and urban legends plague us. We need to ask ourselves, “What are we, as public health leaders, going to do to protect the citizens of this country?”

Let’s begin with the following scenario: the state has convened a planning meeting of public health and pandemic flu experts to debate and discuss how to address such hot issues as isolation, quarantine and vaccine prioritization. Hopefully, you will have the Public Health Code of Ethics (hereafter referred to as the Code) on the table as you discuss strategies. Today, we are going to take this opportunity to incorporate the Code into our discussion and see what we can do with it. I hope this experience will help you when you go home to think about a more formal process for pandemic flu planning.

We will make some assumptions about the pandemic flu epidemic to create a context for today’s discussion:

- The flu will arrive with very little warning.
- It will spread rapidly across the United States.
- It will follow a pattern similar to the 1918 pandemic (The first wave lasted for twelve – sixteen weeks, and wasn’t bad in terms of incidence and mortality, but the second wave hit four – six months later and was devastating.
- Vaccine will not be available for at least six months.
- Antiretroviral medications will be in short supply.
- Everyone will be susceptible to the pandemic virus.

In July of 1957, the Asian influenza hit the United States. By August, the flu had spread throughout the coastal regions. It gained momentum in September and was fully involved by October. For planning purposes, this gives us a good idea of how quickly it will spread and the time you will have to implement your plans.

With our time here, we are going to walk through some of these “hot button” issues (isolation and quarantine, vaccine priority, anti-viral medication and community containment). I would like to hear from you about these issues and how you think the Code might be brought into play. Let’s start with isolation and quarantine which comes into play early in the pandemic phase. Isolation and quarantine can be a useful tool early on when the disease starts to emerge and you are trying to “nip it in the bud” before it spreads. You want to try and delay the spread so “the cavalry” has time to arrive with a vaccine and/or more antivirals. I will start our discussion by posing the following questions:

1. What are your perspectives on isolation and quarantine?
2. What is going to come up on your radar screen during your discussion on pandemic flu planning?
3. Where might the Code be able to provide guidance
4. How would you ensure that features of the Code are put into your decision matrix?

1st Participant: Both Principles 1 and 2 fit under isolation and quarantine because people have a right to be protected from ill individuals. That definitely comes up in Principle 2: *Public health should achieve community health in a way that respects the rights of individuals in the community.* Principle 1 also addresses these issues: *Public health should address principally the fundamental causes of disease and requirements for health, aiming to prevent adverse health outcomes.* In terms of isolation, we do it all the time in hospitals. Hopefully, once the public understands it is for their protection, as well as the protection of people around them, they will buy into it. However, I heard a story about the SARS outbreak in Canada. When they quarantined people in their homes and posted law enforcement officers outside to make sure people didn’t come out, the law enforcement officers asked, “So, if they come outside, can we shoot them?”

Terry Brandenburg: This illustration addresses two issues: we have a duty to protect the population, but we also need to find the balance because individuals are being affected. The hospital situation is also a good example, because it happens there more routinely.

2nd Participant: I agree concerning Principles 1 and

2, but I think Principle 3 would also apply. *Public health policies, programs, and priorities should be developed and evaluated through processes that ensure an opportunity for input from community members.* As we work on updating quarantine and isolation laws, we need to get input from the community.

I think that Principle 4 is also essential. Your whole community needs to understand what you are doing, so they won't have the perception that you are targeting a certain group of people for reasons other than illness. *Public health should advocate and work for the empowerment of disenfranchised community members, aiming to ensure that the basic resources and conditions necessary for health are accessible to all.*

3rd Participant: With quarantine and isolation, communication is going to be especially important and we must make sure that we communicate with the public in a culturally and linguistically appropriate manner. Principle 4 infers that we can create a different perception of isolation and quarantine through culturally and linguistically sensitive communication.

I would also add Principle 7: *Public health institutions should act in a timely manner on the information they have within the resources and the mandate given to them by the public.* With quarantine and isolation, it will be critical that we act in a timely manner.

4th Participant: I am troubled about the use of the Code in this setting, partly because, as was rightly pointed out, Principle 2 points to the right to be protected from ill individuals, but it also points to the rights of people not to be forced to stay in their homes by armed men. Historically, when there were debates in Congress over quarantine and isolation, usually things fell in favor of commercial activity over public health. For instance, ships with yellow fever were not forced to stand outside of port for very long, but were allowed to go about their business despite the public health risks. So, a circumstance like this does not answer the question. Various points obviously are applicable, but various points also contradict each other and themselves.

The flu pandemic situation is, hopefully, an abnormal situation and the Code, more or less, addresses normal practice. In an abnormal situation, there are doctrines called "doctrines of necessity" which are shown in things like the Emergency Powers Act, which set aside ordinary ethical ideals.

I think you were doing the right thing at the start of our discussion, in that you were not so much looking at the Code for answers, but trying to hold on to a few easily remembered principles. As long as we

hold on to them in some way, we can think through these issues. I think there are ways the Code is valuable, but there might be other ways that the Code might hinder us from being clear about our objectives.

Terry Brandenburg: Thank you for two very good points. Depending on the issue, you may find conflicting principles. This exercise is designed to pose questions and it is a balancing act. While we are looking at this from a public health ethics perspective, this is not the end-all to your decision-making process. As you said, there are other venues, legal issues, public health practice issues and the political arena where we have to ask similar questions. We are trying to look at issues from an ethical perspective and identify issues that really need to be on the table and part of the discussion process. Then, when you're in a broader and more diverse planning group, hopefully you'll have the Code on the table, along with the legal, political, and science planning groups, to help guide decision-making. Your example about how economics often sway decisions is a reality check. At a minimum, these principles should be on the table. They may be brushed aside, activated, or partially acknowledged and used, but they will at least be a part of the discussion process.

5th Participant: In a public health emergency, there is a direct conflict between the public's good and the individual's liberty interests. Although they are in conflict as far as an ethical analysis is concerned, it is important to simply recognize that both need to be accommodated. I think the first two points here do that. It won't just be public health ethics sitting at the table, but also politicians and lawyers. To a large extent, there is an overlap in all of these fields – politics, ethics, and law. But for public health advocates, it's our job to bear these in mind.

Regarding Principle 3 concerning advanced communication, you want the public to understand ahead of time that the public health agency is to be trusted. We do not have enough police to guard homes, particularly in a pandemic. We need to get community buy-in and build trust before crises happen, so when voluntary health measures are announced, we won't need to resort to using the police (except in a very few instances).

Terry Brandenburg: Great perspective! If you feel that open communication, community participation and the Code should be a part of your decision making process, how would you incorporate them into a planning step? Would you use town hall meetings, focus groups or stakeholder analysis? How would you approach the problem? You could have a similar discussion about planning for other issues such as infant mortality, tobacco prevention and lead

poisoning, but in all of these situations, communication is the key.

5th Participant (again): Our governor convened a citizen's panel of stakeholders to hear proposals and presentations about the issues facing the state public health agency. The plan was publicized on the web and is available to the public for comments. I think it is a good idea. If you can communicate to the public in advance the reasoning behind your decisions, they will have some time to adjust, even if they don't agree with it. They will have a chance to see some of the logic behind it and you could change the political will and even end up benefiting from it -- they may be willing to pay higher taxes to increase your ability to protect the public. If you have the luxury of telling people ahead of time about what you are going to do and why, you could conceivably head off a social crisis.

Terry Brandenburg: Building on that, you need to take one more step and decide how you are going to communicate to the public. As you know, communicating any concept around public health to your community, county or state can be difficult. Perhaps your plan would include not only the decision process and the need for communicating it, but specific steps or strategies for how you will communicate your message. It's important to think about the structure, timing, and type of message you create and how it is delivered to the public.

6th Participant: Our ideas of quarantine come from when people took care of the ill at home. If someone was ill, the health care provider would come into the home. Today, most of our illness is diagnosed after long waits in public waiting rooms, leading to more people being exposed to a disease and possible quarantine (including health care providers and hospital staff). Even if we are the first site where the disease is diagnosed, we will already be well into it and past containment. If we have warning, because it has happened elsewhere in the country, we can do some pre-planning. But, if we are the one's doing the diagnosing, we are usually diagnosing in emergency rooms or doctors' offices.

Terry Brandenburg: That's a good point. When the West Nile Virus hit the Midwest, we had the luxury of having a year or so to plan, but when it hit -- it hit hard! Many things hit the coasts first and I see the pandemic flu hitting the same way. However, it will move a lot faster, and with the limited time frame we will have in which to act, isolation and quarantine may be beneficial.

Let's move on to vaccine priority. We hope that the "cavalry" will arrive with a vaccine after some point in time. We will probably have six -- twelve months of social isolation and other attempts to contain the illness. But, when your allotment of

vaccine finally comes rolling in and there is not enough to go around, are there pieces of the Code that can help you in your decision-making process regarding prioritization?

7th Participant: I think we need to recognize that this is a no-win situation. This is an issue that hits disenfranchised populations. This brings to mind the scene from the movie, *Titanic*, where the doors were locked on the third class passengers and they were left to die, while the rich were saved. I think these issues will be extremely prominent and we will need to keep the public informed with accurate information, bearing in mind that information will change continually. This relates to Principle 7: *Public health institutions should act in a timely manner on the information they have within the resources and the mandate given to them by the public.* Principle 5 is also important: *Public health should seek the information needed to implement effective policies and programs that protect and promote health.* We will have to have some basis for making decisions regarding who gets the vaccine. I assume some protocol would come from the World Health Organization (WHO) or the Centers for Disease Control and Prevention, but we will have to have some rationale as to why those policies are what they are.

Terry Brandenburg: We saw this in the last couple of years during the flu season. There was a vaccine shortage and some priority groups were identified. This gives us a snapshot of what we might be seeing in a pandemic flu outbreak. You mentioned underrepresented groups and we are looking at situations right now in terms of access to care. We know we have the "haves" and "have-nots." Since you identified this issue, how would you plan for those who do not have access to care? How would you approach this from a planning perspective?

7th Participant (again): All of us look at vulnerable populations as part of our planning. Ideally, we will have a wonderful plan in which all vulnerable populations will have access to care. I don't think we will ever quite get there, but I think the first step is identifying these populations, and then being able to speak to them. We need to know what language to use, not only for those who are bilingual or don't speak English, but for those who aren't going to read the newspaper and other populations, as well.

Terry Brandenburg: I hope you're seeing a pattern here as we talk about these issues in light of the Code. The Code can prompt you to consider areas where you may need more detailed planning so that your plan is more comprehensive in anticipation of an event.

Are there other perspectives on vaccines and a vaccine shortage?

8th Participant: I'm taking a look at number 9 in the Code: *Public health programs and policies should be implemented in a manner that most enhances the physical and social environment.* We don't know what the criticality of the shortage will be, but I'm thinking about the care of caretakers. The people who take care of caretakers certainly enhance the physical and social environment and should be considered when we are talking about vaccine priority.

Terry Brandenburg: I fully anticipate that priorities will be handed down to us and guidelines will be created. But, my experience tells me that we won't get the details we need from federal or state agencies. We will still have to contend with the local decision-making processes in order to have a good plan.

9th Participant: I wanted to share what we did in my area with vaccine priority and delivery. We started monthly pandemic flu planning meetings with a community group in October, 2005. We constructed a 12-month timeline of activities and decided what our priorities would be. Our first priority was communication, followed by pre-education. We hosted a series of four meetings for the business community. During these meetings, we talked about vaccine priority. We went through a hypothetical scenario and discussed who should be on the vaccine priority list (e.g., doctors, infants and the very youngest in our society, the ill, central power workers, etc.). We handed out a list with twenty priorities and instructed the audience to pick three groups to receive the vaccine. This was a good process, not only because it gave us a survey of their top picks, but it helped them realize how difficult it is to make these kinds of decisions. After this exercise, they stopped being so territorial and focused on moving forward on this issue. Sometimes just involving the community in making ethical decisions is important.

Terry Brandenburg: It sounds like you were looking for citizen input, especially from those who would be affected by the decision. You took an ethical principle and translated it into a rather detailed community engagement process to help you get some guidance concerning this issue. Your illustration is outstanding in terms of people realizing the difficulty of making these kinds of life and death decisions.

10th Participant: I work mostly with disenfranchised populations, and I believe you should include them from the point of view of Principles 4: *Public Health should seek to advocate and work for the empowerment of disenfranchised community members, aiming to ensure that the basic resources and conditions necessary for health are accessible to all.* and 8: *Public health programs and policies should incorporate a variety of approaches that anticipate and respect diverse values, beliefs, and cultures in the community.* We tend to forget that these so-called

disenfranchised populations are the ones who have paid the highest price in mortality and suffering when there has been a pandemic. There is no reason to believe that things will be any different if there is another pandemic.

Currently, my agency is giving out information about what we expect to see in case of a pandemic, the reasons why people should be vaccinated, and in what order. They may not believe us, and some might say, "Remember Tuskegee?" But, we are trying to prevent massive migrations of people from different cultures who want to gather their families together in a time of crisis, and in doing so, potentially spread disease. So, communication with disenfranchised populations, especially those from various cultural groups, is a key component in these efforts.

Terry Brandenburg: What should your local health officer be doing to assure that these underrepresented groups are recognized and incorporated into your community's comprehensive plan?

10th Participant (again): We have already translated the lay person's presentation that is posted on the Bioterrorism Preparedness Center website. We use it to help establish a dialog with communities that don't speak English. They are not dumb; they understand that there are key groups in society, and they are usually excluded from those groups. Our biggest challenge is trying to convince them not to move around in the case of a pandemic. We must reach out to all disenfranchised communities and not wait for them to come to us.

Terry Brandenburg: This is an outstanding example. You took the initiative, identified the need and provided the necessary support to make something happen. I would love to see this replicated in every community; community partners stepping forward and becoming part of the process.

11th Participant: We have formed community task forces and have had a local congressmen host a town hall meeting with over 100 people in attendance. But, we have also hosted events where only three people showed up. Has the public been numbed by all the information they have seen and the fact that there is no pressing threat?

In the scenario you presented about vaccine priority, much can happen during those six months while you are waiting for the vaccine to arrive; and, those events will affect the next step. We will have to deal with situations as they arise, before answers come down through policies, recommendations, and regulations from federal and state agencies. We must keep our infrastructure intact in order to do what we

are there to do – practice public health and deal with all the ethical implications that go along with it.

We are making plans with input from the community. We are seriously looking at what happens after influenza has blown through. Should we build a small cache of antivirals to treat subsequent pneumonia? Who will get it first? Again, we need to maintain a healthy infrastructure

Terry Brandenburg: Well put. If you are looking at antivirals now, they will be your front-end defense and it won't be 6-12 months later. Once again, you will have to address the prioritization issue. Will you treat the ill or use it for prophylaxis? Where in the decision process will the people come in?

12th Participant: What are people thinking regarding antivirals, and decisions concerning prophylaxis versus treatment in light of the large quantify difference needed? Do you wait to treat them until after they have the disease, or do you treat them ahead of the game when there is a limited amount and you'll have another wave coming?

Terry Brandenburg: What about the haves and have-nots and access issues? If that is an important principle for you, how are you going to weave it into your plan?

4th Participant (again): I agree that planning, even if things don't go as planned, is extremely helpful. We are better off planning and rehearsing, even if we're wrong about some things, than if we don't make plans. At the same time, I am struggling, as a philosopher, to keep things relatively simple. You keep coming back to including a broad representation of the community, including people who tend to be disenfranchised. I think that is a wonderful way to plan, but then we must ask: "Who is to be involved?" and "What are we going to talk about?"

Are we talking about saving as many lives as possible? If this is the case, people in the commercial, political and legal arena would be interested in all the speculation about whether or not to stockpile. Politics and economy also support life-saving and aren't necessarily extraneous forces. Rather than balancing a miscellaneous set of principles, isn't our goal to maximize our public health efforts and save as many lives as possible?

Terry Brandenburg: I would look at Principle 1, which I believe is core to public health and to any public health practitioner: *Public Health should address principally the fundamental causes of disease and requirements for health, aiming to prevent adverse health outcomes.* Our mission is saving lives, and that is why we are in the business; but, economics and politics are major forces that will come into play.

11th Participant (again): Not to oversimplify it, but it seems that the "what" is pretty clear. It is the "how" that we are getting hung up on.

4th Participant (again): We would need to look at the strength of politics and political forces, and ethics as a force in this decision-making process. I maintain that certain institutions are there to save lives. There is ambiguity in who gets the vaccine. Should our focus be on maintaining certain institutions, or saving lives? Would we vaccinate the police because we need a police force? What about home nurses? Do we save the Mayor, because we believe in political forces? What about our way of life?

Terry Brandenburg: If you were to convene key individuals in your community, state or nation, wouldn't that help set the tone for these decisions? You would bring the seriousness of these issues to the forefront. Opinions will vary greatly, but once again, there are ethical principals in our practice and it would be wise for committees and beneficial for our communities to have these principles on the table during the decision-making process.

4th Participant (again): To focus the conversation, perhaps the Code can be used as a device to help us with the questions: "How is this going to help us maximize the number of lives saved?" and "How will we protect public health by this measure?" We need to come together to create a consensus and to focus the conversation.

5th Participant (again): I don't disagree with anything that has been said. But, I think it is interesting to look back at the lists of people that were slated to be taken into bomb shelters during the Cold War. I think we are all interested in saving lives, but whose life is the best to save? The elected official who plays a role in maintaining order in society or the police chief? Maybe the patrolman would be a better choice? I think these ethical principals still have application. It is going to be a tough decision and mistakes will be made. But, at least you have some time to consider these choices in advance.

Terry Brandenburg: We have experience in prioritizing vaccinations and medications in short supply, but this last issue of community containment gives me the most consternation in terms of planning.

In my area of southeastern Wisconsin, twenty-three health departments have banded together and come up with a regional pandemic flu plan. We are all committed to the process and it includes major media outlets, commerce, and representatives from various populations. We think it is a wise plan. We have tried to plan for things like vaccine distribution and other core public health essentials. However, community containment is a hard issue to address. What do we do about

schools? What about businesses, shopping malls and commerce? If your business community was silent about quarantine and isolation during the planning process, are they going to be active when you restrict people from moving in and out of their places of business? Absolutely! What about churches? I believe you can use the Code to address these issues as they surface during your planning process.

13th Participant: In my organization, we have been thinking about what public health employees are central to carry out the mission should there be a pandemic. We have asked such questions as: 1) Do I need to go to work? 2) Can I work from home? 3) Will I need to be home to take care of my family? and 4) What will happen to me if I have a disease and I am one of the members of society who is disproportionately impacted by this? I think there are two principles that we have yet to talk about. Principle 11 states: *Public health institutions should ensure the professional competence of their employees.* Principle 12 states: *Public health institutions and their employees should engage in collaborations and affiliations in ways that build the public's trust and the institution's effectiveness.* I think these principles could impact each of the categories on the decision matrix. We need to make sure that any employees working within an institution understands how to deal with each of these issues.

Terry Brandenburg: The ten essential services and the Public Health Code of Ethics were designed to be linked. So, if you commit to these principles, you commit to having a workforce that is competent and able to serve the public to the best of their ability.

14th Participant: In public health, we take care of everyone else, but we don't always take care of ourselves. My small staff recently participated in an exercise to determine a "continuation of operations" plan. We realized that there are not many people to take our place should we be unable to carry out our duties. Within our public health ranks, we have to make decisions about what we are going to do and how we are going to take care of ourselves so we can do our jobs and help take care of the rest of the population.

5th Participant (again): The Great Plains Public Health Leadership Institute put together a booklet that is intended to guide public health departments in implementing corrected health measures, if and when they need it. They included a letter to employers should the health department find it necessary to isolate or quarantine an employee. The public health department would contact the employer and verify the legitimacy of the illness so the employee isn't fired.

Another issue is who will pay if quarantine is imposed. Historically, health measures have been the responsibility of the county, so if the county imposes quarantine, they are responsible for paying for it. The financial burden works as a disincentive. There will be powerful, countervailing interests at work during a pandemic. Even if you're a business person who recognizes the public health threat, if you know that the bank holding the notes that finances your factory might not be forgiving, you're going to want to stay open. This brings us back to preplanning and communication. We need to show people with legitimate interests that it is in their best interest to shut down for a certain amount of time and, in fact, it may help them to reopen sooner.

We also need to consider honest hierarchical needs. We can tell someone to stay home, but if they run out of baby formula, they won't stay there. Your public health agency may have to find a way to meet basic needs for 40 percent of the folks who are ill. I suspect the police force might not be too keen on delivering groceries either...

15th Participant: Fast forward a year or so after a pandemic has taken place. What are the practices we will use to look back and assess the ethics of our behavior? How do we build accountability into our prospective planning so that we can have feedback? How do we know, after the fact, how well we did so we can build on our lessons learned? Can we incorporate this feedback into future workshops so that survivors will have a chance to see how well we did in our prevention efforts and also see the consequences of our ethical actions, both intended and unintended?

Terry Brandenburg: I would think there would be performance critiques across the board in the medical, legal and, hopefully, ethical arenas. Our intention is to get the Code on people's radar screens so that it can be a part of their tool kit for preventive public health practice. The Code isn't carved in stone; it is a living document. I hope we won't have to apply it to pandemic flu, but if that does happen, then you go back and critique public health performance across the board. In addition, you also look at how well the Code functioned in terms of planning and decide if it needs to be changed. The Code will undergo changes as we progress in our public health practice as new things come our way. Pandemic flu would be a huge test for the Code and I would expect that it would be revisited after such an event.

15th Participant: Perhaps there is an opportunity for the Code to be applied to Hurricane Katrina – something that has already happened. Given the location of the Public Health Leadership Society in New Orleans, it might be appropriate. So from a public health perspective, we might be able to retrospectively assess our actions through the

Katrina lens; we don't have to wait for a pandemic. From a social perspective, it already happened.

Terry Brandenburg: We have applied a retrospective approach in workshops on smallpox prevaccination. We could also do a retrospective of other major public health events. In conclusion, I am

delighted with perspectives. I hope this was helpful and you will consider using the Public Health Code of Ethics to better your public health practice.

Concurrent Session

Models of Performance Accountability

Kathleen Wojciehowski, M.A., J.D.
Director
Missouri Institute for Community Health

Good afternoon. My job today is to tell you how Missouri got into the business of accrediting local health departments. People started thinking about this in the early 80s. In 1995, the head of the Missouri Department of Health put together a taskforce to examine the public health community and make recommendations about accreditation. The national public health performance standards were starting to surface, but things weren't happening fast enough. So, we put together a taskforce which consisted of academics, elected officials, and representatives from local and state health departments, health care associations, and professional health care provider associations. They shared in designing our standards. Initially, they made a recommendation to the Department that a non-profit agency be responsible for this in Missouri. The reason for this is that we have the Hancock Amendment in our state which essentially means that if the state mandates a program to a local entity, the state has to pay for it. Missouri was not in a position at the state level to recommend mandated accreditation because of cutbacks.

At that time, I was the director of the Center for Local Public Health Services and we had a Turning Point grant from the Robert Wood Johnson Foundation. We looked at what a model agency might look like and started the Missouri Institute for Community Health. During this time, standards continued to be discussed in Missouri. It took a long time because we did everything by consensus. Some issues were particularly challenging, such as workforce education requirements, but eventually the standards were approved. We conducted a pilot run in seven agencies and came back to the drawing board during the summer of 2002 to refine them. We wanted to bring our standards closer to the national public health performance standards and to the Ten Essential Services.

The first round of accreditation began in 2003 and the Kansas City Health Department was the first agency to be accredited. Since then, we have had ten additional agencies apply, go through the process and be accredited. We have 114 agencies in Missouri, but only ten have completed the process. We now have to figure out how we can make things more feasible for our smaller, rural agencies.

One of our goals for the accreditation program was to focus on accountability. We wanted these health departments to be accountable to the public they served and to their governing bodies and

elected officials. We wanted to insure that our public health workforce would be as current as possible and using the most current science available to serve their populations. When we set up our standards, we looked to see what we could actually measure. We looked at infrastructure, process, and how professionals in their agencies did business. Hopefully, someday we will be able to look at outcomes (tracking the result of an intervention), as well. As you know, looking at public health outcomes is very difficult because we are looking 20 years into the future for some of them. In Missouri, as in most other areas, we are trying to come up with some short-term indicators that we will be able to measure. We had to decide how we were going to measure our program. We couldn't do empirical measurement because we didn't have anybody else to compare our program to. We were the only volunteer program in the nation, and actually, I think we still are. So, we came up with using absolute standards. If there was science that we could apply toward a standard, we used it. If we didn't have science – we hammered out the standard by consensus.

The model itself, as I said before, is voluntary and has two components. We have performance standards, and we have agency infrastructure. In Missouri, we have three levels of accreditation: primary, advanced and comprehensive; because, in our state, one size doesn't fit all. We have 114 autonomous agencies, and some agencies have as few as five staff members while others have over 800 employees (e.g. St. Louis County Health Department). Our service areas vary as well. The smallest area we serve has between 2,500 – 4,000 people and our larger areas serve up to a million people. Most of our population in Missouri is concentrated in the metropolitan areas which are St. Louis, Kansas City and Springfield.

We have forty standards, with individual performance measures that go with each of them. The new cycle is just unfolding and will be introduced in January of next year. It will require every agency applying for accreditation to meet at least one measure in each of the standards. If they don't, they cannot be accredited. We are looking at how the agencies contribute to the community health system. We are not in the business of doing contract monitoring or looking at programs. To illustrate, we do not send nutritionists to evaluate the WIC program; our site reviewers come from a variety of backgrounds. And since they aren't just looking at programs within their discipline, we had to find things that are easy to measure.

Besides performance standards, we are also looking at agency infrastructure. We are very concerned with how agencies interact with their communities. Are they doing community assessments? Are they involving stakeholders? Are

the stakeholders included in discussions that are being held? Is the agency operating in a vacuum or does it interact with its governing body and does that governing body provide leadership and direction? We also evaluate the work force. We look at key staff in each of the health departments to determine if they have met the educational requirements. And finally, we are looking to see if the agency is visible in the community. We want to be viewed as a very important part of the community health system.

In our model, we have four steps to complete. First, if an agency decides that they want to apply for accreditation, they must pay a fee. We charge \$1500 - \$1800 for primary agencies, and up to \$4,000 for a comprehensive agency. The fees do not cover the cost of doing business, but it does force the agencies to take a financial interest in being accredited.

Once the agency applies for accreditation, they are given a password and can go to our website and take the self-assessment. The self-assessment is the real "heart" of accreditation in Missouri. This process can take anywhere from four months to a year to complete. Our self-assessment is the quality improvement component of our accreditation process. Agencies get to see where they need to tighten up processes, make sure workforce is appropriately trained, and assure appropriate services are being provided to the community. Once they are ready with their self-assessment, they are visited by site reviewers. Three reviewers are scheduled and we have a liaison person that accompanies them, as well. The reviewers will spend up to four days on site conducting their review, depending on which level was applied for and how well the agency is prepared for their visit. When the reviewers leave, they conduct an exit conference and they give them a little indication of their strengths and weaknesses; however, they do not tell them whether or not they will be recommended. The reviewers turn in a report to the accreditation council; the council looks at it to make sure that it is in accordance with the standards; and the council makes a recommendation to the board of directors. The board of directors issues the decision in Missouri. All this is done within thirty days because the agencies are anxious to know their outcome.

In Missouri, we are very interested in measuring structure and process with our accreditation standards. Although we set minimal standards, for some agencies, they are challenging. Some of our agencies have been very honest about the fact that they had to make sure that their staff was appropriately trained. While going through the process, they discovered that some training sessions were missing and some processes hadn't been shored up in a while. The process helped them

improve quality and raise the bar. This is very definitely a quality assurance approach.

Accreditation has been very important to the ten agencies that have gone through the accreditation process. Each one of them has indicated that the most valuable part of the process was the self assessment. It provided them with a vehicle for taking an introspective look at what they are doing. Very positive changes have been made as a result of those self-studies. Once accredited, they received recognition from their communities and their funders. Several of them have already received additional funding because they are accredited.

We have learned a lot and we are continuing to refine our accreditation process. We are finding that running an accreditation program takes a lot of time and effort and we have to constantly fine tune our standards. This is a virtual organization and we have part-time consultants. Consequently, the real "heart and soul" of this organization rests in the volunteers on the accreditation council and the board of directors. They work very hard to make sure that the standards are current and we avoid duplication.

Finally, evaluation is the "heart" of what we do with accreditation. If you want to do something here in Nebraska, I would recommend that you start with your evaluation program from the very beginning. We do a process and impact evaluation with our agencies that go through the accreditation process. After they have been accredited, they do a one-year impact evaluation which helps them receive some recognition from the community. It also helps them see if their funders are acknowledging their change in status. Our reviewers also go through an evaluation process to make sure that our process is as tight as it can be. We are always refining our evaluation to try and make sure that our reviews are consistent from one to the next. We conduct training sessions twice a year for our reviewers, using a case study approach with them. We are just starting to establish some data baselines so that we will have some benchmarks for future performance measures. We are also starting a database of effective practices so that agencies applying for accreditation will be able to find out what processes helped other agencies when they went through the process and whether those processes might be of assistance to them. We have come a long way in Missouri, but we still have a long way to go.

Les Beitsch, M.D., J.D.
Professor of Health Policy and
Director, Center for Medicine and Public Health
Florida State University College of Medicine

We can learn a great many lessons from Missouri because Missouri looks a lot more like what a national accreditation system might look like than any

other system out there. They have been very willing to share information, and in fact, North Carolina, who is developing an accreditation program from the ground up, has borrowed a lot of their standards and processes from Missouri. Other states have expressed their gratitude for Missouri's inspiration and guidance, as well.

Everybody across the United States ought to be able to receive a fairly consistent level of care from public health services. The ten essential services can serve as a building block to insure quality. Why should we use the ten essential services? First, we have a lot of trouble speaking the same language. Whether or not you are a fan of the Ten Essential Services, it gives all of us the opportunity to be on the same page. Second, we tend to talk very programmatically. The Ten Essential Services enable us to talk about organizations and the practice of public health, rather than specific programs. The National Public Health Performance Standards can help us build a strong foundation for communication as well. If we are going to talk about moving our whole profession forward, we have to raise the bar. We must "think boldly" and set the bar of expectations high. We need to change how we think about ourselves. We debate over whether we should require a Bachelor of Science, Nursing (BSN) for certain positions, but the reality is, if we were the police or fire department, we wouldn't be having this conversation. We would insist upon the higher level of training, and funding would follow. This is not where we should be. It's not enough and we should demand more.

If you run a public health organization, how do you know you are doing a good job? We all want to know how to do our job better. What are the data points that we use to think about such things? By the same token, when things aren't going the way we want them to go, what are the sentinel sources of information that tell you your organization is going in a different direction from what you had planned? Your staff may tell you, or the board of health, but that's generally a bad sign... For most of us, we want to think about something more systemic and systematic.

Balanced Scorecard did some fabulous research and found that nine out of ten companies fail to execute strategy. They identified the following barriers to strategic implementation: vision, people, management, and resources. They discovered that 60 percent of organizations do not link their budgets to strategy. I think that number is low for public health. If we say something is a public health priority in our state or organization, but don't put any funding toward it, how much of a priority is it really? Is it going to be implemented the way you intended for it to be? It's not going to happen. So, if we are going to think

and talk about performance, we need to start with strategic planning and budgeting.

Assessing organizational capacity is also important. You need to know what your baseline is: what are your organizational strengths and needs? Accountability is another issue. Public health systems (governmental public health agencies, partners -- the entire collective), whether regional or local, need to be accountable. Too often, we want to escape this accountability. We do ourselves a great disservice when we aren't held accountable. If we want more resources to do the things we think are important, we have to demonstrate that we are accountable for the resources we already have. By the same token, we also have to be very clear that when given inadequate resources, we can't accomplish all that is expected of us.

Where does this discussion lead us? Hopefully, it leads to accreditation and standards. Something has bothered me for years; why is it that every other aspect of the health care delivery system has credentialing or accreditation standards? Why do we think this shouldn't apply to us? Clearly, it is not serving us well. One of the rationales for not having accreditation and standards is that each health department is unique and each area is different. This is true; your health department is unique and your area is different. But, if you think about public health at the macro level, all of our organizations are far more alike than different. We have chosen to emphasize our differences, rather than our commonalities, and it has not served us well.

The multi-state learning collaborative has been showcasing five states (Missouri being one of them) that are moving forward with accreditation. We have learned a phenomenal amount from them! However, if we want to move forward, we can't just focus on local health. We must include our state public health agencies and our federal partners. So far, really only Washington State has done a sophisticated kind of examination and put forth a process that looks at accreditation at the state level. We need to do a lot more work in this area.

The Robert Wood Johnson Foundation (RWJF) and the Centers for Disease Control (CDC) convened a group of interested public health stakeholders back in December, 2004. They posed the question "Is accreditation desirable and is it feasible?" The timing for this meeting was interesting because it was literally ninety years later from the time the first public health accreditation debate began. The first public health organization that considered accreditation for public health was the American Medical Association (AMA). Not to be outdone, the American Public Health Association (APHA) thought they needed to be part of the process and began accrediting and certifying

organizations who today are the metropolitan health departments of the country. This lasted until approximately 1947. A few weeks back, I stumbled across the accreditation instrument used in 1927. They did it programmatically – they didn't have the Ten Essential Services as I'm sure you know. In looking through the list of programs and their questions, I discovered that we could use the same instrument today, except for the question about the pasteurization of milk. We have that down...

CDC and RWJF gave a substantial amount of money to the National Association of County and City Health Officials (NACCHO) and the Association of State and Territorial Health Officials (ASTHO) to pull together a national steering committee. Their goal was to make definitive recommendations regarding the feasibility and desirability of a voluntary national accreditation system. They worked closely with APHA and the National Association of Local Boards of Health (NALBOH). The steering committee concluded that a voluntary national accreditation system would be feasible.

The system would build on things we already know. (The work of the multi-state learning collaborative in Washington State, North Carolina, Missouri, Illinois, and Michigan is extremely important here.) It has a strong potential for funding and would include a technical assistance component. There are people out there who believe that with the help of startup dollars, a technical assistance component is feasible. Again, look at what these states have already done. You heard how Missouri is starting to collect a set of effective practices. Michigan is doing the same. One of our goals is to increase the evidence base and this will help.

Who is going to do accreditation? The steering committee concluded that there was no known organization that should do it, largely because everyone has staked out a niche for themselves. Because it is a new area, they concluded that it would be more efficiently done by a new organization that worked very closely with other organizations. And because there are states out there that are already doing accreditation, they should work closely with them.

Questions regarding the role of the governing board had to be addressed. How many members should be on the governing board? Most people think nine to thirteen is the optimal number to get something done. The primary function of the governing board is to establish the standards. They have to make decisions ultimately about the accrediting status of agencies and organizations.

One of the important points that came out of their report was the need to conduct research. If you look at the body of literature from various

organizations (health care, mining, manufacturing, any kind of sector), the research appears to be either incredibly shallow or nonexistent. We need to be able to answer questions like: "Does the accrediting process improve the function of your organization?" and "Does it lead to actual outcome improvements?" In this public health research, we need to measure midterm, intermediate and long term outcomes, so that we can bring about change and improve the function of your public health organization. Other health care organizations are just starting to look at outcomes. Public health is trying to incorporate them into the accreditation process from the very beginning.

Who can be accredited? Everybody you know -- any governmental entity with primary legal responsibility for public health in a state, territory, or tribe or at the local level. Guidelines for developing standards include promoting the pursuit of excellence, improving performance and strengthening accountability. I think there needs to be a deliberate and careful process, but if we are going to do this by consensus, we aren't going to get where we need to go. We need to have a very transparent process that involves everyone, but at some point, we have to set some standards and move forward.

What should the standards look like? The Exploring Accreditation Steering Committee created eleven domains for which agencies should be held accountable. They look like the Ten Essential Services with a stronger emphasis on quality improvement and an additional domain regarding the use of resources (human, financial, and physical). Accreditation is costly. In general, people are supportive, but want to know "What will it cost?" Fees must be affordable and the accreditation process should be designed with cost control in mind.

Why should agencies apply for accreditation? In creating incentives for people to motivate them to be accredited, much thought must be given to make sure they are positive and not punitive. Positive incentives include being recognized for high performance and quality improvement, demonstrating accountability to the public and governing bodies, gaining improved access to resources and being part of a learning community dedicated to excellent health outcomes.

In Missouri, one of the county health departments gained enormous clout with their board of health and their county commissioner after being accredited. They were able to get ordinances passed that previously did not have sufficient backing. This type of recognition really means something. We are hopeful that some grant-makers and even some of our federal partners will facilitate or simplify grant application processes, or in some way give extra credit to accredited organizations.

Evaluation and research have not been done well on virtually any type of accreditation process. We need to be sure that we get it right so that our progress isn't hampered. We need to use logic models to provide a framework and determine the confidentiality of our data at the outset. Key questions must be built into the evaluation such as: "Does accreditation result in improved agency performance?" and "Does agency performance influence health outcome?" At some point, there must be some indication that improved health status is connected to accreditation or your funders may not support it.

The Planning Committee will meet next week to determine how to implement the national accreditation program. They will set up a governing board, develop a detailed business plan and set up the organization. This new organization will develop the standards and begin pilot testing.

Through a grant from RWJF, the National Network of Public Health Institutes (NNPHI) and the Public Health Leadership Society (PHLS) established a multi-state learning collaborative to explore and enhance accreditation-like programs already in existence. Twenty-three states expressed interest in participating and eighteen states applied. Five selected states received up to \$150,000 for twelve months to enhance their existing systems.

The idea behind the multi-state learning collaborative (MLC) was to improve existing systems within states, promote collaborative learning (the networking and exchange of information was wonderful), provide information regarding the feasibility of a voluntary national accreditation model and expand the knowledge base for accreditation and assessment to the broader public health community.

We are fortunate to have five states that already did this. The new MLC will have their experiences to refer to. They will be able to ask them questions, get feedback, and learn from them. Our goal for the next phase is to look at how far we have improved in performance management and determine how it can be more effectively incorporated into the assessment/accreditation process.

To successfully achieve accreditation, some form of a quality improvement/performance management (QI/PI/PM) system must be in place so that no matter what the outcome is, agencies will still learn. The bottom line is, accreditation has momentum and will move forward in tandem with quality improvement.

Conference Speaker List

Leslie M. Beitsch, M.D., J.D.
Professor of Health Policy and
Director of the Center for Medicine and
Public Health
Florida State University College of Medicine

Betty Bekemeier, M.S.N., M.P.H., B.S.N.
Former Deputy Director
Turning Point National Program Office
Lecturer, Health Services
University of Washington
School of Public Health and Community Medicine

Terry Brandenburg, M.B.A., M.P.A.
Health Commissioner
West Allis Health Department
(Wisconsin)

The Honorable Dennis Byars
State Senator
Nebraska Senate, District 30

Ann Conway, M.A., Ph.D.
Director
Maine Center for Public Health's Area Health
Education Center

Paul Halverson, Dr.P.H.
Professor
Department of Health Policy and Management
University of Arkansas for Medical Sciences

Joe Kyle, M.P.H.
Director
Office of Performance Management
South Carolina Department of Health and
Environmental Control

Representative Martha McLeod, M.O.E., R.D.
New Hampshire House of Representatives
Grafton County, District 2
Executive Director
North Country Health Consortium, Inc

Representative Lisa Miller, M.P.H.
Maine House of Representatives, District 52
Senior Program Officer
The Bingham Program

David Palm, Ph.D.
Administrator
Office of Public Health
Nebraska Health and Human Services System

Magda Peck, Sc.D.
CEO and Senior Advisor, City**MatCH**
Professor and Associate Chair for Community Health
Chief, Section on Child Health Policy
Department of Pediatrics
University of Nebraska Medical Center

Richard Raymond, M.D.
Under Secretary for Food Safety
Food Safety and Inspection Service
United States Department of Agriculture

Rota Rosaschi, M.P.A.
Executive Director
Nevada Public Health Foundation

Joann Schaefer, M.D.
Regulation and Licensure Director/
Chief Medical Officer
Nebraska Health and Human Services System

Jonathan Stewart, M.A., M.H.A.
Director
New Hampshire Community Health Institute

Lisa Tuttle, M.P.H.
Director, Office of Public Health Informatics
Department of Health and Human Services
Maine Center for Disease Control and Prevention

Tanya Uden-Holman, M.A., Ph.D.
Associate Dean for Education and Student Affairs
Associate Professor (Clinical), Department of Health
Management and Policy
Deputy Director, Institute for Public Health Practice
Director, Institute for Quality Healthcare
College of Public Health
The University of Iowa

The Honorable Maurice E. Washington
State Senator
Washoe County Senatorial District No. 2
Nevada Legislature

Kathleen Wojciehowski, M.A., J.D.
Director
Missouri Institute for Community Health

