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Building Community Health Partnerships—Oklahoma Style

Neil Hann and Larry Olmstead

"Healthy Communities is our vision for Oklahoma in the 21st century. In order to achieve this vision, work must begin now to change the health culture in Oklahoma through state and local partnerships…we must find innovative ways of working together, taking risks, in order to achieve our shared vision of healthy communities. These risks include questioning the business of health in Oklahoma as well as losing the comfort of predictability…we begin a new working dialogue in Oklahoma, in which community partners engage in a stronger leadership role and state partners assume a stronger technical resource position."

This quote is from the opening paragraph of Oklahoma's Turning Point application submitted to The Robert Wood Johnson Foundation more than two years ago. As the Oklahoma Turning Point Advisory Committee and community Turning Point partnerships began this journey, change was expected to occur, but none predicted the dramatic effects Turning Point is beginning to have on Oklahoma's public health system. Risks indeed have been taken, innovative ways of working together have occurred, and communities have taken a leadership role in public health decisions with technical support from state partners. The astounding results include the nation's first public health trust authority in Cherokee County, a public health planning process in Texas County that has resulted in a new transit system and new housing ordinances to protect public health, a large coalition of partners in Tulsa with a particular focus on business that has resulted in significant community support for public health, and a formal recommendation from the Oklahoma State Board of Heath to fully implement the Oklahoma Public Health Innovation Plan.

It's all about system change

To understand the significance of Turning Point for Oklahoma, it is important to look at the history of Oklahoma's public health infrastructure and the transformations

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that are beginning to occur. Public health in Oklahoma evolved primarily into a centralized system. The Central Office of the Oklahoma State Department of Health (OSDH), located in Oklahoma City, traditionally directed public health decisions for Oklahoma. This centralized system is the result of how the OSDH was formed through the historical actions of the State Legislature, as well as how categorical funding came through federal sources. Although the centralized system resulted in some positive outcomes, including a comprehensive "brick and mortar" infrastructure with county health departments in 69 of Oklahoma's 77 counties, significant improvements in health status indicators have not been realized.

The lack of improvement in the public's health, despite a good physical public health infrastructure and a well-trained workforce, has been an area of tremendous concern for the State Board of Health and others in the health field. The Oklahoma Turning Point

Turning Point: Building Healthy Communities in Oklahoma through PARTNERSHIPS

Initiative's analysis and various other studies of Oklahoma's public health system have made it clear that the missing element is the direct involvement of communities in public health decisions. Unless communities are actively engaged not only in determining their own public health needs but also in developing and implementing solutions, improvement in community health will not be realized. As a result of the Oklahoma Turning Point Initiative's Public Health Innovation Plan, the centralized system is reorganizing itself to:

- Accept recommendations from stakeholder groups and coordinating untapped expertise between physicians and other health professionals, businesses, education, public health, citizen groups, and faith communities
- Share responsibility for a community's health
- Find ways to share resources among agencies at the state and local level
- Use available public health resources differently with greater flexibility at the local level
- Accept accountability for the outcomes of public health decisions at both the local and state levels

These fundamental steps represent an extraordinary system change for Oklahoma. For the first time, communities have an equal voice in public health decisions. For the first time, public health workers in the Oklahoma State Department of Health see their role as supportive of community-based decisions and initiatives. And for the first time, community members see the important role they play in assuring a healthier state for future generations.

What are the results of these system changes?

- Twenty-four active Turning Point partnerships
- Twenty-five additional communities that have requested technical assistance to start new partnerships
- A shift toward population-based public health activities
- A formal recommendation from the State Board of Health to use Oklahoma Turning Point's Public Health Innovation Plan as the guide for restructuring public health in Oklahoma
- The transformation of the Oklahoma

Turning Point Advisory Committee into the Oklahoma Turning Point Council that supports community Turning Point partnerships
- A new Office of Community Development established by the State Board of Health that combines, and lists on the agency's organizational chart, the offices of Turning Point, Rural Health, and Primary Care
- The hiring of a community person to head up the Turning Point Initiative and implement the Oklahoma Public Health Innovation Plan

It's all about relationships

Of course these system changes did not just happen on their own. They took people who were not afraid to redefine their relationships with one another. Key leaders in Oklahoma's counties and at the OSDH committed to spending the time necessary to build relationships and think differently about how to approach public health. Many trips were taken between Oklahoma City and Guymon, Tahlequah, and Tulsa. Many things were discussed, and some arguments occurred. But in the end, what mattered was that we all began to realize—at the local and state levels—that we simply wanted to help the people of Oklahoma. What we had been doing wasn't working. And we committed ourselves to turning things around by connecting with each other and redefining our relationships as true partners.

Now, it's not about the *state* people or the *local* people. It's about *us*, working together to build healthy communities. We simply work together as partners to improve health. If a community needs assistance in finding data, we figure out how to find the data. If someone from a community has a better idea how to improve the health of their citizens, we work together to make that idea happen.

Have our health status indicators turned around as a result? Well, not quite yet. But we are confident that these new relationships and our roles as public health partners are going to turn them around, and soon. We certainly are hopeful about the future and look forward to continued positive system changes as we work together as partners to improve our state's health.

Neil Hann, MPH, CHES, is chief of the Office of Community Development. He has been involved with the Turning Point initiative since its inception. Larry Olmstead, BS, formerly the administrator of the Texas County Health Department in Guymon, Oklahoma, helped establish the Texas County Turning Point Partnership. He recently accepted the position of director of the Oklahoma Turning Point Initiative at the Oklahoma State Department of Health.

Now, it's not about the *state* people or the *local* people. It's about *us*, working together to build healthy communities.

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

University of Washington School of Public Health and Community Medicine

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

Turning Point State Priorities for Change

As a result of a two-year planning process, Turning Point partnerships have identified a variety of public health system infrastructure changes to implement in the coming four years. Recently The Robert Wood Johnson Foundation asked the Turning Point state partnerships to identify, from their Public Health Improvement Plans (PHIP), a high-priority strategy for foundation implementation funding. The selected strategies include improving data systems, eliminating health disparities, and developing education, training, and technical assistance programs for the public health workforce.

Increasing local public health capacity

Maine, **Nebraska**, **New Hampshire**, and **South Carolina** state grantees committed a portion of their implementation dollars to go to local agencies for public health improvement through an RFP or award process. Maine and New Hampshire plan to stimulate and support the development of local health districts where none has previously existed. Nebraska and New Hampshire will partner with Kellogg Turning Point communities to replicate the Turning Point community experience. An ambitious four-year expansion of Turning Point is underway in **Oklahoma** using the Kellogg Turning Point communities as partners. The Oklahoma State Board of Health has recommended that a Turning Point process be implemented in each of Oklahoma's 77 counties. **Virginia** and Maine also seek statewide expansion of partnerships dedicated to health improvement. Virginia has identified communities as "ready, willing, or able" to begin a mobilization process. Each will receive a different level of support. Virginia, **West Virginia**, and **Louisiana** will rely on a technical assistance model to provide support development of local capacity. West Virginia has also created tools to help define the public health service structure and to set public health performance standards. **Arizona** has a unique partnership with its state library system to develop regional public information centers. These sites in communities and tribal centers will serve as "academies without walls" to strengthen local community capacity. **Missouri** will continue to support the development of seven "model local health agencies" through technical assistance, networking, and training in a new Center for Excellence in Public Health.

Data system improvement

Based on requests from communities, tribes, and other state agencies, **Alaska** will work with many partners to develop an integrated, responsive public health data system, and will develop community profiles and provide technical assistance to communities on how to access and use the information in planning for health improvement. **Kansas** is developing a statewide, integrated public health data warehouse. **Wisconsin** will construct an integrated electronic data/information system. Many states included smaller, more focused data improvement projects in their overall plans.

Elimination of health disparities

Colorado will work to build capacity in the Minority Leadership Forum and in rural communities, so they can take the lead in initiatives for eliminating health disparities in those communities. Colorado Turning Point is providing scholarships for leadership training and funds for community grants. Currently it is working with African American, Latino, Vietnamese, and rural communities that experience health disparities. **Minnesota** has focused part of its implementation funding on the work of its Social Conditions and Health Task Force. It is testing new health impact assessment tools and developing new tools for community-focused, asset-based, capacity enhancement. Kansas is working on a data system to identify and locate health disparities in Kansas.

Education, training, and technical assistance

New York is developing a Community Health Institute to strengthen the skills of the public health workforce within and outside official government agencies. **Montana** is developing a Public Health Training Institute to support and enhance the public health workforce.

Illinois has adopted a crosscutting strategy to implement a prevention focus throughout the Illinois public health system, using performance-based measurement. **North Carolina** will develop and implement a social marketing plan. In addition, it will provide training in social marketing, media advocacy, and strategic communication. **Oregon** is developing plans to change from a funding-driven system to a needs-driven system through performance management, legislative education, and statute review at both the local and state level.

Update on Collaboratives

Turning Point's National Excellence Collaboratives have been hard at work. Here's a brief update on their current activities.

1. *Public Health Statute Modernization Collaborative*—developed a framework for a model public health enabling statute (with participation by the National Governors Association and the National Council of State Legislatures).
2. *Information Technology Collaborative*—designed a survey of public health information tools in use at state and local public health agencies for eventual use as a Web-based inventory.
3. *Leadership Development Collaborative*—completed a literature review linking collaborative leadership to improvement in health status; convened a panel of national experts, recorded in video format, to inform a training curriculum of the skills and competencies needed for "collaborative leadership."
4. *Social Marketing Collaborative*—piloted a survey to inventory current uses of social marketing techniques and practices in public health.
5. *Performance Management Collaborative*—designed an assessment of public health performance management practices in the states.

More detailed information on each Collaborative is available on the Turning Point Web site at www.turningpointprogram.org.

Building a Sustainable Public Health Infrastructure in Nebraska

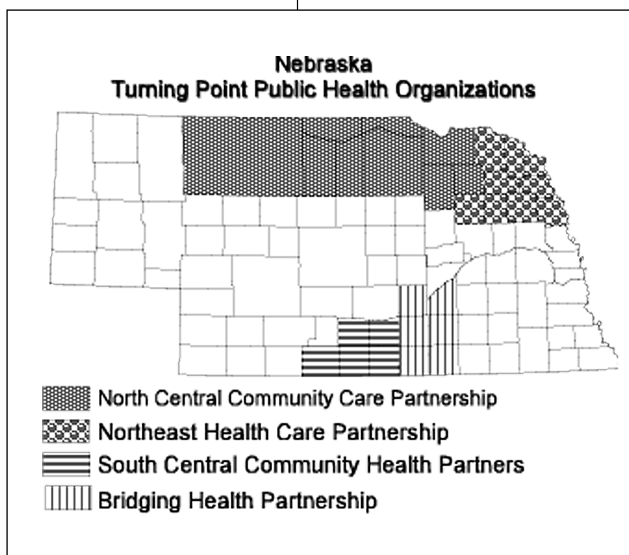
by David Palm

The Nebraska Turning Point Project is based on the premise that a strong public health system is essential to create healthy communities and to improve the health of all individuals. The project has provided the impetus for strengthening the public health system through new collaborative partnerships with both traditional and nontraditional organizations (such as schools, worksites, hospitals) at the state and community levels.

During Phase I of the Turning Point Project, the Nebraska Public Health Improvement Plan was developed. This plan identified eight new strategic initiatives for strengthening and transforming public health in Nebraska. In Phase II, many new initiatives and activities are moving forward, but the primary emphasis is on building the public health infrastructure at the community level.

Why does the current system need to change?

The current public health system in Nebraska is weak and extremely fragmented. Local public health departments cover only 22 of the state's 93 counties and most of these departments have limited staff and few financial resources. Although some public health services are provided through other agencies and organizations (for example, hospitals and community action agencies), there are major gaps in the delivery of services, and for the most part, the system does not adequately provide the core functions of assessment and policy development.



Other community partnerships are also a part of the current public health system. The most successful partnerships are the Buffalo County Community Health Partners and the North Central Community Care Partnership, funded by the W.K. Kellogg Foundation as part of Turning Point. Although these partnerships are at different stages of development and have different geographic boundaries (a single county versus a nine-county area), they both have organized diverse coalitions and focused on a community planning process that identifies the health needs of the population, the assets/resources available to meet these needs, the priority areas, and appropriate intervention strategies. Both have assumed a leadership role in changing local policies (such as the sale of alcoholic beverages near schools), and they have been successful in obtaining financial resources to fund some of their high priority projects.

New community-based partnerships

Based on the success of these two community partnerships, the Turning Point Project developed a Phase II implementation initiative that provides funding from The Robert Wood Johnson Foundation for four new community-based partnerships. The overall goal

is to develop new multi-county public health organizations capable of providing the core functions of public health. These public health entities are expected to provide a leadership role in building partnerships that will collectively address community health problems. It is envisioned that these new organizations will collaborate with new partners and focus on a broad definition of health that goes beyond the absence of diseases to address the underlying factors that create a high quality of life for everyone in the community. They will assess community health needs of the entire population, develop intervention strategies and policies to meet those needs, and evaluate the effectiveness of the interventions. These new organizations may provide some direct services as a provider of last resort, but they will mainly focus on coordinating the delivery of health services in the community and eliminating access barriers for underserved populations.

Each organization is required to have multiple counties because of the relatively small population base in most Nebraska counties. These new entities must also develop a formal organization, form a broad-based coalition, prepare a community public health improvement plan with special emphasis on the health needs of racial/ethnic minorities, and hire a full-time director. The new entities are not required to become local health departments, but they are expected to provide the core public health functions. If they choose not to become local public health departments with legal authority, the entities must build strong coalitions and political consensus in order to influence policy at the local level.

In January, 2001, four organizations were selected based on a competitive grant process. These organizations cover a total of 29 counties, including two counties that already have local public health departments. Each organization will receive a total of $40,000 a year for four years. This level of funding includes $15,000 from The RWJ Foundation implementation grant, a $15,000 state match, and a $10,000 local match. In addition, a considerable amount of technical assistance is provided by state Turning Point staff in the Office of Public Health. Technical assistance activities include building diverse coalitions, conducting an area-wide needs assessment, setting priorities, formulating appropriate intervention strategies, and developing evaluation and outcome measures. Staff essentially serve as a liaison between the community partnerships and other organizations and individuals at the state and local levels.

The level of funding for the four community partnerships is not sufficient to provide all of the core functions of public health in the long term. As a result, the success of these organizations depends on securing new funding streams. Although some funding is possible from local governments and private businesses, it is unlikely that sufficient funds can be obtained from these sources. Most businesses are quite small and local governments are near or at their tax lids. Some grant money is available from state agencies and private foundations, but it is difficult to maintain and build the public health infrastructure through these funding sources.

In May of 2001, short-term funding for public health infrastructure development became a reality.

New public health legislation

The momentum generated by the Turning Point plan and the implementation initiatives stimulated the development of new public health legislation. In May 2001, short-term funding for public health infrastructure development became a reality. Using money from the tobacco settlement fund, this new law has the potential not only to

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strengthen the public health system but also to refocus the public health system on the core public health functions and the ten essential services.

The law provides a total of $11.4 million over a two-year period to establish multi-county health departments across the state. Of this $11.4 million, a total of $4 million is available for base funding for infrastructure development (staffing, equipment, supplies, etc.). Each local public health department that has at least three contiguous counties and a minimum of 30,000 people will receive base funding of $100,000 per year. Public health departments that serve larger populations will receive $125,000 or $150,000 a year.

Most of the remaining funds will be allocated to local public health departments on a per capita basis. These funds can be used for a variety of programs and activities, including health risk assessment, the development of health policies, or the provision of new services, primarily focused on health promotion and disease prevention.

In addition to funds for local health departments, another $5.6 million is available to counties during the next two years to address minority health needs in areas such as infant mortality, cardiovascular diseases, and diabetes. These funds will be distributed on a per capita basis to those counties that have the highest concentration of racial and ethnic minority populations. Although multiple grant applications will be accepted, each county that is eligible for the funds will be encouraged to submit a single application. This application must include goals, measurable objectives, and appropriate intervention strategies to meet the unique needs of the population. It must also demonstrate that all of the key partners are involved in the development of the application.

What is the short-term effect?

In the short term, it is anticipated that the vast majority of counties will be covered by a multi-county public health department. The Turning Point community partnerships will carry out the original intentions of the grant and continue to develop effective and sustainable public health organizations in their respective areas, either by developing a district health department or by creating a nonprofit organization to carry out the core functions of public health.

What are the prospects for long-term state funding?

The likelihood of maintaining funds for public health infrastructure development and minority initiatives beyond the next two years is highly dependent on fulfilling the Turning Point mission of creating a network of community health partners that supports collaborative decision-making and collective action to address a broad array of health problems (social, economic, and environmental) and improves the quality of life for everyone in the community. Through these collaborative partnerships, there is more likely to be a shared responsibility and a genuine buy-in from all segments of the community.

Turning Point has provided an opportunity to strengthen and transform the public health system in Nebraska. As a result of the tobacco settlement funds, stable, long-term funding can become a reality by expanding the scope of public health to address all the major determinants of health and quality of life and ensuring collaborative decision-making and action.

David Palm, PhD, is administrator of the Office of Public Health in the Nebraska Department of Health and Human Services.

Turning Point Meets in Charleston

Sue Hassmiller, Laurie Garrett, and Barbara Sabol at the Turning Point meeting in Charleston.

A warm salty breeze, the pungent aroma of magnolia blossoms, horse-drawn carriages, and historic narrow houses made Charleston, South Carolina, the perfect environment for a stimulating dialogue on improving the health of states and communities by changing the public health system. One hundred seventy people came to Charleston for the annual Turning Point State Grantees and National Excellence Collaboratives meeting, May 2nd through May 4th.

Several Turning Point National Excellence Collaboratives met early on May 2nd, before the start of the main meeting, to continue their work: the Collaborative on Public Health Statute Modernization, with a large list of invited collaborative members; the Social Marketing Collaborative, in preparation for a presentation of social marketing principles to the entire conference group the next morning; and the Leadership Development and Performance Management Collaboratives. All the Collaboratives met again on Thursday afternoon. (Look for updates on their progress in a future issue of *Transformations* and on the Turning Point Web site.)

"Public health systems are extremely fragile," said keynote speaker Laurie Garrett, Pulitzer–Prize-winning *Newsday* reporter and author of *Betrayal of Trust*. Speaking to an audience of Turning Point representatives and invited South Carolina health officials, Ms. Garret pointed out that public health systems are among the first government functions to suffer under societal stress. She illustrated this assertion by showing slides of her travels through India, Africa, and Russia. She described Zaire, where the conditions that spawned the 1995 Ebola epidemic have only worsened and where HIV is destroying the population. She went on to discuss Russia, which is experiencing terrible setbacks in life expectancy and livelihood options. Finally, she talked about the inadequate state of U.S. food, water, hospital, and community health safety. She described numerous problems in the U.S., including the troubling predominance of food-related diseases and the growing incidence of bacterial diseases resistant to antibiotics. Her powerful, thought-provoking message focused the meeting on the serious challenges of public health today in the world.

Thursday morning, May 3rd, a panel of meeting attendees (Jill Hunsaker from Colorado, Christopher Cooke from North Carolina, Doug Nelson from Oklahoma, Tamara Hubinsky from New York City, and Bobby Pestronk from Michigan) shared personal reflections on Ms. Garrett's message and its application to public health.

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The Social Marketing Collaborative presented a workshop on factors that influence behavior and social marketing as a model for interventions that facilitate change. During the workshop participants worked on a case study that used social marketing principles to reduce domestic violence. The Collaborative distributed a Social Marketing Resource Guide for Turning Point partnerships, which included important definitions, resources, and articles on social marketing. Partnerships also received magazine subscriptions and two important textbooks: *Marketing Social Change* by Alan R. Andreasen (Jossey-Bass Publishers, 1995) and *Hands-On Social Marketing: A Step-by-Step Guide* by Nedra Kline Weinreich (Sage Publications, 1999).

Deborah Jones, from CDC's Public Health Practice Program Office, described a crucial law passed during the 106th Congress—the Public Health Threats and Emergencies Act of 2000 (S.2731 [Frist-Kennedy]/ H.R. 4964 [Burr-Stupak]). The law mandates that the HHS Secretary, in collaboration with state and local health officials, establish "reasonable capacities" for national, state, and local public health systems and personnel. The Act authorizes funding to perform an evaluation to determine whether capacities can be achieved, and then authorizes grants to states to address core public health capacity needs. In addition grants are authorized for work on antibiotic resistance and bioterrorism. Unfortunately only a small appropriation was authorized for the 2001 budget, and additional funds must be sought for future years.

During the morning on May 4th, six small group breakout sessions examined a variety of issues affecting Turning Point Partnerships: sustaining the Turning Point state and local partnerships; strategies for collaboration between government and nongovernment entities; workforce development; innovation in local and tribal public health; orientation to new tools; and a public health improvement toolbox demonstration session.

Dr. Cynthia Barnes-Boyd, from the University of Illinois Neighborhoods Initiative, wrapped up the conference with a discussion of power in organizations from an individual and an organizational perspective. She helped the participants think about the definitions and sources of power and ways to think about the formal and informal structure of organizations. She concluded by suggesting strategies for being most effective in situations where you have no legitimized power.

The meeting accomplished many things: updating the work of the National Excellence Collaboratives; education on the principles and practice of social marketing; personal inspiration on the importance of public health systems; networking between attendees; insights into the sources of power in organizations. All this—and in a beautiful setting!

Grantees Donate for Improved Public Health in Africa

Turning Point partners know first-hand what timely, collective action can accomplish. We work year round to improve public health and eliminate health disparities in our states and communities. At the May 2001 Turning Point Grantee Meeting in Charleston, attendees extended their focus to the international level. Prompted by Laurie Garrett's presentation on the international public health crisis, attendees immediately collected $350 for a program working to alleviate the devastation of AIDS in sub-Saharan Africa.

The funds were donated to the Elizabeth Glaser Pediatric AIDS Foundation's Call to Action Project—Reducing Mother to Child HIV Transmission in the Developing World. This tremendously successful program provides testing as well as drugs to help prevent mother to child transmission of HIV in sub-Saharan Africa.

The Elizabeth Glaser Pediatric AIDS Foundation directs 94% of donated funds to programs or research. For more information on the Foundation please visit their Web site at www.pedAIDS.org.

New Federal Legislation for Public Health Preparedness

Deborah Jones, deputy director for the Public Health Practice Program Office at the Centers for Disease Control and Prevention, at the Turning Point meeting in Charleston, South Carolina, on May 3rd, 2001, presented an update on the Frist-Kennedy Public Health Improvement Act of 2000, signed into law by President Bill Clinton on November 13, 2000. Commonly referred to as "Frist-Kennedy," in recognition of its key sponsors Senator William Frist and Senator Edward Kennedy, the act passed with strong bipartisan support. The law creates a comprehensive framework for assessment and enhancement of public health capacity.

As Senator Frist explained on June 14, 2000, as the legislation was introduced, "Our nation faces alarming risks from a number of potential public health threats…. It is vital that we take steps to address current inadequacies and ensure that our public health infrastructure is prepared to meet the challenge of any public health crisis." Senator Kennedy's remarks also addressed the importance of this legislation: "It is one of the highest duties of Congress to protect the nation against all threats, foreign and domestic … Our proposal will strengthen the nation's public health agencies, which provide the first line of defense against bioterrorism and many other threats to the public health."

The major provisions of the law include a mandate for development of capacity standards for public health systems, assessment and planning, and infrastructure development assistance based on assessment activities. The legislative intent is to build capacity to assure preparedness of local, state, and federal health agencies, provide uniform assessment methods, and authorize grants and technical assistance to assess and enhance capacity and system performance.

As a first step, the Public Health Threats and Emergencies Act authorized funds for four specific areas: public health capacity, antimicrobial resistance, bioterrorism response/planning, and CDC facilities/ laboratories. Funds were not appropriated in the budget, but could be provided in the federal budget in future years.

For the purpose of the law, infrastructure is defined as the core capacity needed to support the conduct of prevention programs. This basic infrastructure consists of a competent workforce, robust information and knowledge systems, and organizational capacity. Capacity is measured by an assessment of performance using standardized, validated tools. The assessment section authorizes $45 million for grants to state and local agencies to assess and inventory specific needs in public health infrastructure. The improvement section authorizes $50 million to address demonstrated needs in areas such as developing electronic information networks, training public health personnel, enhancing local and state laboratory capacity, and developing detailed, coordinated emergency response plans for such events as bioterrorism, natural disasters, and significant outbreaks of communicable disease.

A New Approach to Coordinating Public Health Resources in Virginia

by Sherry Dunphy and Anne Terrell

In 1998, the Prince William Partnerships for Health, a Turning Point group in Virginia, gathered information from 250 county residents through 31 focus groups about their priorities for improving community health. This information, coupled with community health status data, revealed many areas of duplication, inefficiency, and gaps in the provision of health services in the Prince William County Health District's three local jurisdictions: Prince William County and the cities of Manassas and Manassas Park, Virginia.

To address the need for better coordination of health services, the Prince William Partnerships for Health, in collaboration with local public officials, proposed a multi-jurisdictional Health Authority that would provide the opportunity for government, private entities, and citizens to coordinate community health services. A local delegate to the Virginia Assembly spearheaded the necessary legislation to create the Authority, and it passed without opposition. The legislation establishes a two-year pilot program to be managed by the existing Prince William Partnerships for Health, with monitoring, technical advice, and evaluation by Virginia's Joint Commission on Health Care, and also allows governmental organizations to participate fully in the Authority and its partnerships.

...the Prince William Partnerships for Health, in collaboration with local public officials, proposed a multi-jurisdictional Health Authority...

The purpose of the Health Authority

The Health Authority will guide, support, and coordinate the delivery of health-related services through ongoing community assessment and priority setting. The Authority will minimize duplication of effort and ensure that services are available in accordance with priorities set by the Authority Board. Ultimately, this will result in more efficient use of and better-targeted resources. The Authority will seek to overcome barriers to the delivery of services by addressing the issues related to volunteer liability and confidentiality. The Authority can also provide a "legal home" to programs that cannot assume the financial and administrative burdens of becoming independent tax-exempt organizations.

Uniqueness of the Prince William model

Two aspects of the Health Authority make it different from other health care delivery models. First, it is *citizen-driven.* Assessment and priority setting will be accomplished through a board of directors, the majority of whom must be citizens with no direct association to health care or related industries.

Second, the Authority is *quasi-governmental* in nature. In some respects it functions like a governmental entity. In other respects, it functions like a private, nonprofit organization. For example, the Authority can act as an intermediary for local entities by accepting Medicaid reimbursement. On the other hand, contributions to the Authority or programs under the Authority will be tax-deductible.

Addressing confidentiality and information sharing

Participating organizations will be legally able to share confidential patient information with *verbal* permission from a client. For example, the Parish Nursing program provides home nursing assessment and follow-up on referrals from the Area Agency on Aging. However, the attending physician for the patient cannot legally share information with the parish nurse until the patient signs a written Release of Information. Under the Authority, information sharing can take place before the visit is made, with the verbal permission of the client.

Policy issues

Liability coverage

Liability issues will be the responsibility of the Authority as a separate entity vested with the powers of a corporate body. This means that it may be sued in its own name. Local jurisdictions will not be held liable for the actions of the Authority. The legislation grants immunity only to licensed health care providers acting as volunteers of the Authority or its partners. The Authority will be responsible for obtaining appropriate insurance coverage for its Board, staff, and other volunteers. Locating an insurer willing to underwrite the Authority without knowing exactly what the Authority will be doing may prove challenging.

Decision-making

The Authority Board will have to determine how decisions will be made concerning partner membership, priorities, programs to support, and programs to assume under the Authority. Issues of turf and special interests among partners will undoubtedly have to be resolved as the Board solidifies organizational structure and operations.

Technical assistance for new organizations

The Authority does not plan to provide many direct services on a long-term basis. Rather, it will assist new programs that do not fit logically under an existing agency or program. Assistance is most needed in the critical stages of program infancy when new programs often find themselves in a Catch-22 dilemma. They have immediate needs for start-up funding in order to begin offering services, yet lack the organizational structure, policies and procedures, finances, and tax-exempt status to accept donations.

The Authority will be able to give these programs a legal tax-exempt home while the program board decides how best to secure its start-up and maintenance funding. An initiative in the local Latino community to provide life skills education for its residents, for example, would benefit greatly from the infrastructure and technical assistance available under the Authority umbrella.

Financial support for the Authority

The Authority will act as its own fiscal agent for operation. Costs for the two-year pilot program, including the administration, staffing, space, and operating expenses, will be partially funded through a joint commitment of $40,000 from Potomac and Prince William hospitals. Additional funding for an executive director and part-time administrative support is being sought from foundation grants.

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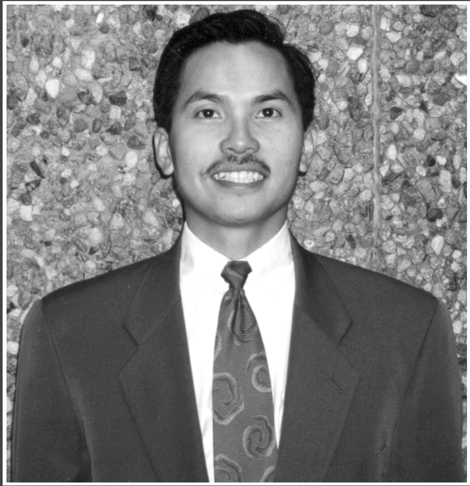
Turning Point Member Profile

Dr. Hai Bui



Dr. Hai Bui, member of the Colorado Turning Point Steering Committee, was a Vietnamese refugee who overcame extreme hardship to become a physician and an activist. After enduring a seven-day boat ride plagued by pirate robberies and a yearlong stay at a refugee camp, Dr. Bui finally reached America. He quickly learned English and went on to earn a medical degree from the University of Texas.

Dr. Bui is the newly elected president of the Vietnamese Community of Colorado, a not-for profit organization whose goal is to help Vietnamese people adapt to new lives as Asian American citizens. As a Colorado Turning Point partner in the elimination of health disparities, Dr. Bui received funding to conduct training of Vietnamese community members to be outreach workers who can provide valuable and timely health information to their neighbors. These outreach workers are instrumental in translating between English and Vietnamese, distributing information on social, health, and environmental issues, and producing media notices to address issues of importance to the community. An office was also established to house these activities and serve as a center for communication, coordination, and individual consultation for people with problems. An estimated 30,000 Vietnamese live in the Denver Metro Area.

Dr. Bui is a major in the Colorado National Guard and a member of the State Board of Health. He also participates on the Asian Pacific Development Office Board of Directors, and Kaiser's Regional Diversity Council. In honor of his continuous and unselfish service to the state of Colorado, Governor Bill Owens proclaimed April 8, 2001, Dr. Hai Bui Day.

New Approach *(continued from p. 13)*

Upon successful completion of the pilot program and permanent establishment of the Authority, private funding will be sought from local businesses, foundations, and state government. Local governments have made it clear that they do not intend to provide financial support for the Authority in the future.

Where we go from here

In the next few months, Prince William Partnerships for Health will be making final presentations to the local governing bodies in the participating jurisdictions, as well as attending public hearings to answer questions and explain this new concept. Each of the three participating governmental jurisdictions must hold a public hearing to elicit citizen input prior to final approval by the governing bodies. Once final approval is given, the Health Authority Board of Directors will be appointed, and the pilot project begins!

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Minnesota Turning Point Web Site

The Minnesota Turning Point Program's Web site has a "mini-toolbox" with a variety of materials describing its work on social and economic determinants of health. PowerPoint presentations, a bibliography, discussion questions, talking points, reports, news articles, and presentation outlines are included in this toolbox. Any committee member or community person can access and use these materials when talking with groups, writing articles or reports, or making presentations. To find the mini-toolbox:

1. Go to **http://www.health.state.mn.us**
2. Select Minnesota Health Improvement Project, and click GO.
3. Scroll down to Social Conditions and Health Action Team, and click it.
4. Scroll down to Presentation Materials and Community Engagement Tools, and click it.

Check out this creative way to share resources and engage others in spreading the word!

RWJF News

New RWJF Web site

The *RWJF News,* providing Foundation updates, is a new regular feature in *Transformations*. This issue focuses on the foundation's newly designed Web site (**www.rwjf.org**). RWJF recently did an extensive redesign of its Web site to improve its interactivity. Look for updated graphics, streamlined navigation, and new registry/login. "Something New Every Day" on the home page showcases news and events, with links to American Healthline and NPR. "People Making Progress" is a new monthly feature highlighting a grantee. New "Resource Centers" have been added focusing on areas of special interest to the Foundation, such as substance abuse, chronic conditions, and end of life.

A particularly useful section, with a convenient link from the main page, is "Applying for a Grant." It describes the kinds of projects RWJF does, and does not, fund and tells how to apply.

Dates to Note

Nov. 27-29, 2001 National Conference on Tobacco or Health, New Orleans (www.tobaccocontrolconference.org)

Nov. 29-Dec. 1, 2001 7th Annual Community Care Network Conference and the Meeting of Public/Private Health Care Delivery Networks: Accent on Results: Improving Health Through Community Networks. New Orleans (www.healthycommunities.org)

Feb. 27 – Mar. 1, 2002, 16th National Conference on Chronic Disease Prevention and Control: Cultivating Healthier Communities through Research, Policy and Practice. Atlanta (www.cdc.gov/nccdphp/conference)

May 1-3, 2002 Turning Point State Partnership Grantee Meeting. Location TBD (www.turningpointprogram.org)

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

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

Sept 9-13, 2002 ASTHO Annual Meeting. Nashville (www.astho.org)

Oct. 1-3, 2002 Turning Point State Partnership Grantee Meeting. Location TBD (www.turningpointprogram.org)

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