

The Turning Point Initiative

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Editors' Introduction

In 1999, The Robert Wood Johnson Foundation formally reorganized its grantmaking strategies in a manner that emphasized the distinction between the two elements of its mission: improving health and improving health care. The first element, health, focuses on the nonmedical care aspects of staying healthy, such as behavioral and lifestyle choices, socioeconomic factors, and the public health system. The second element gives attention to the system of medical care that attempts to restore health after illness, injury, or disability occurs.¹

The 1999 reorganization gave formal recognition to a shift in the Foundation's priorities that had been taking place for a number of years as the Foundation moved toward a more balanced approach to grantmaking between health care and health. In the mid-1980s, the Foundation initiated programs to reduce the harm caused by the use of alcohol, tobacco, and illegal drugs—a focus that accelerated in the 1990s as grantmaking to reduce smoking became a high priority. With the increasing attention being given to health, it became apparent within the Foundation that it had neglected one key component in improving health: the public health system. This was reinforced with the publication of a series of influential books, reports, and articles demonstrating that medical care was responsible for only a small fraction (around 10 percent) of good health² and highlighting the weakness of the public health system.³

As a result of these internal and external forces, the staff began to consider how the Foundation might play a role in improving the public health. This led, ultimately, to the development and funding of *Turning Point*, an ambitious initiative designed to transform the nation's public health system. A distinctive feature of the initiative has been the collaboration between The Robert Wood Johnson Foundation, which supports activities at the state level, and the W.K. Kellogg Foundation, which focuses on public health at the county and community levels.⁴

In this chapter, Paul Brodeur, an award-winning health and environmental writer and a veteran author for the *Anthology* series, examines the concept behind and the activities of the Turning Point grantees, highlighting their work in five states. Brodeur also examines the implementation difficulties that the initiative encountered and reviews the reactions—both positive and negative—that Turning Point has evoked in the public health field.

Turning Point was conceived and largely implemented in a pre-September 11th, pre-anthrax world. In some ways, the concerns about bioterrorism and the infusion of federal money for bioterrorism preparedness complicated the initiative, forcing states to deal with terrorism as a transforming event

even as they tried to be the forces that transform the public health system. Where public health will end up after Turning Point and post-9/11 is still unclear, but the chapter offers some insights about how the various forces buffeting the public health system are acting and interacting.

1. McGinnis, J. M., and Schroeder, S. "Expanding the Focus of The Robert Wood Johnson Foundation: Health and an Equal Partner to Health Care." *To Improve Health and Health Care 2001: The Robert Wood Johnson Foundation Anthology*. San Francisco: Jossey-Bass, 2001.
2. See, for example, McGinnis, J. M., and Foege, W. "Actual Causes of Death in the United States." *Journal of the American Medical Association*, 1993, 270, 2207–2212; Evans, R., Barer, M., and Marmor, T. *Why Are Some People Healthy and Others Not? The Determinants of the Health of Populations*. New York: Aldine de Gruyter, 1994.
3. Institute of Medicine, *The Future of Public Health*. Washington, D.C.: National Academy Press, 1988.
4. Isaacs, S., and Rodgers, J. "Partnerships Among National Foundations: From Rhetoric to Reality." *To Improve Health and Health Care 2001: The Robert Wood Johnson Foundation*. San Francisco: Jossey-Bass, 2001.

Public health is what we, as a society, do collectively to assure the conditions for people to be healthy.¹

In 1988, a committee convened by the National Academy of Sciences' Institute of Medicine issued a report finding that the public health of the nation was in an alarming state of disarray. Citing immediate crises, such as the AIDS epidemic, as well as enduring problems such as injuries, chronic illnesses, teenage pregnancy, drug abuse, aging of the general population, and exposure to toxic by-products of the modern economy, this twenty-two-member group—the Committee for the Study of the Future of Public Health—determined that current capabilities for effective public health actions were inadequate, and that “the health of the public is unnecessarily threatened as a result.”² The committee members also declared that the states “must be the central force in public health,” and identified a number of weaknesses in state public health systems—among them lack of funding, the need for partnering with the private sector, and deficiencies in leadership, training, and data gathering and analysis.³

Partly in response to the Committee’s findings, a working group led by Nancy Kaufman, then a vice president of The Robert Wood Johnson Foundation, and Marilyn Aguirre-Molina, at the time a senior Foundation program officer, began meeting during the early 1990s to devise ways in which the Foundation might help modernize and strengthen state health departments. At about the same time, the W.K. Kellogg Foundation, under the leadership of Gloria Smith, a vice president, had begun work on a plan to revitalize county health departments and community public health. In November 1995, at a roundtable meeting sponsored by the Institute of Medicine, in La Jolla, California, Kaufman and Tom Bruce, a program director at Kellogg, learned for the first time that their respective foundations were working separately toward a common goal. “Tom and I got together that night,” Kaufman recalls, “and decided that the only way to proceed was to work together with the understanding that it would take states and communities working together to revitalize the public health system.” Since senior executives of the two foundations had already been meeting to explore ways in which they might collaborate, the idea engendered initial enthusiasm among officials of both institutions.

In January 1996, the staff of The Robert Wood Johnson Foundation presented a request to the Board of Trustees, seeking a two-year \$7 million authorization of a new program in which fifteen to twenty

states would explore restructuring their public health system, reallocating human and financial resources, developing leadership, increasing the skills of public health officials, expanding the use of technology, improving health surveillance systems and epidemiology, and extending public health partnerships with the private sector. The Kellogg Foundation would collaborate with The Robert Wood Johnson Foundation in this initiative by contributing up to \$17 million to support an analogous program at the local level. The \$24 million-plus joint venture between the two foundations (which by 2004 had reached a funding level of more than \$40 million) represented the largest privately funded effort to strengthen the public health system in the nation's history.⁴

The goal was nothing short of transforming and strengthening the public health infrastructure in the United States. The means of reaching this ambitious goal was the development of collaborative partnerships between public health departments, other state and local health agencies, schools of public health, the business community, health maintenance organizations, hospitals, environmental organizations, and faith-based groups. The timing, as the staff's request to the Board pointed out, was urgent: "The window of opportunity presented by the unprecedented changes in the health care environment, the compelling need faced by states to prepare for the increased responsibilities as resources diminish, and the state of the public health infrastructure make this a critical time for intervention."

The new initiative, which was called Turning Point: Collaborating for a New Century in Public Health, was approved by the Board, and in November 1996 a call for letters of intent was sent to potential applicants nationwide. In the call for letters of intent, the Foundation described the essential public health challenges facing the nation as follows: "A study by the Department of Health and Human Services of the ten leading causes of death concluded that only 10 percent of premature deaths are avoidable through improved access to medical care. The remainder were attributed to personal risk behaviors (52 percent), environmental risks (20 percent), and human biology (18 percent). Thus, public health approaches have the potential to prevent the majority of early deaths by targeting factors that contribute to these deaths."

"The response to the call for letters of intent and the subsequent invitation to submit proposals was an avalanche," recalls Bobbie Berkowitz, who directs the Foundation's Turning Point National Program Office at the University of Washington School of Public Health and Community Medicine, in Seattle.⁵ "Forty-six states sent proposals to us, and five hundred and twenty-five communities responded with proposals to the Kellogg Foundation. The applications were evaluated for evidence of progressive approaches to the formation of public/private partnerships that would carry out core public health functions and develop new strategies for addressing emerging health challenges. We spent October and November of 1997 sifting through the proposals before winnowing them to twenty-nine, which we sent to the Turning Point National Advisory Committee, whose members winnowed them further to fourteen."

Each of the fourteen states selected—Alaska, Arizona, Illinois, Kansas, Louisiana, Montana, Nebraska, New Hampshire, New Mexico, New York, North Carolina, Oklahoma, Oregon, and Virginia—received a two-year \$300,000 grant to develop a plan for modernizing and improving its public

health system. At the same time, forty-one communities and counties in the fourteen states received grants of up to \$60,000 from the Kellogg Foundation for two to three years of planning and implementation. In order to enhance collaboration, the state partnerships created under The Robert Wood Johnson Foundation grants included the communities funded by the Kellogg Foundation and vice versa. The National Advisory Committee provided overall guidance for the Turning Point initiative, but separate National Program Offices were designated to manage the grants of each foundation. The Robert Wood Johnson Foundation's grants were administered by a National Program Office located at the University of Washington's School of Public Health and Community Medicine. The Kellogg Foundation's grants were administered by the National Association of County and City Health Officials, or NACCHO, in Washington, D.C.

The Planning Phase

During the planning stage that began in 1998, the initial fourteen grantee states were required to assess public health needs in their state and to submit public health improvement plans with specific goals. (In 1999, The Robert Wood Johnson Foundation awarded planning grants to seven additional states—Colorado, Maine, Minnesota, Missouri, South Carolina, West Virginia, and Wisconsin—bringing the total to twenty-one.) The needs, which varied widely from state to state, were reflected in the range of plans. For example:

- Montana's plan found a need for better training and education of its state and local public health personnel, and called for the establishment of a public health training institute.
- The Turning Point initiative in Louisiana gave priority to expanding access to and quality of health care for people living in rural areas and proposed enlisting the state's Office of Public Health and the Tulane School of Public Health in this effort.
- In Virginia, leaders of the Turning Point initiative, convinced that local citizens should be consulted about what public health needs they considered most important, planned to establish teams to hold regional forums.
- In Nebraska, where less than a quarter of the state's counties provided any measure of public health service, the overriding challenge was to develop a plan that would expand public health services throughout the state.
- In New Hampshire, which also suffered from a lack of a functioning public health system at the local level and where most of the state's 234 cities and towns employed health officers whose only qualification for the job was that they be residents of the state, the Turning Point initiative proposed forming coalitions of towns to pool resources, thereby expanding public health services.

The National Excellence Collaboratives

In October 1999, The Robert Wood Johnson Foundation authorized an additional \$15 million to carry out the implementation phase of the Turning Point initiative and, within it, to develop a number of National Excellence Collaboratives. Bobbie Berkowitz, the National Program director, and Susan Hassmiller, a senior program officer at The Robert Wood Johnson Foundation who has overseen the program since 1997, had identified certain recurrent issues that cut across state lines and required special attention. Among them were the need for (1) acquiring better information and technology systems, (2) updating public health laws, (3) improving the performance management of local

public health systems, (4) developing leadership, and (5) adopting commercial marketing techniques to persuade people to change unhealthy behaviors, such as cigarette smoking and drug abuse. As a result, The Robert Wood Johnson Foundation decided to create five National Excellence Collaboratives. Consisting of representatives from each state partnership and community partners, the collaboratives were charged with analyzing the five issues in greater detail and developing models that would provide solutions.

The states applying for implementation phase grants were given the opportunity of participating in up to two of the National Excellence Collaboratives. They could also apply to be the lead state for a particular collaborative, in which case they were required to show considerable expertise in the topic. States that were selected as participants in a National Excellence Collaborative received an additional grant of \$150,000, and states designated as leaders of a collaborative received a supplementary \$150,000.

The collaboratives met four times a year over the next four years.

- The Information Technology Collaborative developed an online Public Health Information Technology Catalogue to help community health agencies make decisions about which data systems could best meet their information needs.
- The Leadership Development Collaborative produced a core curriculum for leadership training and a set of leadership self-assessment tools.
- The Performance Management Collaborative, after testing a four-part model in two states, developed a performance management tool kit.
- The Social Marketing Collaborative designed a social marketing CD ROM based on work done by the Centers for Disease Control and Prevention. It was tested in two programs—one to promote the adoption of public health careers in Minnesota and the other to promote effective diabetes management in Virginia.
- The Public Health Statute Modernization Collaborative contracted with the Center for Law and the Public's Health at Georgetown and Johns Hopkins Universities, which drafted the Turning Point Model State Public Health Act.⁶ As of January 28, 2004, twenty-two states had introduced legislative bills or resolutions containing some of the provisions found in the model law, and sixteen of these bills had passed. However, because of provisions allowing for substantial increases in governmental powers to detect and contain bioterrorism threats or naturally occurring disease outbreaks, the model law has come under attack by a number of health professionals and civil liberties groups.⁷

The Implementation Phase

In March 2000, The Robert Wood Johnson Foundation awarded four-year implementation grants totaling \$500,000 to each of the thirteen states—all but New Mexico—that had received planning grants and submitted public health improvement plans. (The seven states that had been awarded planning grants in the second wave of funding in 1999 received implementation grants in 2001.) Conversations with leaders of various Turning Point partnerships and visits to a number of states in the autumn of 2003 revealed the range of approaches that the partnerships had adopted to improve public health in their states.

Nebraska

In the first year of the implementation phase, only twenty-two of the state's ninety-three counties had local health departments. However, two community partnerships that were funded by the Kellogg Foundation—the North Central Community Care Partnership, a coalition of nine counties in the north central section of the state, and Buffalo County Community Health Partners, in the central region—implemented plans to address public health problems such as unhealthy aging, teen pregnancy, violence, obesity, poor water quality, and inadequate housing. Given the success of these efforts, the Nebraska Turning Point Project funded four new community-based partnerships in January 2001. Each of them received \$15,000 from the Nebraska Turning Point Partnership, \$15,000 in state matching funds, and a \$10,000 local match.

The momentum generated by the Turning Point initiative helped to stimulate new public health legislation. In May 2001, the Nebraska legislature passed a law that appropriated \$11.4 million from the state's Tobacco Settlement Fund to establish public health departments across the state over a two-year period. In addition, the law provided \$5.6 million over a two-year period to address minority health needs, such as those reflected in disparate rates of infant mortality, cardiovascular disease, and diabetes.⁸ By the summer of 2003, a wholesale transformation of Nebraska's public health infrastructure had occurred through the establishment of sixteen new multicounty public health departments that now provide public health services in all of the state's ninety-four counties.

David Palm, who is the administrator and coordinator of the Turning Point Initiative in the Nebraska Health and Human Services System, is proud of the achievements of Nebraska Turning Point, but aware that much remains to be done. "For the past two years, we've been holding statewide workshops to train the members of our newly established county departments of health in how to assess public health needs, develop policy, and diagnose problems," he said not long ago.

Like other states, we're using bioterrorism money—in our case, \$3 million of the \$9 million we received in 2003 from the Centers for Disease Control and Prevention's Emergency Preparedness Fund—to strengthen our public health infrastructure. For example, we have used bioterrorism funds to buy fax machines, computers, and cell phones for our multicounty health departments so that their members can communicate effectively with one another in the event of attack. Among our unsolved problems are drinking-water contamination caused by pesticide pollution of wells and rivers, as well as by waste products from hog-confinement lots. Unfortunately, Nebraska's state and local health departments do not have sufficient regulatory power to deal adequately with this situation.

New Hampshire

Like Nebraska, New Hampshire has long been saddled with a fragmented and inadequate local public health system. Indeed, the first report deploring the lack of public health capacity in the state was issued back in 1883. In 1995, the state Department of Health and Human Services arranged for the creation of the Community Health Institute, a nonprofit organization that was originally charged with improving access to primary health care. Two years later, the Community Health Institute and the New Hampshire Public Health Association responded to The Robert Wood Johnson Foundation's

Call for Proposals to join the Turning Point initiative. With the Institute acting as the Foundation's primary grantee, the two organizations took the lead in developing a public health improvement plan that gave priority to developing local public health coalitions.

By 1999, a new commissioner of the New Hampshire Department of Health and Human Services had been appointed, and Dr. William Kassler, formerly the director of a health services and evaluation program at the CDC, had been named state medical director. "When I arrived in New Hampshire at the end of 1998, I became involved in a battle taking place in two cities over whether a drinking-water fluoridation initiative should be placed on the ballot," Kassler said not long ago. "One city had a strong health department; the other had a weak one. In the city with the strong department, the initiative got on the ballot and was eventually approved. In the city with the weak department, the initiative failed to get on the ballot. It was an object lesson I haven't forgotten."

From the beginning, Kassler has proven to be a powerful supporter of the New Hampshire Turning Point initiative, whose leaders launched the program by competitively selecting four public health coalitions covering thirty-seven New Hampshire towns to receive funding and technical support. Most of these towns had large numbers of residents without health insurance, without adequate transportation to health care facilities, with poor dental care, and with annual family incomes that were well below the state average. One of the four public health coalitions was the North Country Health Consortium—a collection of thirty-five rural northern New Hampshire towns—whose members completed a health needs assessment and a public health improvement plan, and then used a grant from the New Hampshire Turning Point Initiative and the state to set up a mobile dental laboratory and develop a tobacco prevention program. The consortium also established the Northern New Hampshire Area Health Education Center, which trains health professionals in how to deal with diabetes, identify victims of domestic violence, screen for breast cancer, improve communication with patients, and care for terminally ill patients and those with dementia.

Kassler persuaded his former colleagues at the Centers for Disease Control and Prevention that CDC Health Alert Network funds could best be employed to strengthen local public health departments, and these funds were used to strengthen other health coalitions in the state. He also persuaded the state Department of Health and Human Services to create local initiatives with several million dollars of the \$10 million in bioterrorism and emergency preparedness funds the state received from the CDC. At the same time, under the leadership of Jonathan Stewart, director of the Community Health Institute, Turning Point funds were used to provide training and technical assistance to the regional coalitions. At the end of 2003, the Turning Point coalitions had become the New Hampshire Public Health Network, and the collaboratives were serving eighty-seven communities and more than 60 percent of the state's residents. Future plans call for the expansion of the Public Health Network until all of the state's 234 towns and their residents are covered.

New York State

Unlike Nebraska and New Hampshire, New York State has had a long-established public health system that includes health departments in fifty-eight of its sixty-two counties (a single health department covers all five counties [boroughs] of New York City), and health commissioners who are

physicians in the twelve largest counties—those with more than 250,000 residents. In 1998, the state received a Turning Point planning grant from The Robert Wood Johnson Foundation, and funding from the Kellogg Foundation for local public health partnerships in the five boroughs of New York City, in Chautauqua county, and in the Capital District counties of Albany, Rensselaer, and Schenectady. Over the next two years, priorities and strategies for strengthening the public health system were developed by members of the New York State Department of Health, the New York State Community Health Partnership (the name given to the state’s Turning Point initiative), and the three local partnerships. At the conclusion of the planning phase, a steering committee selected training to improve the skills of the members of the public health workforce and of community health coalitions as the primary goal of New York’s Turning Point initiative. In April 2000, New York State was awarded a four-year \$950,000 Turning Point implementation grant to provide workforce training, participate in and lead the Social Marketing National Excellence Collaborative, and participate in the Collaborative on Performance Management.

Initially, New York State thought that an independent community health institute would be the most suitable way to provide public health training and education. During the second year of the implementation phase, however, it was decided that this training and education could best be provided by working within the New York State Department of Health system in collaboration with a number of academic and professional organizations, including the State University of New York, or SUNY, Albany School of Public Health, the New York and New Jersey Public Health Training Center, the New York State Nurses Association, and the New York State Association of County Health Officials. These institutions offer a wide-ranging public health curriculum that includes orientations for county health commissioners and public health directors, basic courses in public health, programs in environmental health, and training for public health nurses in community health assessment. The New York State Department of Health allocates \$650,000 to SUNY Albany for much of this training.

According to Sylvia Pirani, who is director of the New York State Community Health Partnership, as well as of the New York State Health Department’s Office of Local Health Services, one of the most successful of the training initiatives has been the Third Thursday Breakfast Broadcasts, known as T2B2, which were begun in 1999. “There are more than 12,000 public health workers in the New York State Department of Health and in the fifty-eight health departments in the state,” Pirani said. “Many of these practitioners are eager to stay abreast of current public health issues, such as West Nile virus, Lyme disease, smallpox, SARS, lead poisoning, emergency preparedness, and biological threats such as anthrax, but have little time or resources for travel to meetings and workshops. The Third Thursday one-hour broadcasts have addressed the problem with a format that features a professional moderator interviewing a public health expert on a specific subject, and includes time for telephoned or faxed questions during the final ten minutes of the program. Satellite technology has made it possible to distribute the program nationally, and, thanks to financial support provided by the New York State Department of Health, the broadcasts now reach a live audience of up to 300 public health practitioners each month.”

Virginia

The Commonwealth of Virginia established a board of health in 1872, and is one of a dozen or so states that operate a state-supervised public health system at the local level. The Virginia Department of Health serves the commonwealth through a central office in Richmond and thirty-five health districts made up of 119 city and county health departments throughout the state. Some of the health districts are made up of one city, such as Richmond, while other districts, such as the Three Rivers Health District, may contain up to ten counties. Each of them is directed by a full-time physician.

Virginia has chosen to reorganize its public health system by emphasizing collaboration between the public and private sectors. For example, the Virginia Department of Health elected to submit a joint proposal for Turning Point funding with the Virginia Hospital Research & Education Foundation, a subsidiary of the Virginia Hospital & Healthcare Association, which is a statewide trade association that enjoys considerable clout with members of the Virginia state legislature. As further evidence of Virginia's bent toward a public/private partnership, the Department of Health asked the Hospital Research & Education Foundation to serve as the fiscal agent for Turning Point funds.⁹

During the Virginia Turning Point planning phase, the members of a steering committee identified several goals and methods for improving the commonwealth's public health system. Among them were conducting a community health needs assessment, developing public awareness about health issues, assessing the economics of disease prevention programs, emphasizing the use of information-based health decisions, and enhancing the skills of the public health workforce. To reach these goals, Virginia Turning Point officials recommended the formation of a new partnership that would also serve as a vehicle for building bridges with the business sector. In March 2000, urged on by the efforts of the Virginia Hospital & Healthcare Association, the Virginia Legislature authorized the creation of the Virginia Center for Healthy Communities, which was established as a nonprofit 501(c)(3) entity. The center's board of trustees was made up of members from public and private entities, whose mission included forging "a stronger link between the interests of the business and health sectors," on the assumption that the two have "common goals of effective interventions that are cost effective."¹⁰

Whether the public/private partnership that characterizes the Virginia Center for Healthy Communities is improving the public health of the Commonwealth is not yet known, because, as with Turning Point initiatives in other states, it is too early to measure outcomes. According to Jeffrey Wilson, who is the coordinator of Turning Point and Strategic Planning for the Virginia Department of Health, an early success has been the *Virginia Atlas of Community Health*. The *Atlas* is a Web-based interactive map that contains county and ZIP-code-level data for 114 population, economic, and health indicators in Virginia. It enables planners and health officials to identify health needs in specific neighborhoods. "This kind of mapping allows decision-makers to focus their efforts on localities where the health needs are most acute," Wilson says. "For example, we can use data from the *Atlas* to approach asthma victims and train them how to manage their asthma attacks without using hospital emergency rooms. Data from the *Atlas* can also help us determine where problems like diabetes are most acute, and that information can help us target resources to the areas of greatest need."

South Carolina

South Carolina ranks as one of the nation's five worst states in terms of health indicators, including very high rates of mortality from stroke and heart disease and of HIV/AIDS. Moreover, persistent disparities exist between African Americans and whites living in the state. Not surprising, members of the South Carolina Department of Health and Environmental Control were disappointed when The Robert Wood Johnson and Kellogg Foundations turned down its initial application for a Turning Point planning phase grant. However, the state was able to provide \$150,000 for strategic planning to improve South Carolina's public health system, in the event that the application for Turning Point funding was rejected, which meant that the planning phase was able to proceed on its own. Thanks largely to this extracurricular effort, which was spearheaded by Lisa Waddell, deputy commissioner for health services, and Jerry Dell Gimarc, senior planner in the health department's planning office, The Robert Wood Johnson and the Kellogg Foundations approved South Carolina's second application for Turning Point funding in June of 1999.

A department of health official for twenty-four years, Dell Gimarc has directed the state's Turning Point initiative since the beginning. When she retired from the health department in 2000, she moved to the University of South Carolina Center for Health Services and Policy Research, which the department had designated as the fiscal agent for Turning Point. "South Carolina's public health system is strong and well integrated, with health departments in each of the state's forty-six counties that are affiliated with one of twelve multicounty health districts," she said recently. "What we wanted to accomplish with Turning Point was to strengthen local health departments." "Our chief goals have been to improve the competency of our workforce and to reach out to our communities and engage their support," added deputy commissioner Waddell. "Thanks largely to health department funds, we've sent forty-six health professionals to train at the University of North Carolina Public Health Leadership Institute. With funding from the Centers for Disease Control and Prevention, we've enrolled 249 health officers in an executive education course at the University's Management Academy for Public Health." During the planning stage, which took place from 1999 to 2001, funds from The Robert Wood Johnson Foundation were used to support pilot projects in Anderson County in the northwest part of the state, Horry County in the east, and Hampton County in the south. South Carolina's Turning Point is currently using its implementation grant funds to support partnerships in six additional counties.

Controversies and Issues

As might be expected, an undertaking of the magnitude and complexity of Turning Point did not occur without engendering some controversy and raising fundamental issues. The main issues concern the conceptual bases of the program, the way it was implemented, and, in a broader public health context, the use of bioterrorism funds for public health purposes.

The Conceptual Bases of the Turning Point Initiative

A number of academics have questioned the basic premises of Turning Point. They have wondered whether, in endeavoring to transform public health, the program was oversold; whether collaboration would bring about improvements in the public's health; and whether partnership of government

with the private sector was desirable or realistic. Many of these questions were raised in the January 2002 issue of the *Journal of Public Health Management and Practice*, which was devoted to exploring the Turning Point Initiative.

In that issue of the Journal, Rebecca Socolar, clinical associate professor of pediatrics and social medicine at the University of North Carolina School of Medicine at Chapel Hill, reviewed three articles written by Turning Point officials and found that the authors had failed to make clear whether collaboration—the quintessential mantra of Turning Point—was a goal in and of itself or a tool to use toward achieving improvement in public health. “Part of the problem is that until a group has defined its goals explicitly and clearly, the desired outcome may be so nebulous that it is unclear what tools may be useful in reaching those goals,” Socolar wrote. “Goals such as ‘creating a new approach to community health’ or ‘improving health’ are so vague that it is unclear what exactly the goals are and unclear what processes are best to achieve these goals.” She concluded by observing that “there still needs to be better evidence about outcomes related to collaboration.”¹¹

Stephen Linder, associate professor of management and policy sciences at the School of Public Health of the University of Texas, in Houston, questioned the basic premise of public-private collaboration and the borrowing of private sector practices for public health purposes. Such borrowing, he wrote, favored “private over public provision of services and market virtues over government responsibilities,” and he predicted that after privatization in businesslike partnerships, “public health would be ‘branded’ like laundry soap and promoted to communities of customers.” Moreover, he said that the articles he had reviewed echoed the promotional tone of materials disseminated by The Robert Wood Johnson and Kellogg foundations, and were written in a bewildering and self-congratulatory language he referred to as “TurningPointSpeak.”¹²

Peter Jacobson, associate professor in the Health Management and Policy Department at the University of Michigan School of Public Health, in Ann Arbor, questioned the strategy of public-private collaboration and the motives of the private sector for participating in public health partnerships. “Will they co-opt public resources without providing adequate services, leaving a void?” he asked. “Or will they simply overwhelm the public sector, only to abandon the field when it becomes inopportune? After the public sector is dismantled, it will be very difficult to put back together.”¹³

Another conceptual issue is whether the public health infrastructure is so weak that, despite the best efforts of the Turning Point initiative, it will remain subject to political and commercial pressures and unable to carry out significant aspects of its mandate, such as addressing environmental health problems in a timely fashion. In some cases, this is because health departments are separate entities from departments of the environment. In other cases, political or commercial interests have managed to thwart health department officials from addressing environmental health issues. The aftermath of September 11th offers a dramatic illustration. A week after the terrorist attacks on the World Trade Center, the White House Council on Environmental Quality downplayed the tremendous environmental health problems in lower Manhattan, and the Environmental Protection Agency declared that the air in lower Manhattan was safe to breathe. The public health leadership in New York City

did not protest, despite the high levels of asbestos and other toxins in the air and on the ground that threatened the health of workers and residents and whose harmful effects have since been demonstrated in a number of reports.¹⁴

Implementation

As happens with many programs—especially those relying on the formation and work of coalitions—implementation was not rapid or smooth. The Robert Wood Johnson Foundation’s Susan Hassmiller has noted, “The process has been slow and tedious. It’s hard to break down public health barriers. Neither side—public health on the one side and others, such as business, on the other—has much incentive to work with the other. Also it is cumbersome for agencies within state government to work in a collaborative fashion.” In the case of Turning Point, implementation was made even more difficult by the divergent cultures of the two foundations that had conceived of the initiative.

The cultural differences between Kellogg and Robert Wood Johnson became apparent almost from the start. “Kellogg is a grassroots kind of organization, really interested in the community,” Bobbie Berkowitz has said. “Robert Wood Johnson is more large-scale, systems-oriented, and interested in having a major impact nationally.” Marilyn Aguirre-Molina, who left The Robert Wood Johnson Foundation to become a professor of public health at Columbia University’s Mailman School of Public Health, explained that “Kellogg initially wanted to give local health departments very wide latitude about what they could do under Turning Point,” whereas “Robert Wood Johnson had a tendency to let the health departments know what results it expected them to achieve.”¹⁵

Because of such cultural differences, teams from the two foundations charged with selecting state and community sites had a difficult time coming to agreement. Moreover, when agreement was reached, the initial fourteen state and forty-one community grantees were placed on different timetables. For example, The Robert Wood Johnson Foundation authorized only two years of funding for the planning phase, while agreeing to consider additional funds for more sites and for an implementation phase at a later time, whereas the Kellogg Foundation authorized three years of funding up front for both planning and implementation. Tension between the two foundations was further exacerbated in October 1998 when, without alerting The Robert Wood Johnson Foundation, NACCHO, the National Program Office for the Kellogg Foundation’s part of Turning Point, sent a letter to the forty-one Kellogg Foundation grantees stating that because of a stock market decline that reduced Kellogg’s endowment, their activities might have to be curtailed.

To salvage a deteriorating situation, Susan Hassmiller suggested holding a retreat for key staff members from both institutions and their respective National Program Offices. The participants in the meeting, which took place in Chicago in August 1999, agreed upon a plan of regular communications that alleviated many of the interfoundation problems. However, certain inherent weaknesses in Turning Point remained difficult to overcome. Gloria Smith of the Kellogg Foundation has pointed out that “it would have been far better for both foundations to have been on the same timetable from the start and to plan the program around a common framework.”¹⁶ Vincent Lafronza, Turning Point program director at NACCHO, believes that the financing of the initiative was flawed from the beginning. “States and communities should have been financed jointly and allowed to

agree together on how to use the money,” he says. “Instead, when it came to funding the implementation grants, Kellogg and Robert Wood Johnson acted independently of each other in selecting the communities they would finance. This, of course, was antithetical to the basic premise of Turning Point, which was to encourage collaboration.”

The Use of Bioterrorism Funds

Since the terrorist attacks of September 11, 2001, nearly \$1 billion in federal grants has been made available to state and local health departments to enhance public health preparedness to handle a range of potential public health emergencies.¹⁷ Two schools of thought have emerged as to whether this huge influx of federal money focused on bioterrorism has been beneficial or harmful to the overall goals of Turning Point. Some experts, such as Jeffrey Koplan, vice president for academic health affairs at the Woodruff Health Sciences Center at Emory University and former head of the CDC, argue that strategies developed in response to bioterrorism threats expand the ability of state public health departments to fulfill their broader mission to protect against a full range of risks to the public’s health. “The tools we develop in response to bioterrorism threats are ‘dual use’ tools,” he wrote. “Not only will they ensure that we are prepared for man-made threats, but they also ensure that we will be able to recognize and control the naturally emerging infectious diseases and the hazardous materials incidences of the late 20th century.”¹⁸

Others believe that the overriding focus on bioterrorism siphons money and public health personnel away from arguably greater threats and from broad community partnerships capable of addressing a wide variety of public health issues. Victor Sidel and Barry Levy, both past presidents of the American Public Health Association, assert that extraordinary political and economic pressures have subverted sound public health principles in favor of addressing the threat of bioterrorism, and that urgent problems are being neglected.¹⁹

Clearly, the challenge posed by the current national preoccupation with bioterrorism is something that state health departments will have to deal with if they are to carry out their essential mission of preventing and controlling disease. The challenge affects, and is affected by, Turning Point. As Betty Bekemeier, deputy director of the Turning Point National Program Office, and Jan Dahl, a senior consultant to Turning Point, noted, “the strong relationship between bioterrorism preparedness planning and the broader concepts of public health system development include issues such as local capacity building, information technology infrastructures, and workforce development”—the very basics of the Turning Point program.²⁰

Conclusions

Turning Point is an ambitious initiative with the admirable if somewhat amorphous goal of improving the public health systems of states, counties, and communities through the development of collaborative partnerships between public health departments, other state and local health agencies, schools of public health, the business community, health maintenance organizations, environmental coalitions, and faith-based groups. The premise behind Turning Point holds promise, not least of all because of the enthusiasm and the dedication of the initiative’s participants across the nation—an

enthusiasm and dedication that can be found from those working in the north woods of New Hampshire to those toiling in isolated and impoverished counties of South Carolina.

On December 16 and 17, 2003, eighty-five public health leaders—among them representatives of The Robert Wood Johnson Foundation, the Turning Point National Program Offices, state Turning Point directors, national public health organizations, and business executives—met at the Foundation’s headquarters, in Princeton, New Jersey, to discuss what had been learned and accomplished during the six-year initiative.

At this meeting, the program’s evaluators, Todd Rogers and Dianne Barker of the Public Health Institute, summarized the major themes they observed in the course of their qualitative evaluation of the Turning Point initiative. They pointed out that new structures had expanded the ability of a number of Turning Point states to respond to public health issues, among them:

- The creation of offices dedicated to public health improvement in state health departments in Montana, Nebraska, Oklahoma, and Wisconsin
- The establishment of public health institutes outside of state health departments in Illinois, Louisiana, Missouri, and Virginia
- The expansion of local public health systems through government structures in Nebraska and Nevada and through partnerships in Minnesota, New Hampshire, and Oklahoma

Rogers and Barker also cited the work done by some of the National Excellence Collaborations, and described efforts by several states to institute enhanced leadership programs and to expand training opportunities in order to provide a more competent public health workforce.

The meeting’s participants agreed that Turning Point had transformed the way people think about public health in terms of partnership, culture change, and the need to improve public health systems. They emphasized the importance of partnerships in lessening the impact of state budget cuts, and of communication as a way of overcoming the generally poor understanding of public health by members of the general population. The Robert Wood Johnson Foundation’s Hassmiller suggested that one of the initiative’s legacies would be the creation of public institutes in many states. “These nonprofit institutes,” she said, “work with state and local government health departments to get work done in a more expeditious fashion than government can do alone.”

Turning Point has already made significant progress by helping to enlarge the scope of public health systems, especially in states such as Nebraska and New Hampshire, where dozens of multitown and multicounty partnerships have been formed to provide public health services to populations that were previously deprived of them; by facilitating the education and training of public health professionals through such methods as New York State’s monthly radio broadcasts; and by compiling data on community health status as exemplified by the *Virginia Atlas of Community Health*.

In spite of its achievements, the jury is still out on Turning Point, for a number of reasons. First, after only four years of implementation funding, it is too early to know whether the progress made so far in states and communities can be sustained in the face of huge budget cuts that are taking place at all levels of government across the nation. Second, it is questionable whether public health coalitions

and better trained public health officials will be any better equipped than their predecessors to stand up to the powerful political and commercial interests opposing their efforts. Third, there is as yet no hard evidence to support the premise that the public-private-nongovernmental collaboration that lies at the heart of the Turning Point vision will result in improving the health of the public.

Finally, the contributions of Turning Point's partnerships at the state and community level must be seen in the context of a public health system that the Institute of Medicine described in 1988 as being in "disarray"²¹ and, in 2003, found to be characterized by "vulnerable and outdated health information systems and technologies, an insufficient and inadequately trained public health workforce, antiquated laboratory capacity, a lack of real-time surveillance and epidemiological systems, ineffective and fragmented communications networks, incomplete domestic preparedness and emergency response capabilities, and communities without access to essential public health services."²² While Turning Point has produced valuable insights and changes in a number of states and communities, the challenge of transforming the public health system is an enormous one. Meeting it will require not only the efforts of foundations like Robert Wood Johnson and Kellogg but also a transformation of the public's awareness of the importance of public health to the nation.

Notes

1. Institute of Medicine. *The Future of Public Health*. Washington, D.C.: National Academy Press, 1988, p. 19.
2. *Ibid.*, p. 19.
3. *Ibid.*, pp. 139–155.
4. Hassmiller, S. "Turning Point: The Robert Wood Johnson Foundation's Effort to Revitalize Public Health at the State Level." *Journal of Public Health Management and Practice*, 2002, 8(1), 4.
5. The first director of the program was Gilbert Omenn. Berkowitz became program director when Omenn left in 1997.
6. The Model Act was drafted in October 2001 in collaboration with the National Governors Association, the National Conference of State Legislatures, the National Association of Attorneys General, the Association of State and Territorial Health Officials, and the National Association of County and City Health Officials. *Transformations in Public Health*, Spring 2002, 4(1), 1. Turning Point National Program Office, University of Washington, Seattle.
7. Sidel, V. W., and Levy, B. S. "Policy Corner." *Transformations in Public Health*, Winter, 2003, 4(4), 10. Turning Point National Program Office, University of Washington, Seattle.
8. Palm, D. "Building a Sustainable Public Infrastructure in Nebraska." *Transformations in Public Health*, Autumn 2001, 3(4), 7–8.
9. Lake, J. L., and Peterson, E. A. "An Alternative Structure for Improving the Public's Health." *Journal of Public Health Management and Practice*, 2002, 8(1), 77.
10. *Ibid.*, pp. 80–81.
11. Socolar, R. "Collaboration: The End or the Means?" *Journal of Public Health Management and Practice*, 2002, 8, 34.
12. Linder, S. H. "On the Politics of Policy Development." *Journal of Public Health Management and Practice*, 2002, 8, 62–63.
13. Jacobson, P. D. "Form Versus Function in Public Health." *Journal of Public Health Management and Practice*, 2002, 8, 92–93.
14. DePalma, A. "Many Who Served on 9/11 Are Still Pressing the Fight for Workers' Compensation." *New York Times*, May 13, 2004, A24; Kennedy, R. F., Jr. "The Junk Science of George W. Bush." *The Nation*, March 8, 2004; Pope, C. "Whitewash at Ground Zero: How the White House Covered Up Post-September 11 Hazards." *Sierra Magazine*, January/February 2004.
15. Isaacs, S. L., and Rodgers, J. H. "Partnership Among National Foundations." *To Improve Health and Health Care, 2001: The Robert Wood Johnson Foundation Anthology*. San Francisco: Jossey-Bass, 2001, p. 232.

16. Isaacs, S. L., and Rodgers, J. H. "Partnership Among National Foundations." *To Improve Health and Health Care, 2001: The Robert Wood Johnson Foundation Anthology*. San Francisco: Jossey-Bass, 2001, p. 233.
17. Bekemeier, B., and Dahl, J. "Turning Point Sets the Stage for Emergency Preparedness Planning." *Journal of Health Management and Practice*, 2003, 9, 377–383.
18. Koplan, J. "Policy Corner." *Transformations in Public Health*, Winter 2003, 4(4), 10. Turning Point National Program Office, University of Washington, Seattle.
19. Sidel, V. W., and Levy, B. S. "Policy Corner." *Transformations in Public Health*, Winter 2003, 4(4), 10. Turning Point National Program Office, University of Washington, Seattle.
20. Bekemeier, B., and Dahl, J. "Turning Point Sets the Stage for Emergency Preparedness Planning." *Journal of Public Health Management Practice*, 2003, 9, 377–383.
21. Institute of Medicine. *The Future of Public Health*. Washington, D.C.: National Academy Press, 1988.
22. *Ibid.*, page 3.