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Transformations in public health

In This Issue

Mapping a Pathway to Careers in Public Health

Danie Watson and Tricia Todd

Having a strong public health workforce is vital for protecting the public's health. That's why, when public health leaders in Minnesota looked at workforce trends in the state, red flags went up.

Not only were many skilled public health workers expected to retire over the next decade, but Minnesota's demographics were changing, which meant that public health would be competing for a shrinking pool of college-age prospects. On top of that was the growing desire to see more people with formal postgraduate training in public health, which would better equip the workforce to deal with emerging public health challenges. And finally, Minnesota's population changes also included large influxes of immigrant groups, but the current and projected future workforce did not reflect the state's growing diversity.

The question was "what to do?" The answer was "build a broad-based partnership and apply social marketing!"

Bringing hands, heads, and hearts together

Leaders in the Office of Public Health Practice at the Minnesota Department of Health contacted leaders in the University of Minnesota School of Public Health, shared their concerns, and expressed a strong desire to find ways to creatively address the pending problems. Other stakeholders, from local public health agencies to K-12 and undergraduate schools, were all identified as potential partners in a project that came to be known as "Pathways to Public Health."

Coincidentally, representatives of the Minnesota Department of Health were participating in the Social Marketing National Excellence Collaborative, funded by the Turning Point initiative of The Robert Wood Johnson Foundation. The Collaborative had partnered with the Centers for Disease Control and Prevention to develop *CDCynergy–Social Marketing Edition*, a comprehensive social marketing planning tool

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From the Turning Point National Program Office

Rethinking Messages for a Key Audience

Bobbie Berkowitz, Director

Social marketing in public health is the theme of this issue of *Transformations,* and we have several terrific stories to tell. As public health contends with numerous preventable epidemics, carefully crafting our messages to the key audiences is crucial for improving health outcomes. Changing behavior through marketing has been a successful technique of business for the past century, and public health is just beginning to realize the potential for using the same tools to change health behaviors and improve outcomes.

The chief aim of the Turning Point Social Marketing National Excellence Collaborative has been the development of free and accessible social marketing resources that public health workers can use to improve the reach and effect of their programs. Since 2000, this collaborative has published four books: *Social Marketing: a Resource Guide, Lessons From the Field, The Basics of Social Marketing,* and *A Manager's Guide to Social Marketing*, in addition to *CDCynergy–Social Marketing Edition*, produced with CDC.

The uses of social marketing in public health are as varied as the problems we confront. In Minnesota, for example, social marketing is being used to expand the public health workforce; in Maine the tools are applied to increasing physical activity among people with diabetes. In developing case studies for *Lessons from the Field,* we had a host of options to choose among. One area in particular, however, was virtually devoid of any examples of the use of social marketing—influencing policy.

A constant theme of Turning Point has been the improvement of public health infrastructure. Public health has historically been a government activity, and it requires the support of policy makers and governmental leaders. A next step for those interested in both social marketing and public health infrastructure is to use social marketing to affect the policy environment as well as to reach the policy audience so crucial for achieving public health goals. We can use social marketing principles to effectively understand key audiences. To reach these audiences, we can apply social marketing tools such as market research (focus groups, interviews, surveys), product development, placement, and promotion. We can engage with partners to promote changes in the policy environment that would benefit public health goals. And we can look at our messages and our partners to understand what would be a fair exchange among governmental leaders, policy makers, and our profession.

Policy is a ripe area for public health social marketers to explore. We look forward to the day when a future case study is written detailing what is learned and gained when we engage in a dialogue with the intention of understanding the key audience of policy makers and then developing a social marketing strategy to change the direction of public health policy.

[Mapping—continued from p. 1]

on CD-ROM, and the Pathways project was selected to receive funding and technical support to pilot the tool.

Happiness is a warm data set

The Pathways team formed a steering committee and hired a social marketing expert to guide and advise the project. The team was eager for hard data to answer some basic marketing questions.

- What geographic areas and disciplines were facing the greatest workforce shortages?
- Why do people choose to pursue advanced education in public health?
- What makes it easier or harder for them to choose public health?
- What other fields of study are students choosing instead of public health? In other words, who's the competition?
- At what point in their schooling or career do people make these decisions?
- Whose advice do they listen to?

Answers to these questions would come from market research, but to focus the research, the problem at hand had to be clearly articulated.

Defining the problem

Defining the problem posed the first challenge for the team. They wrestled extensively with the definition of the public health workforce, since government agencies, community health nonprofits, public policy advocates, and many others contribute to the work of public health. They finally concluded that the only workforce they could actually define and count was governmental employees in local or state public health agencies.

Next, they surveyed state and local public health workers about their backgrounds and estimated retirement dates. What emerged was a clear picture of the shortages on the horizon (35 percent retiring within the next ten years), and the realization that few of the current employees held an advanced degree in public health (just 13 percent of local public health staff held an MPH). The greatest shortages were forecast for upper management (55 percent retiring within ten years).

The group made the assumption that advanced education would enhance the public health workforce regardless of the work setting. The project goal became to increase the number and diversity of qualified people who received advanced education in public health.

Stop, look, and listen: research with the target audience

The next step was to conduct market research with the target audience to answer the market research questions. First the team surveyed the incoming class of the UMN School of Public Health. These students had actually performed the desired behavior (applying to an MPH program) and therefore were known in social marketing parlance as "doers."

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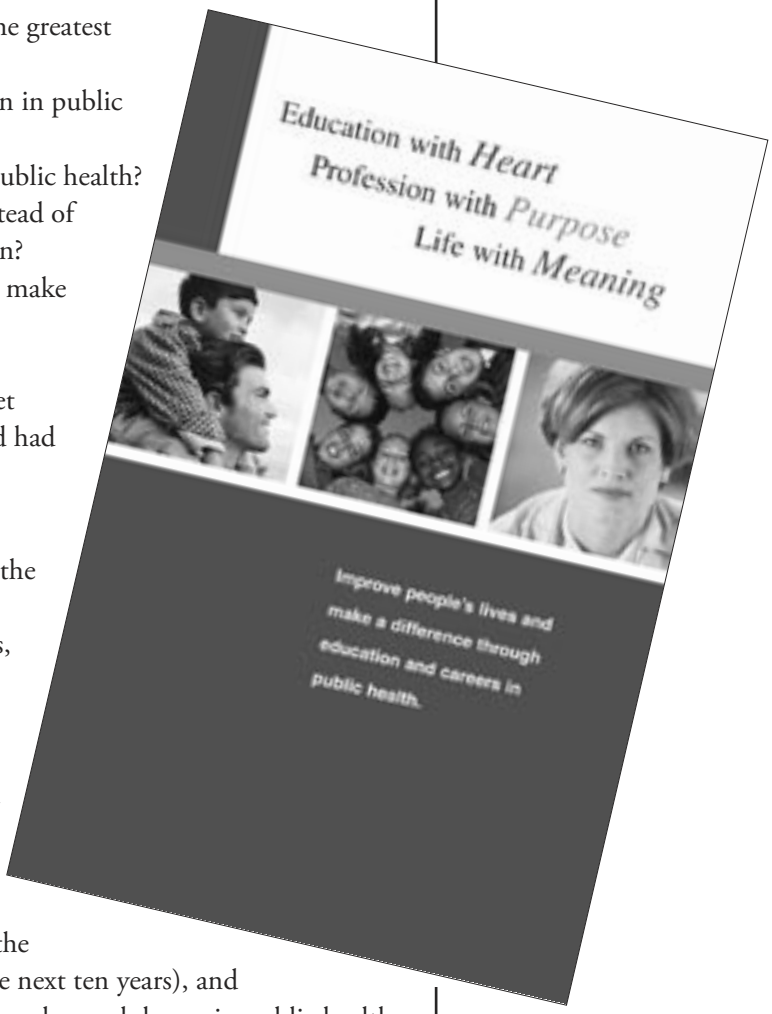

The benefits of education in public health, identified through research, are featured in this new brochure.

[Mapping—continued from p. 3]

Key findings from the survey were:

- A desire to make a meaningful contribution is the primary motivation to pursue graduate studies in public health.
- Exposure to public health through experiences and relationships motivates the decision to apply.

A series of focus groups was then conducted with "doers" and "non-doers." The team wanted to learn what distinguished those who had chosen public health from those who were likely candidates but had chosen other fields, such as social work, medicine, psychology, or public policy. From the focus groups, the team learned:

- Doers and non-doers feel that their fields reflect many of the same benefits, such as social justice, a fit with personal values, and a broader (socio-ecological) view.
- Lack of awareness of public health leads non-doers to choose another field; an experience in public health was often the one thing that persuaded doers.
- A perceived need to disconnect from their community in order to meet the demands of public health schooling is a barrier for diverse applicants.

The importance of concept testing

The team crafted some message and program concepts based on findings from the first round of focus groups, and then tested the concepts in a second round. Major findings were:

- Appealing messages offered a way to realize life goals, especially "making a difference" and "improving people's lives"—as well as motivation and inspiration "to act to change the world."
- The opportunity to interact with public health professionals and alumni was attractive to participants.
- The chance to connect to community, for example through paid or unpaid community health jobs, resonated.

Let's do launch: planning, initiating, and evaluating the program

Now it was time for the team to take the tested concepts and create actual program materials. They started with a new brochure that reflected the perceived application benefits and language of the target audience. The School of Public Health also expanded its mentoring program and identified "ambassadors" to carry the brochure and the messages to target audiences. As a final step, the School is retooling its Web site to make it easier to find community-based opportunities for learning and working.

With two of the three planned interventions launched, and an outcome evaluation structured, can the team sit back and watch the results of its social marketing intervention roll in? Not when there are program tweaks to make on the basis of ongoing feedback from the target audience.

Was this effort worthwhile? The researchers were moved by the passion, drive, intelligence, and commitment of the students they spoke with. If even a handful of these inspired young people choose careers in public health, the researchers see a brighter future ahead for Minnesota public health.

Danie Watson is president of The Watson Group. Tricia Todd, MPH, is principle planner at the Minnesota Department of Health.

Turning Point Member Profile

Mike Newton-Ward

Mike Newton-Ward, of North Carolina's Division of Public Health, has been a proponent of social marketing for many years. Even before the implementation of social marketing concepts broadly within the Division, Mike used social marketing to promote the benefits of family planning best practices in North Carolina. In the past four years, while working with Turning Point's Social Marketing National Excellence Collaborative, Mike has expanded his expertise as a social marketing consultant.

With an undergraduate degree in religion and psychology and master's degrees in social work and public health, Mike's educational background reflects his desire to help people. Early in his career with state government, he worked in the Division of Mental Health with children and adolescents. Subsequently, he served as program consultant in Family Planning within the Division of Public Health before becoming the social marketing consultant for the Division under the auspices of the Turning Point grant.

During his tenure as social marketing consultant, Mike's successes have been numerous, bringing North Carolina to national and international recognition in the use of social marketing. In order to facilitate the incorporation of social marketing techniques within public health's framework, Mike has facilitated a Social Marketing Matrix Team in the Division of Public Health. With Mike's guidance, the team has provided resource and program development, coalition building, policy change, and branding strategies to strengthen public health at the state and local levels. As a result of the team's work, the Maine Department of Health and the Boulder County (Colorado) Health Department have also instituted matrix teams, using North Carolina's team as a prototype.

Along with increased program requests for social marketing consultation, Mike has been involved with the preparation of grant proposals using social marketing approaches. As a part of program development, he has crisscrossed North Carolina providing social marketing certification trainings for local health department health educators. His articles about North Carolina's social marketing expansion in public health have appeared in *Social Marketing Quarterly, Eta Sigma Gamma Health Education Monograph,* and the *Journal of Nonprofit and Public Sector Marketing* (in press). He is also a frequent contributor to the Georgetown Social Marketing Listserv.

Mike likens his love of social marketing to his early career in social work, saying, "There are a lot of parallels—they both honor the dignity of individuals." When asked what he is proudest of in his work, Mike replied, "Being able to shepherd the process along and getting other people excited about using social marketing in their own programs." He added that the greatest accomplishment was establishing the matrix team as a permanent presence within the Division and using social marketing to build capacity from a systems perspective.

As far as the future for social marketing in public health, Mike believes that it should be an area of practice within public health because it gives the best opportunity to really understand the groups being targeted and enables public health to be accountable. Mike firmly believes that "it gives us a 360 degree view of what is going on and provides us with one of the best ways to support lasting positive health changes in people."

It's time to *Move More*!

Alison Jones Webb

"Just 150 minutes of walking a week, 10 minutes at break time, after work, or with your family, can prevent complications of diabetes like heart disease, blindness, and stroke." That's the Move More Diabetes message.

Move More Diabetes campaign poster.

Move More Diabetes was developed by Move More, an informal collaborative in central Maine that includes representatives from schools, health clubs and fitness centers, hospitals, social service agencies, and businesses. Move More addresses the major barriers, including lack of access to convenient facilities and safe environments in which to be active, that most people face when trying to increase their levels of physical activity. Move More began addressing these barriers a few years ago by focusing on the CDC Best Practices found in the *Guide to Community Preventive Services* (www.thecommunityguide.org).

We first developed safe in-town walking paths and indoor walking spaces. We then promoted those resources by publishing maps and a "Walking Warm this Winter" bookmark, and by developing the Move More Web site (www.movemore.org). These promotional resources were distributed free of charge to community groups, municipal government offices, work sites, faith communities, and health care settings.

Move More decided the next step was to promote physical activity among adults with chronic disease. Population data indicated that the prevalence of diabetes, as well as hospitalization and mortality rates of people with diabetes, were higher in our region than in the state as a whole (MaineGeneral Health, *Kennebec Valley Health Status Report Card*, 2002). Again, we looked to CDC Best Practices and decided to develop an intervention that provided peer support. MaineGeneral Health, the health system in our area and a key partner in the Kennebec Valley Diabetes Care Initiative (DCI), took the lead in applying for grant funding for this work.

Move More Diabetes 5 Ps of Social Marketing

- **Place** – Worksites, health care providers, faith and community settings, local newspapers, Web site
- **Price** – Time spent doing other things in exchange for feeling better
- **Product** – 150 minutes of physical activity/week
- **Promotion** – Lay Health Educators ("people like me"), health care providers, print materials, newspaper articles, Web site
- **Policy** – Ongoing work with partners to promote environmental change

Putting social marketing to work

Move More took a social marketing approach in formulating a targeted intervention that would provide peer support to people with diabetes who are trying to increase their physical activity levels. We used the *CDCynergy–Social Marketing Edition* tools to identify our target audience—adults aged 30-70 with type 2 diabetes who are already doing some physical activity but not at the recommended level of 150 minutes or more a week. These people were ready to increase their physical activity levels but were identified as confronting some barriers that needed to be addressed by our intervention. (We thought this subpopulation would be easier to reach than more sedentary adults.)

We also identified our behavioral objective: 150 minutes of physical activity a week. At this therapeutic level of physical activity, individuals with type 2 diabetes may reduce their blood sugar levels, blood pressure, and blood lipids, and may also delay the onset of diabetes complications.

We conducted formative research, which included a literature search on peer support for adults with type 2 diabetes, a survey of adults in the region, and focus groups with people with type 2 diabetes, risk factors, or pre-diabetes. The intervention strategies we developed include peer support in the form of volunteer Lay Health Educators, who deliver the message about physical activity and who also refer individuals to diabetes self-management resources in the area.

We also focused on what social marketing calls the "exchange" that would take place. In return for filling out an enrollment form and forgoing some sedentary activity such as watching television, individuals with type 2 diabetes would receive a pedometer and other incentives, companionship provided by Lay Health Educators, a feeling of well-being, improved health, a sense of control, and hope for the future.

Working for sustainability

In year one, we conducted our formative research and a pilot project. We have completed a full year of the project and are in the middle of year two. This grant-funded project ends October 31, 2006, and we are developing strategies for sustaining the Lay Health Educator peer support. Volunteer Lay Health Educators are now linked to key work sites, faith communities, and health care settings, and we are working with DCI partners to sustain these positions. MaineGeneral Health has committed to providing ongoing training for Lay Health Educators and to providing incentives for people enrolled in the program.

Our evaluation includes the types and number of contacts Lay Health Educators provide to people who enroll, to determine if they are effective. An outside evaluator is conducting surveys of enrollees, and collecting clinical data. Interim results indicate that our network of 35 Lay Health Educators have provided support to 80 enrollees through mail, phone, e-mail, and face-to-face contacts.

Alison Jones Webb is project coordinator for Move More Diabetes.

Key Research Findings

- Exercise opportunities must be close to home, no more than a half hour away.
- Exercise opportunities should be similar to what is now acceptable, such as walking.
- Exercise must be somehow spontaneous and not repetitive or boring.
- Home exercise equipment is not preferred, but if it is used, it must be integrated into daily routines.
- Exercise opportunities must not be time consuming, must take into account the climate, and must provide some kind of incentive.
- Social support programs of some kind work well as motivators for physical activity.
- Using identified CDC Best Practices (walking clubs, a buddy system, pedometer program) will be acceptable as long as the activity is not perceived as repetitive or boring.
- Many sources of information can be used to find out about physical activity opportunities in the area, and newspapers are the single most important source.
- Physical activity needs to be incorporated into everyday activities. This is especially true for women.
- Physical activity programs must be age appropriate. For example, younger individuals are interested in physical activity opportunities at the work site. All focus groups view social supports of various kinds as motivators.

Combating Sexual Abuse of Children Where It Starts

Stop It Now! Minnesota successfully applies social marketing strategies

Marleyse Borchard and Judith Yarrow

Child sexual abuse is a serious public health problem in our community and society, but the majority of sexual abusers of children rarely seek help for their problem, fearing public exposure, job loss, and prison. Most prevention programs focus on children, for example, teaching them how to prevent their victimization or encouraging them to report abuse after it has occurred. Abuse prevention programs targeted at adults have primarily focused on teaching concerned adult bystanders to recognize the warning signs of sexual abuse and take action. These programs are necessary and successful, but they ignore one crucial element of the abuse equation: the abuser.

In 2005 the Stop It Now! Minnesota program tested a revolutionary approach to stopping the cycle of child sexual abuse. The campaign aims to reach people before they cross the line and harm a child, in addition to reaching people who are already abusing children. Through billboards, TV, radio, Web, and print communication, the program reaches out to abusers and potential abusers, offering them a safe and confidential way to get help.

The focus on adults at risk to abuse isn't the only thing that makes this campaign revolutionary. The development of the outreach campaign is an example of the power of social marketing principles to create successful programs that improve the public's health.

Know your audience

One of the key principles of social marketing is to know your audience and listen to your audience. So the first thing Stop It Now! Minnesota did was interview adults who were in, or had completed, treatment for sexual behaviors toward children. A majority said they wanted to stop, but didn't know how. Social marketing would interpret this response as "This means there is a demand for the services offered."

A majority of interviewees said they had sought help for other issues, such as depression, drug and alcohol abuse, or relationship problems. This identifies a way, or "Place," to reach the target audience, by working through therapists and social service agencies to increase screening and referral. This was a crucial piece of information because abusers, and especially potential abusers, are otherwise virtually impossible to identify until after a child has been harmed.

The interviews also offered information about how to craft an effective appeal—what words to use or not use (do say "safe and confidential;" do not mince words but be blunt and specific that this is about being sexual with children), what images to use (pictures of distressed adults, sad children, or families in turmoil), and the importance of offering understanding, hope, and assurance that people who struggle with sexual thoughts and behaviors toward children are not alone and that they can change.

Lay the groundwork

Stop It Now! Minnesota also made use of the results of a similar 1992 campaign in Vermont. One problem the Vermont campaign faced was difficulty in getting the media to air their messages for a number of reasons, including that the media outlets did not want their listeners or readers to think that sex offenders liked their programs.

As a result of Vermont's experiences, the Minnesota campaign developers invested time in building strong collaborative partnerships with stakeholders and media before beginning their research. They also conducted message- and concept-testing with focus groups of stakeholders (adult survivors, law enforcement, corrections, therapists) and members of the media. The program wanted to make sure it developed ads that the media would print or air. And before advance media relations began, the campaign developers briefed partner organizations. The campaign had allies and supporters in place before a single story or ad appeared.

The campaign developers also talked with media venues to provide important context, such as the epidemic nature of child sexual abuse and that, as with HIV/AIDS prevention campaigns in the past, the community needs to speak candidly about uncomfortable topics in order to promote healthy behavior. The developers emphasized that many ad venues were participating, and that the community was united in a desire to stop sexual abuse. In the end the media were far more willing to accommodate the campaign with free space, and the press response to the campaign has been largely positive.

Stop It Now! Minnesota's campaign includes a series of five advertisements. The ads were developed through the social marketing process:

- Define the problem, desired behavior change, and the target audience
- Conduct research to develop key messages
- Listen to your audience to determine appropriate and effective ways to intervene
- Design a product that meets the needs of the audience as well as other stakeholders
- Understand the "market dynamics" of price and exchange that underlie consumers' decision to change their behavior
- Consider "place" both in terms of where potential abusers could seek help and what venues would be best to use to promote the program
- Consider policy implications and opportunities
- Understand the "competition"

Yvonne Cournoyer, program director of Stop It Now! Minnesota, reports that calls to the helpline have increased since the campaign began. In particular, calls from adults concerned about their own behavior have increased significantly. "The goal of this campaign is simple: to prevent the sexual abuse of children. We conducted extensive research to better understand what makes it harder or easier for adults at risk of sexually abusing a child to voluntarily come forward, seek treatment, be accountable for their actions, and abstain from future abuse. The ads direct them to our Web site and our 1-888-PREVENT helpline—where they can get confidential information and referrals to help." Cournoyer emphasizes that Minnesotans need to know that people who receive specialized treatment for child sexual abuse can and do learn to control their behavior. "We realize that these ads deal with a sensitive subject matter," says Cournoyer. "We have tried to balance the need for the ads to be direct and therefore potentially to change behaviors, with the sensitivities of the broader community."

Marleyse Borchard is manager of public relations and communications and Judith Yarrow is editor and Web manager. Both are in the Turning Point National Program Office.

Stop It Now! Minnesota is a local site of Stop It Now!, a national nonprofit founded in 1992. The Minnesota site is sponsored by Project Pathfinder, Inc. in collaboration with the Jacob Wetterling Foundation, the Midwest Regional Children's Advocacy Center, Minnesota Coalition Against Sexual Assault, the Minnesota Department of Corrections, the Minnesota Department of Health, Prevent Child Abuse Minnesota, the Sexual Violence Center, and Survivors Network Minnesota.

For more information about social marketing, explore the social marketing materials on the Turning Point Web site at turningpointprogram.org.

Promoting Environmental Change in St. Louis

Marcus G. Rivas

Air toxics reduction projects in St. Louis, Missouri, are using social marketing to help them achieve their goals of lower air toxics and healthier air. The *CDCynergy–Social Marketing Edition* CD-ROM has been a useful tool to re-direct efforts to gain healthier air for St. Louis.

The community steps out

The St. Louis Community Air Project (CAP) was concerned about air quality challenges. CAP is a collaborative partnership representing businesses, government agencies, institutions, residents, neighborhoods, and nonprofit organizations. With assistance from the US Environmental Protection Agency (EPA), the Missouri Department of Natural Resources, and the City of St. Louis, CAP monitored St. Louis air from May 2001 to October 2002. The group identified a variety of pollutants of concern, including diesel exhaust (a mixture of many different fine particles and gases produced when diesel engines burn diesel fuel).

The original CAP implementation strategy was not constructed as a social marketing effort. It followed a campaign structure based on the belief that good science and good ideas would motivate change.

The group was not introduced to the CDCynergy materials until December 2004, but they had already completed several of the CDCynergy phases. The scientific investigation and community-building models are quite complimentary to the social marketing roadmap set forth in *CDCynergy–SOC*. CAP started with a clear goal in mind—healthier air. In an early phase, it had collected data on more than 100 toxic chemicals in the air. It also explored public opinion on the impairing sources, governance, and responsibility for air quality and identified target efforts and groups for engagement. Although its findings involve four action plans, this article deals with only one of those plans.

Defining the issue

CAP research confirmed that petroleum-burning vehicles are a major source of pollution. Because others were working to reduce automobile emissions, CAP decided to focus on reducing diesel engine emissions. As CAP knew, asthma was a critical health issue among local school children, so it seemed a natural decision to target emissions from diesel school buses. CAP used a dual strategy: technology and policy practice. The technology fixes change how the engines burned diesel fuel. These are effective fixes, but come at a cost that many districts cannot afford. The policy fix (idle reduction) is much less costly, but implementation requires significant changes in humans—therefore the need for social marketing.

CAP developed an idle-reduction campaign targeting school buses. It framed the idle reduction campaign using three arguments—protecting children's health, saving fuel costs, and complying with existing ordinances that place time limits on vehicle idling. The CAP partners thought they could successfully reduce diesel emissions by presenting a tailored argument to a particular audience.

CAP developed intervention presentations for district and contractor executives. It also created educational programs for drivers and mechanics. Despite CAP's research,

strategizing, planning, and intervention, its monitoring showed low participation among key stakeholders.

This is when social marketing was integrated into the project. The EPA project manager participated in Turning Point's workshop at the 2004 American Public Health Association annual meeting. He took the materials back to his St. Louis compatriots and sold them on the value of a clearer structure for social marketing campaigns, especially the critical need for more specific market research.

Obstacles to overcome

Earlier in the idle reduction implementation process, CAP had heard anecdotes identifying potential barriers to implementation. CAP began to suspect some of their implementation barriers were deeply rooted in Midwest culture. "Show-Me" is not just the Missouri state slogan, it's an attitude that permeates the culture when it comes to embracing changes in lifestyles or daily routines.

CAP is preparing another round of research to better identify potential barriers and the means to overcome them. This means returning to phase two of the social marketing campaign (market and audience research) to get a better sense of the incentives and disincentives to turning off an idling school bus engine. It will use focus groups and targeted stakeholder discussions to learn how to develop more successful marketing messages.

Based on the information from this research, CAP will create a network to use these newly developed messages to encourage individual schools and their school bus drivers to create idle-free zones around the schools. The network will include the traditional CAP partners (health agencies and nonprofits) and newly recruited volunteer "reporters" who have vested interests in healthier, idle-free zones.

CAP intends to use pacing events to celebrate those schools and districts that have taken up diesel emission reduction (either by implementing technology or idle reduction efforts). EPA is building local capacity to use pacing events that build environmental stewardship through the use of bold requests and offers.

Challenges to integrating social marketing

One significant challenge CAP faced was that its efforts were under way when the project discovered the Turning Point social marketing resources. Another challenge has been that environmental efforts have not routinely adopted social marketing campaigns. Most environmental activity has been imposed through regulatory directive. These regulatory controls are necessary and vital for environmental management, but they have less success in changing personal behavior. Social marketing, on the other hand, is an extremely powerful tool for engaging populations in personal change.

The guidelines provided on the *CDCynergy-SOC* CD-ROM have been a critical resource to ensure that the project is covering the process phases. The deliberate, defined phases in the social marketing process are helping St. Louisans develop a stronger campaign to reducing idling from diesel school buses and bring healthier air to St. Louis.

CAP's primary lesson has been to persevere and recognize that one must develop strong, socially relevant marketing data to enable change, especially in uncharted environmental social marketing programs. The traditional "do it because it is environmentally correct" does not succeed when trying to create societal change through changes in personal behaviors.

Marcus G. Rivas, BE, is an environmental engineer with the US Environmental Protection Agency. He has served as a project officer/liaison with the St. Louis Community Air Project for more than five years.

Although this document was prepared by an employee of the US Environmental Protection Agency, it has not been subjected to the Agency's product and administrative review. It might not necessarily reflect the views of the Agency. No official endorsement should be inferred.

No Quick Fixes

Hurricane response exposes a system in need of sustained political and financial support

Betty Bekemeier

The poorly coordinated public health response to hurricanes in the Gulf Region in 2005 was stark evidence to the public and to policy makers that our public health system is not ready to respond effectively in an emergency, let alone to fully and equally protect the health of the public. Public health workers throughout the Gulf (and many who came from elsewhere) were a remarkable testament to the commitment, resiliency, generosity, knowledge, and dedication of our workforce. The public health system, however, was unable to adequately support their efforts. Lack of sufficient coordination between federal, state, and local officials, inadequate emergency planning, failed sanitation, water, and health care systems, compounded the natural disaster. By December 2005, state and local public health systems were still struggling to address the basic public health needs of thousands of evacuees. The inadequate support for relief efforts exposes the lack of consistent, long-term political support for the core public health mission of creating conditions in which all people in this country can be healthy.

Recent public health advances

Public health professionals are knowledgeable and experienced, our science is sound, and we know more about the nature of an effective public health infrastructure than we ever have before. The public health community actively responded to the 1988 Institute of Medicine report's call to action and has, over the past decade, articulated the ten Essential Public Health Services, established competencies for public health workers, created National Public Health Performance Standards, and is now working toward, among other things, the accreditation of local health departments.

But fundamental problems still remain. For our public health system to use these new tools to detect disease, respond effectively in an emergency, improve population health status, and coordinate with partners, there must be a sufficient supply of competent public health workers, organizational capacity to respond to change, and modern information and communication systems to track and communicate health data.

Although the last decade has seen unprecedented efforts to strengthen our systems, the recent priorities placed on bioterrorism preparedness and, at the same time, on reducing the size of local and state government, demonstrate how vulnerable public health's core mission is to shifting political priorities.

Turning Point demonstrates value of investment

In 1997, The Robert Wood Johnson Foundation (RWJF) initiated long-term support for the national Turning Point initiative, an initiative that has shown the value of investment in infrastructure improvement. The Turning Point National Program Office and Turning Point states are well aware of the value of a substantial, long-term investment in improving something so abstract as "public health systems." Evidence of positive results of this funding on capacity-building among state and local health departments is demonstrated by expanded public health efforts and successes through coordinated, systematic planning and partnering within Turning Point states.

Findings from a study of the Turning Point states' response when CDC released

funds for emergency response planning in 2002 suggest that "ongoing public health systems development that works across sectors on broad and non-categorical improvements that impact health can have strong implications for a system's ability to respond more effectively and efficiently under more emergent conditions" (Bekemeier and Dahl, 2003).

Despite extremely difficult budgetary times and national crises, many of these Turning Point states leveraged their RWJF investment more than four and five times over. In doing so, they created local public health systems in regions of their states not previously receiving public health protection, developed statewide systems that now monitor and respond to health disparities where even simple data related to minority populations had not previously been available, and developed cross-sector planning relationships that made many of them more able to establish effective plans for responding in emergencies.

Sporadic funding vs. long-term investment

In 1988 CDC's Public Health Practice Program Office was established specifically to focus on improving public health infrastructure through strengthening the public health workforce, enhancing organizational effectiveness, increasing the scientific capacity of public health laboratories, and modernizing the systems that manage public health information and knowledge. In 2000 the Frist-Kennedy bill provided new money broadly allocated toward further strengthening the public health infrastructure.

These programs (as well as others) brought tremendous resources to local and state health departments in the form of information technology, training, leadership development, performance standards, and many other forms of capacity building directed toward enhancing core public health foundational infrastructure elements—workforce, organizational capacity, and information.

Although these efforts still exist in various forms, they have fallen victim to a shift in federal funding priorities toward bioterrorism-specific preparedness and away from building basic public health system capacity to respond to a varied and changeable landscape of emerging public health issues. As a result of this shift, momentum, attention, and dollars in support of developing our basic infrastructure have suffered. States, however, have used preparedness funding to its fullest and many are better-prepared to respond to a bioterrorist threat or event. But now this funding, too, is being cut back, leaving state and local health departments to face new mandates and public expectations with persistently shrinking budgets. As health departments try to operate in a shifting environment of funding and priorities, new public health issues will continue to emerge, and natural disasters will occur that put our systems to the test.

Public health systems need continued broad and generous investment in large-scale, long-term initiatives that will strengthen our public health infrastructure. The current spotlight on our poor system response in the Gulf region provides an opportunity to educate the public, policy makers, and funders about how much we know about what is needed for an effective public health system and how much support is still needed for getting there.

Betty Bekemeier is deputy director of the Turning Point National Program Office.

Resources

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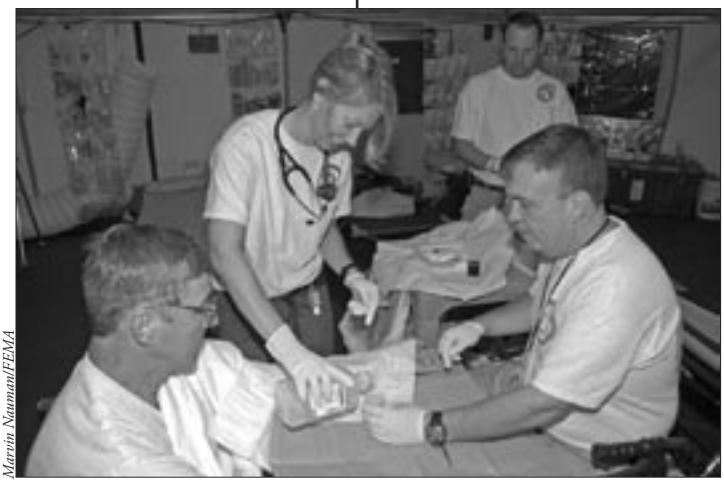
Using Volunteer Health Workers in Large-Scale Emergencies

James G. Hodge, Jr., Lance A. Gable, and Lawrence O. Gostin



Marvin Nauman/FEMA

In New Orleans after Hurricane Katrina, emergency medical personnel attend to a patient with a cut arm in a portable, self-contained Disaster Medical Assistance Team center.

The immediate devastation faced by populations in the Gulf Coast region following Hurricanes Katrina and Rita resulted in emergency declarations in Alabama, Louisiana, Mississippi, Oklahoma, and Texas. Due to extensive flooding in New Orleans that shut down most health care providers and stranded thousands of city residents for days, Louisiana separately declared a state of public health emergency. This declaration simulated provisions of the Turning Point Model State Public Health Act.

During these states of emergency, federal, state, and city officials worked extensively to address major gaps in the delivery of health care and public health services in New Orleans and elsewhere. They relied particularly on volunteer health professionals (VHPs) (such as, physicians, nurses, public health workers, and emergency medical responders) to fill surge capacity. The federal Department of Health and Human Services (DHHS) estimates that thousands of VHPs were organized and deployed to the Gulf Coast region through governmental programs, such as state-based emergency systems for the advance registration of volunteer health professionals (ESAR-VHP) or Medical Reserve Corps (MRC) and private sector efforts such as the American Red Cross. Perhaps thousands more volunteers arrived spontaneously without any formal organizational affiliation.

Volunteer services raise legal questions

The need for VHPs during emergencies is unquestioned. However, as seen in the Hurricane Katrina and Rita response efforts, a series of legal and regulatory questions affected their participation. What constitutes an emergency sufficient for the initiation of volunteer efforts, when and how is it declared, and what are the legal and practical ramifications of such declarations? When may VHPs who are licensed or certified in one state legally practice their profession in another state? When may VHPs face civil liability for their actions in response to public health emergencies? Who will compensate them for the injuries or other harms they incur? These and other legal issues pervaded the deployment of VHPs in the Gulf Coast region and, in some cases, inhibited more extensive use of volunteer services. Some volunteers were unable or reluctant to respond or engage in some efforts in the absence of sufficient legal protections or authorizations.

In September 2005, the Center for Law and the Public's Health at Georgetown and Johns Hopkins Universities (the Center) worked extensively to address these and other legal issues governing VHPs. (For more information, see the Center's Web site at www.publichealthlaw.net/Research/Katrina.) These efforts followed on the Center's prior work to draft the Turning Point Act (funded by The Robert Wood Johnson Foundation) as well as its existing project (funded by the Health Resources and Services

Administration) to assess the legal environment concerning VHPs registered through state-based ESAR-VHP systems.

Key observations about volunteer emergency efforts

- Declarations of an emergency or public health emergency can be crucial for the successful deployment of VHPs. Public health emergency declarations similar to those set forth in the Turning Point Act, for example, change the legal landscape in ways that greatly facilitate the use of VHPs by eliminating some non-emergency barriers to their rapid deployment.
- One of these barriers is the potential for VHPs licensed or certified in one state to practice their profession in another state. In non-emergencies, such practices are greatly limited. During emergencies, the Turning Point Act and other legal mechanisms such as the Emergency Management Assistance Compact (EMAC) allow medical practitioners to practice in another state by temporarily recognizing their valid licenses or credentials in their home state.
- Civil liability of VHPs for unintended injuries to patients is always a concern. However, during declared emergencies, many states specifically grant broader immunity or indemnification for VHPs who are officially responding to identified needs. (These liability protections may not apply, however, to spontaneous or other types of volunteers).
- Compensation for job-related injuries is typically provided through federal or state workers' compensation systems. These protections may not apply to VHPs (specifically because they are not viewed as employees). Some states and the federal government extend workers' compensation protections during emergencies by temporarily recognizing VHPs as employees.

Although the legal environment during the Gulf Coast hurricane-related emergencies flexed to sustain VHP deployment and use, multiple challenges remain. In partnership with HRSA, the Center is continuing to examine these challenges through guidance based in part on the structural and substantive provisions of the Turning Point Act.

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Social Marketing Collaborative Extends Work

The New York State Department of Health, convener of the Turning Point Social Marketing National Excellence Collaborative, has received a $100,000 grant from The Robert Wood Johnson Foundation to provide training and technical assistance on the use of social marketing to achieve public health outcomes. The grant provides partial staff support and support for roll-out of the newly enhanced *CDCynergy–Social Marketing Edition* Version 2.0 CD-ROM (available early 2006), updated trainings (beginning late spring/early summer 2006), and up to 20 days of technical assistance to public health professionals around the country who want assistance in implementing social marketing projects. The grant will also be used to develop a Web site and business plan to establish the Collaborative as an independent entity so that it can continue its work. The original *CDCynergy–Social Marketing Edition* CD-ROM will be available at www.tangibledata.com/CDCynergy-SOC until the release of Version 2.0. Watch for pre-ordering of the Version 2.0 CD-ROM to begin in early March (at the same URL).

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

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