Louisiana Turning Point Partnership

A Catalyst for Change

Public Health Improvement Plan

Louisiana Public Health Institute

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Public Health Improvement Plan

A Project of the
Louisiana Public Health Institute

The Turning Point Partnership and the publication of this document were funded by the Robert Wood Johnson Foundation.

April 2000

A Message from the Steering Committee

This document is the product of a collaborative process that has involved many diverse peoples and organizations across the state of Louisiana. Progression from experiences, to ideas, to words, to plans, and finally to action has necessitated the dedicated participation of hundreds of individuals committed to Turning Point's vision of an enhanced health system. Thus, we wish to express our gratitude to all those who participated in a variety of capacities in the development of this work.

The Steering Committee of the Louisiana Turning Point Partnership also wishes to recognize the significant contributions of the most integral groups and individuals. We were fortunate enough to benefit from the outstanding skills and leadership of Linda Holyfield, who served as the Chair of the Steering Committee. Her tireless efforts and enthusiasm are greatly appreciated by the Committee. We also extend deep gratitude to the following Workgroup Chairs: for the Access to Care Workgroup, Fred Cerise and Gary Peck; for the Prevention and Health Promotion Workgroup, Rebecca Meriwether and Ann Corrigan; for the Policy Development Workgroup, Patricia DeMichele and Liz Sumrall; and for the Health Assessment Workgroup, L. Philip Caillouet and Mark Shields. Also deserving of thanks are the committed members of all the aforementioned workgroups. We are grateful to the Environmental Advisory Group and the Marketing Support Group, chaired by Valerie Wilson and Kate McCaffery respectfully. Both contributed valuable information to this process and lent a great deal of expertise. We are confident that their roles will continue to be critical to the Plan's success.

Deserving of no less gratitude are the local Turning Point Partnerships, the Southwest Louisiana Partnership, the Northeast Louisiana Partnership, and the Healthy New Orleans Partnership, because their participation is critical to maintaining the comprehensive scope of the Turning Point initiative. In the production of the Public Health Improvement Plan, we have certainly benefited greatly from the expansive skills and knowledge of the Peer Reviewers, thus we extend our gratitude to those individuals. We would also like to thank the designers of the Tools for Change workshops, Linda Usdin, Robert Goodman, Bryan Weiner, and Joseph Kimbrell, for their valuable contributions.

The Steering Committee would like to express our appreciation to all our organizational partners as well. Because we were fortunate enough to gain the support of so many contributors we are unable to mention all of them here. However we perceive all our organizational partners to have been of great value to this process, and thus we extend our deepest gratitude to those involved. The State Office of Public Health, the Tulane University School of Public Health and Tropical Medicine, the Louisiana State University Medical Center and Health Care Services Division, the Louisiana Primary Care Association, Inc., the Louisiana Health Care Campaign, EXCELth, Inc., the New Orleans Health Department, Franciscan Ministries of Our Lady Health System, the Area Health Education Centers, and the Tulane Xavier Center for Bioenvironmental Research all deserve mention for their outstanding support.

This document would not have been possible with out the tireless effort of the staff of the Turning Point office: Executive Director, Anne Witmer; Program Coordinator, Vaishali Mane; and Administrative Assistant, Koki Otero. These individuals were indispensable in coordinating the manifold and complex components of this project and maintaining an environment conducive to the exchange of ideas across diverse backgrounds. Their work was complimented by the efforts of Program Associate, Heather Joseph, as well as several other graduate students from Tulane University School of Public Health and Tropical Medicine. Integral to this process was Kim Longfield, who edited several drafts and greatly enhanced the style and organization of this document. We would also like to extend our gratitude to TLW Productions for their excellent efforts with the graphic design and production of the PHIP. We must also extend our appreciation to the Louisiana Public Health Institute for serving as a fiscal agent and providing administrative support to this process.

And finally, we are grateful for the generous support bestowed upon us by the Robert Wood Johnson Foundation, who along with the W. K. Kellogg Foundation, developed a vision of an improved public health system. Without their support, this great opportunity to make a positive change would not have been possible.

Sincerely,
The Louisiana Turning Point Partnership Steering Committee

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Executive Summary

The Public Health Improvement Plan (PHIP) serves as the Turning Point (TP) Partnership's commitment to improve Louisiana's health system through improved communication, collaboration, and coordination among stakeholders. This document represents two years of work by statewide partners and articulates their vision for an improved health system that is collaborative and effective and has the capacity and competence to carry out four key activities: health assessment, policy development, health promotion, and assuring access to care. The work of TP Partners also demonstrates how effective collaboration between public health and medicine, as well as across other sectors such as academia and business, can transform the public health system and prepare for health challenges to be faced in the 21st century.

The chapter, Health Assessment in Louisiana, examines Louisianians' ability to access data and use health information systems to improve health outcomes. Strategies are proposed for improving statewide health information systems, increasing user access, and promoting the use of information systems to make informed public health decisions. Workgroup members examined key players involved in data collection, database locations, data analysis methods, and the capacity to which data are used throughout the state. Their findings reveal that current data collection efforts are uncoordinated among agencies, leading to problems of duplication and a replication of efforts. In addition, local-level health organizations lack accessibility to data and state-disseminated health reports are not kept up-to-date, resulting in outdated and inaccurate information. Measures to address these shortcomings include enhancing Louisiana's capacity to support data collection and dissemination at state and local levels. Likewise, local capacity must be improved so organizations may conduct their own health assessments and collect data.

The chapter, Health Policy in Louisiana, presents Louisiana's current public health policy environment and development process. This section recommends policy change, proposes strategies for improving policy, and expands constituent involvement in policy making to provide improved statewide health programs. National interviews with TP state coordinators and local surveys with key health and environmental policy developers revealed several concerns about the current state policy-making process. Major themes included interviewees' feelings of exclusion from the policy-making process, disenfranchisement from the health system, insufficient governmental accountability for laws and policies, and the lack of methods used by decision makers and constituents to evaluate policy. Several strategies are presented for addressing these concerns including empowering communities to participate in health care debates and decision-making processes, convening government officials and community members, establishing a system of statewide multi-sector forums, and creating measurement tools for systematic policy evaluation shaped by community input.

The chapter, Prevention and Health Promotion in Louisiana, covers statewide prevention efforts and health promotion campaigns as well as methods for improving Louisianians' health behaviors and lifestyle choices. Special attention is given to three topics: actual causes of death, clinical preventive services, and health disparities among sub-populations. After a statewide assessment and data analysis, workgroup members determined that each of these issues must be addressed and, in order to reach Healthy People 2010 goals, several improvements are necessary throughout the state. More effective prevention campaigns will require program planners to target actual causes of death rather than disease-specific causes of morbidity and mortality and enhance existing clinical preventive services. That is, future programs will address root causes of mortality attributed to lifestyle, environmental, and behavioral factors. In addition, prevention activities must be culturally appropriate in order to reach disparate subpopulations, particularly African-Americans, who demonstrate disproportionately high levels of behavioral risk factors and are less likely to receive clinical preventive services than whites. Finally, more collaboration is required across health agencies and sectors in order to avoid replicated efforts and poor use of meager resources. Workgroup strategies demonstrate that effective health prevention programs do not require an increase in the number of agencies that provide services; rather, they call for improved communication between decision makers and coordination of existing resources.

The chapter, Access to Care in Louisiana, presents access-to-care issues as well as barriers facing individuals and communities when seeking health care services or adopting prevention efforts. Workgroup members determined several major challenges present in Louisiana's health system including a large number of uninsured individuals throughout the state, too few primary care

providers for service delivery, rising insurance and care costs, and cultural issues that impede service delivery and access. A number of recommendations are outlined that maximize existing resources and promote methods for joint problem solving, enhancing community capacity for health decision making and policy development, and promoting existing services for the uninsured. Several policy changes are also recommended to increase insurance coverage, assure the geographic distribution of facilities and providers, improve services for public insurance program recipients, and ensure collaboration between providers and social services to decrease cost and improve health outcomes. Central to all of these recommendations is the importance of including community members in problem identification and solution implementation to improve service delivery throughout the state.

The final section of this document describes the direction of future TP efforts and the sustainability of partnership activities. An implementation framework integrates the recommendations for all four public health functions and includes both a statewide and community-level focus. Implementation efforts on the local level will enhance community capacity to perform public health functions through collaborative leadership training, skill development, support for local initiatives, and technical assistance that promotes resource development. State-level priorities include developing statewide forums for enhanced communication and joint problem solving, continuing assessment activities and tool development, promoting public health "best practices," and encouraging organizations to be more accountable to communities. These activities are vital to achieving the partnership's vision of an effective health system.

The authors and collaborators intend this document to serve as a tool for individuals, communities, and health organizations striving to change and improve public health efforts throughout the state of Louisiana. Central to this process is the maximization of existing resources, inclusion of community members in decision making, and coordination of efforts among organizations and across sectors. Although many of the recommendations and strategies contained within this document are specific to health assessment, policy development, health promotion, and access to care, they are readily transferable to other health needs expressed by communities and serve as models for creating change.

How to Use this Document

The Public Health Improvement Plan (PHIP) is a reference tool for individuals with a desire to see Louisianians enjoy improved health and understand how the current health system can be changed to achieve this goal. Although this body of work presents topics of interest to "traditional" public health agencies and decision makers, it also serves as a guide for individuals who perceive themselves as "outside" the public health realm because it contains practical information to initiate change at the community level. In addition, this document presents the utility of multi-sector collaboration and the benefit of local communities working side-by-side with state decision makers to make Louisiana's improved health system a reality.

Information and proposed recommendations provided in each chapter present innovative approaches to health care delivery and improved public health performance. Practical models and conceptual frameworks provide readers with methods for transferring theoretical health knowledge into realistic field applications as well as implementing health activities at the local level. Models are also intended to be adapted to organizational needs and provide planners with information on organizational goal setting, health activities, and ideas for grant writing. Additional resources contained within this document include contact information, data collection tools, literature resources, and statewide assessment reports. Readers are encouraged to skim different sections and reference those most applicable to their needs.

Although each chapter presents comprehensive and valuable information, it is important to recognize the relationship between chapters because they demonstrate how health assessment information, public health policy, prevention efforts, and access-to-care issues are complementary elements within a larger health system. All chapters are cross-referenced throughout the document and readers are directed to supporting information found in chapters and appendices. Readers are encouraged to incorporate this "systems approach" into their own agenda setting and recognize the importance of policy, prevention, access, and information issues and how together they shape public health efforts.

As noted above, the PHIP serves multiple audiences since it offers several suggestions for improving health delivery systems from a variety of health perspectives. However, some readers may find particular chapters more relevant to their organizational needs than others. A brief description of each chapter is offered below along with suggestions for appropriate audiences.

Introduction

An introductory chapter explains the TP Partnership, the history of this document, and a work plan for improving the public health system. This section also sets the foundation for issues presented in subsequent chapters, namely local capacity building, coordination among health organizations, communication between agencies and policy makers, collaboration across sectors, and maximizing limited resources to deliver improved health services. The introductory chapter will assist all audiences in understanding the Turning Point (TP) process and the importance of a system-wide approach to improving health care.

Health Assessment

This chapter examines several topics including the importance of adequate health information systems, the utility of data for informed decision making and policy environments, the need to improve local communities' access to data, and the benefit of sharing health information among agencies and with local communities. Interested audiences may include state- and local-level decision makers, policy makers, facility administrators, community organizations, grant writers, academicians, and students.

Policy

This chapter offers information on methods for creating, implementing, and evaluating state health policy. Readers are strongly encouraged to read the Policy Assessment Report found in the appendices since it is rich in practical information about Louisiana's policy environment and reviews theoretical models for policy making. Audiences who may be most interested in this chapter include legislators, community organizers, local and statewide health organizations, decision makers, special interest groups, and academicians.

Prevention

This section examines the complexity of health prevention efforts and outlines several root causes of morbidity and mortality. In addition, social and cultural influences on individuals' health status are examined as well as practical suggestions for multi-sector collaboration to create effective health promotion campaigns. Interested audiences may include providers, insurance agencies, health consumers, employers, medical students, academicians, researchers, and students in schools of public health.

Access to Care

This chapter examines current access-to-care issues in Louisiana and barriers that individuals and communities face when seeking services or adopting prevention efforts. Several advantages are outlined for improving Louisianians access to care, assuring public health, and preventing illness. Audiences who may be most interested in this chapter include insurance agencies, providers, health consumers, community organizations, and members of the business community.

Implementation

This section provides implementation priorities and integrates recommendations made in the assessment, policy, prevention, and access chapters for a comprehensive approach to improving Louisiana's health system. Several components of the implementation process are covered including a description of needed resources, key organizations, opportunities for coordination with local TP initiatives, and methods for monitoring improvements in the health system. Audiences who may be most interested in this chapter are program planners and individuals wishing to initiate change at the community level. This section examines the future of the TP process and the sustainability of efforts to improve Louisianians' health through system-wide changes.

Acronyms

AAP	American Academy of Pediatrics
ACIP	Advisory Committee on Immunization Practices
AHEC	Area Health Education Center
ATSDR	Agency for Toxic Substances and Disease Registry
BRFSS	Behavioral Risk Factor Surveillance System
BYNET	Bayou Teche Community Health Network
DHH	Louisiana Department of Health and Hospitals
DHHS	U.S. Department of Health and Human Services
DOE	Department of Education
DOI	Department of Insurance
DOL	Department of Labor
DPS	Department of Public Safety
FMOLHS	Franciscan Missionaries of Our Lady Health System
GIS	Geographic Information Systems
HCIA	Health Care Information Advantage
HICA	Health Informatics Center of Acadiana
HIRS	Health Information Retrieval System
HIV	Human Immunodeficiency Virus
HP 2000	Healthy People 2000
HP 2010	Healthy People 2010
HPSA	Health Provider Shortage Area
HRSA	Health Resources and Services Administration
IOM	Institute of Medicine
LaCHIP	Louisiana Child Health Insurance Program
LHCR	Louisiana Health Care Review
LHIN	Louisiana Hospital Information Network
LPHI	Louisiana Public Health Institute
LRHAP	Louisiana Rural Health Access Program
LSU	Louisiana State University
LSUMC	Louisiana State University Medical Center
LTU	Louisiana Technical University
NHSC	National Health Service Corps
NGO	Non-governmental Organization
NOPCU	New Orleans Partnership for the Care of the Uninsured
OLAP	On-Line Analytical Processing
OPH	Louisiana Office of Public Health
PHIP	Public Health Improvement Plan
RFP	Request for Proposal
RWJ	Robert Wood Johnson Foundation
STD	Sexually Transmitted Disease
SWOT	Strengths, Weaknesses, Opportunities, and Threats analysis
TFC	Tools for Change
TOT	Training of Trainers
TP	Turning Point
ULL	University of Louisiana at Lafayette
ULM	University of Louisiana at Monroe
USDA	U.S. Department of Agriculture
USPSTF	U.S. Public Health Service Preventive Services Task Force
WHO	World Health Organization
YRBS	Youth Risk Behavior Survey

Introduction

“Public health" is defined as "a field of medicine that deals with the physical and mental health of a population or community (Anderson 1994)," and since the establishment of the U.S. Public Health Service in 1798, it has had a major impact on the health and well-being of Americans. As health care moves into the 21st century, challenges to the public health system are complex and marked by great changes, some more positive than others.

Many of the challenges faced by the American health care system, namely downsizing, staff cutbacks, and limiting services, reflect those taking place in other industries. The health care sector, like the business sector, has been pressured to adopt many of these methods for reducing costs and streamlining activities. For example, health care’s rising costs have forced governmental public health agencies to operate with limited funding. In addition, changes at the system level have complicated the delivery of health care, and the expansion of managed care organizations has shifted the roles and responsibilities of physicians and other health care professionals from service delivery to more system administration.

Given these growing pressures on the public health system, the Robert Wood Johnson (RWJ) Foundation and the W.K. Kellogg Foundation developed an approach for exploring innovative methods to improve public health practice. The resulting initiative, the national Turning Point (TP) program, was designed to explore means for transforming, strengthening, and modernizing the American public health infrastructure. The ultimate goal of this program is to create a more responsive and efficient system to protect and improve the public’s health.

National Turning Point Program’s Purpose and Philosophy

The vision behind the national Turning Point initiative is to transform the public health system in America as well as the public’s perception of it to prepare for the challenges of the 21st century. This transformation includes expanding the notion of what the public health system is, what it does and who plays a role in it. Through TP, the RWJ and W.K. Kellogg Foundations seek to redefine the relationship between clinical health care and the public health system and strengthen collaboration between them to improve the public’s health.

In the past, public health activities and medical services often occurred independently of one another, most likely due to a lack of understanding and under-appreciation for work performed by the other. The TP initiative's guiding principle is to share responsibility for the public's health through collaboration between public health and medicine, as well as across other sectors such as academia and business. TP's contribution to improving public health is facilitating change through sector collaboration to result, ultimately, in improved health for everyone.

History of Turning Point in Louisiana

Louisiana is one of the first states (in an initial group of 14) to receive this prestigious grant from the RWJ Foundation. In addition, the W.K. Kellogg Foundation has funded three TP programs at the local level in Louisiana, the northeast and southwest regions of the state and the New Orleans metropolitan region. The Louisiana Public Health Institute (LPHI) is the official TP grant recipient for the statewide program and acts as fiscal and administrative agent for the initiative. This institute is a non-profit agency whose mission is to improve health in Louisiana by implementing innovative programs and research that benefit from community input. Such programs also emphasize collaboration and accountability across sectors and organizations. The LPHI board of directors represents several sectors and members hail from academia, primary care, public health, consumer advocacy, and health care provider agencies. The institute's philosophy and diverse board make it an appropriate organization to house TP and oversee its activities.

Once Louisiana was awarded the grant, the first priority was to recruit a variety of individuals and key stakeholders from around Louisiana and across sectors to join the TP Partnership and shape the program's direction. The Louisiana TP Partnership draws representation from diverse sectors including academia, business, governmental health agencies, consumer advocacy groups, and private hospital systems from around the state. Member agencies include but are not limited to:

- State agencies such as the Department of Health and Hospitals (DHH), the Louisiana Office of Public Health (OPH), and the Louisiana State University Medical Center (LSUMC) - Health Care Services Division
- State professional associations such as the Louisiana Primary Care Association, Louisiana Medical Society, and Louisiana Nurses Association
- Academic institutions including The University of Louisiana at Lafayette (ULL), Louisiana State University (LSU), Tulane University, and Xavier University
- Major private hospitals, health systems, and community providers such as Ochsner, Daughters of Charity, CHRISTUS, Bayou Teche Community Health Network (BYNET), and the Franciscan Missionaries of Our Lady Health System (FMOLHS)
- Consumer advocacy groups such as the Louisiana Health Care Campaign and Resources for Independent Living
- Community-based organizations (CBOs) and other non-profit agencies such as the United Way, the League of Women Voters, Great Expectations Foundation, and Area Health Education Centers (AHEC)

Fundamental Questions to Initiate Change at the Systems Level

Early in the strategic planning process, the partnership asked itself five fundamental questions. Answers to these questions formed a vision and outlined future strategies to improve Louisiana's health system.

I. What is health?

"Health" is defined by the World Health Organization (WHO) as "a state of complete physical, mental and social well-being (WHO 1948)." This comprehensive definition of health includes the absence of a negative condition (i.e. disease) as well as the existence of a positive condition (i.e. well-being) that has multiple determinants. Discoveries in social epidemiology confirm what public health professionals have always believed; namely, that social economic, cultural, and environmental factors have a profound effect on the health status of populations.

II. What impacts health?

Turning Point embraces a holistic, multi-dimensional concept of health that includes physical, mental, social, and environmental components, all of which are interrelated.

Factors determined to impact health include the following:

- Biological factors including genetics, immunity, and host response
- Behavioral factors including diet, exercise, occupation, alcohol use, tobacco use, drug use, and other lifestyle choices
- Health sector organization, financing, and delivery including issues of care, quality, comprehensiveness, continuity, affordability, and availability of care services (primary, secondary, and tertiary)
- Social and economic conditions including social ties, economic status, crime, discrimination, cultural or ethnic behavior, housing, food, education, and community-wide social capital
- Physical environment including air and water quality, sanitation, housing standards, and exposure to adverse elements

These factors cover a wide range of conditions that have a direct and indirect effect on health. Health is a complex and multi-dimensional issue, as are the factors that influence it and the methods to improve it. Turning Point's vision of a collaborative, multi-sectoral public health system addresses health from several perspectives, supports efforts to correct ineffective health delivery systems, and strives to improve conditions that impact health.

III. What or who is the public health system?

This question is more complex than one may initially think because, in the past, the public health system was comprised solely of governmental agencies. However, a broader definition of the system is needed because governmental agencies alone are insufficient to create positive health outcomes in populations.

The TP Partnership expands the definition of the public health system to include all individuals, groups, and organizations that have a responsibility for promoting public health and fulfilling public health functions. This system includes governmental organizations, such as public health agencies, public hospitals, and social service agencies. It also includes non-governmental organizations (NGOs) such as private hospitals, universities, and statewide professional

agencies. In addition, formal and informal CBOs including community clinics, churches, schools, neighborhoods, and civic groups contribute to the public health system (See Introduction).

This broad definition of the public health system addresses several determinants of health and acknowledges and supports work performed by non-clinical organizations for promoting health. Such organizations impact the health of individuals, directly and indirectly, and may play a larger role in individual health than more traditional providers of health care.

IV. What does the public health system do?

The 1988 Institute of Medicine report, *The Future of Public Health*, defined the core functions of the public health system. Three of these functions are health assessment, policy development, and assurance. The Louisiana TP Partnership also included prevention and health promotion as the fourth core function of the public health system because this function supports the central philosophy of public health, namely preventing disease. Furthermore, prevention efforts offer individuals the most direct route to improving their health status.

Each public health function is described in more detail below:

- Health assessment includes gathering, analyzing, and disseminating information on health status, health determinants, and health resources.

- Policy development sets priorities on local and/or statewide health needs, establishes health improvement goals, formulates actions to achieve those goals, and evaluates the results of those actions.

- Prevention and health promotion include activities to prevent individuals from contracting illness as well as activities to promote healthier behaviors and positive lifestyle choices. These activities include providing the public with safe drinking water, food that meets federal and state regulations, and health education campaigns that promote healthy lifestyles (such as smoking cessation and seat belt use).

- Assurance includes monitoring the quality of and access to services that influence health and enforcing standards and regulations for health providers and facilities. In addition, assurance activities determine existing barriers that preclude health care access and explore methods for overcoming those barriers.

V. What does it mean to improve the public health system?

The mission of the public health system is to prevent disease, injury, disability, and premature death and to promote the health and well-being of populations. However, a lack of funding, inadequate resources, and challenging policy environments present barriers to fulfilling this mission. Furthermore, a lack of collaboration exists between organizations that provide care or otherwise impact the health of different populations and they often carry out their activities independent of one another.

Organizations that affect health must cooperate in order to improve the health system. An important first step is to increase communication between these organizations and develop new channels of communication that allow them to share experiences and learn from one another. Organizations can then coordinate activities and help offset the effect of shrinking resources and budgets.

Turning Point's Vision for an "Ideal" Public Health System in Louisiana

Once fundamental questions were answered, the TP Partnership developed an "ideal" vision for Louisiana's public health system. The first step in creating this vision was to have partners share their impressions of the existing public health system. Most participants did not paint the state's system in a positive light and they failed to recognize the scope of its activities. Some participants shared images of "crumbling old buildings" and "marginal health care" while others expressed concern over program administrative policies. Some participants admitted to a lack of understanding about the system altogether and most informants viewed the public health system as one large governmental agency that implements a narrow range of activities that limit its delivery to only specific segments of the population. Overall, participants demonstrated confusion over the public health system and its responsibilities as well as its daily impact on the lives of Louisianians.

Once these concerns were shared, TP and its partners created a vision for an improved system:

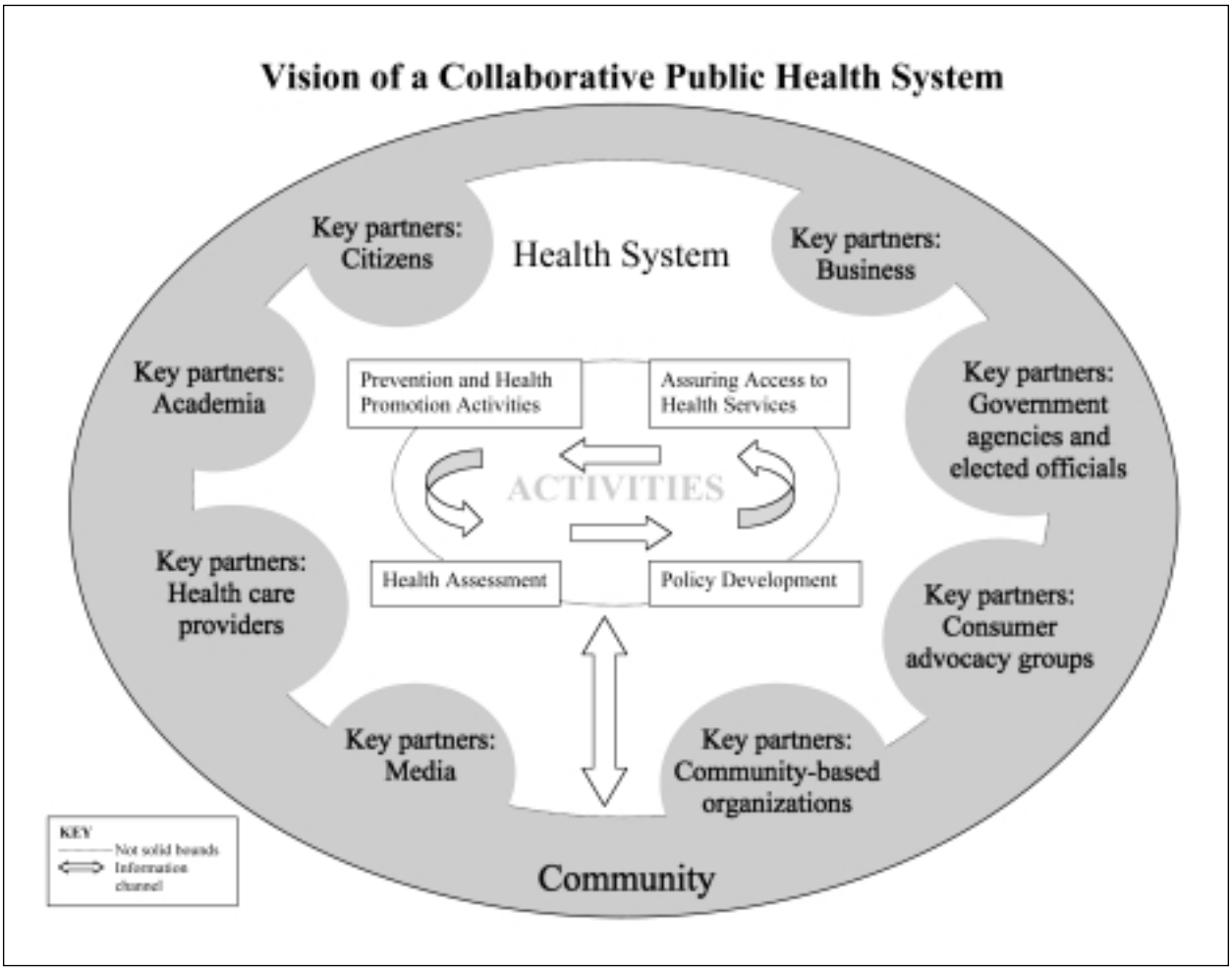
A *collaborative* and *effective* public health system that has the *capacity* and *competence* to carry out four key activities, namely health assessment, policy development, assurance, and prevention and health promotion. In addition, partners agreed that such a system is comprised of multiple organizations and sectors – traditional and nontraditional alike - that share responsibility for ensuring the public's health.

VISION

The resulting vision is **collaborative** because multiple organizations and individuals (rather than single government agencies) play a role and have a stake in keeping Louisianians in good health. Partners recognize that several factors affect an individual's ability to maintain good health including access to preventive services and treatment, exposure to environmental hazards, social issues, educational opportunities, and cultural influences. Therefore their shared vision of the health system extends beyond traditional health agencies to include representatives from multiple sectors. In addition, TP Partners recognize that collaboration must exist among and across groups with all agencies taking responsibility for their unique role in improving health.

The ideal health system will be **effective** because it involves a coordination of efforts between organizations and results in maximizing resources and creating innovative systems of delivery. Such an approach responds to community priorities and is able to adapt to emerging needs, opportunities, and challenges that arise during the TP implementation process.

Finally, the ideal public health system will have the **capacity** and **competence** to implement assessment, policy, assurance, and prevention and promotion activities since the human and material resources are sufficient to undertake change and improve the existing health system. These resources are also capable of creating effective intervention activities and ensuring that programs continue to promote the health and well-being of Louisianians.


Vision of a Collaborative Public Health System
Key partners: Citizens
Health System
Key partners: Business
Key partners: Academia
Prevention and Health Promotion Activities
Assuring Access to Health Services
Key partners: Government agencies and elected officials
ACTIVITIES
Key partners: Health care providers
Health Assessment
Policy Development
Key partners: Consumer advocacy groups
Key partners: Media
Key partners: Community-based organizations
KEY
Not solid bounds
Information channel
Community

Turning Point's Workplan for Improving the Public Health System

The overall focus of the TP program is promoting change at the health delivery **system** level. Efforts are concentrated on health organizations, their capacity for collaboration, and methods by which they can incorporate the communities they serve into the change process. In addition, TP aims to create a statewide learning community among different agencies, sectors, and populations to increase their capacity for leadership and planning. Such a community will convene individuals and organizations to share health information and implementation experiences, thereby promoting joint problem solving to reach a common goal of improved health for Louisianians.

Turning Point Partners created a workplan that outlines steps toward realizing the goal of an improved public health system. The following workplan was developed to accomplish project goals and identify key tasks within each implementation phase. From this framework, the TP Partnership created an organizational structure to enable and support progress toward realizing its vision.

The following list highlights steps required in creating a collaborative public health system and outlines TP's current and future activities:

- Convene major health organizations across the state to engage in strategic planning
- Form collaborative partnerships between organizations that increase communication and lesson sharing to strengthen the public health system
- Assess current state capacity and competence for the health system to perform health assessment, policy development, prevention and health promotion, and assurance
- Propose changes to improve the public health system and its ability to perform these functions collectively
- Create strategies for implementing recommendations
- Obtain commitments from partners
- Implement strategies through demonstration programs, pilot models, and the creation of appropriate mechanisms to achieve change

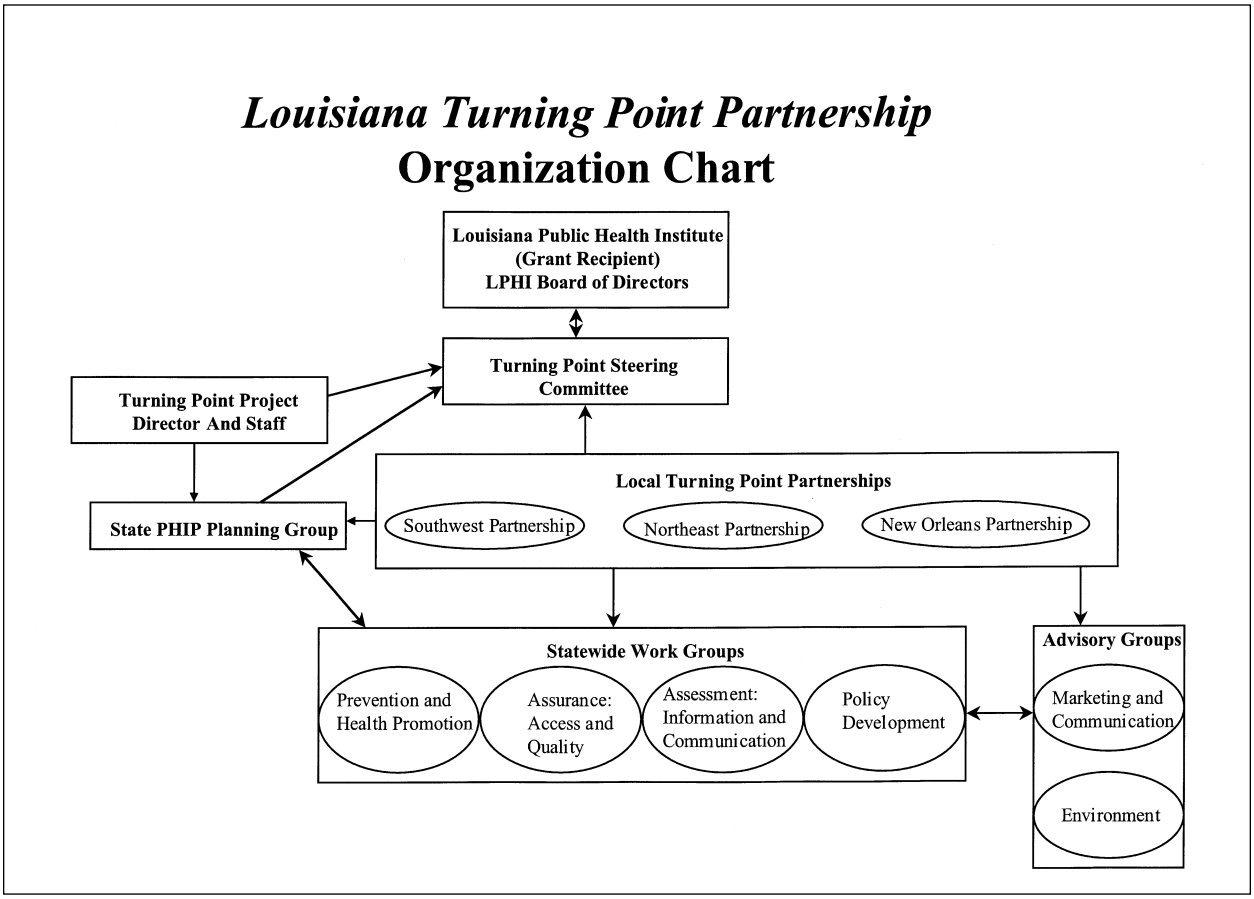
These activities will result in the TP Partnership achieving its three key objectives:

- **Promote an expanded definition of health and its determinants and endorse shared responsibility for the public's health across multiple sectors and organizations**
- **Develop statewide and local partnerships among key individuals, organizations, and sectors that define, advocate, and sustain the notion of shared responsibility for improving health**
- **Develop a Public Health Improvement Plan that defines criteria for an improved public health system, the capacity needed to develop it, and strategies for implementing and sustaining necessary changes**

3 KEY OBJECTIVES

Turning Point Organizational Structure

Promoting collaboration across sectors and among different health agencies led to the creation of several different committees and workgroups. Together they comprise the TP Partnership and are instrumental in realizing the activities and objectives outlined above. The following organizational chart highlights committee responsibilities, collaborative efforts, and their relationship to one another.



Turning Point Steering Committee

The Steering Committee is comprised of members from key organizations throughout the state that have a stake in transforming the public health system. Members were selected based on their level of knowledge and expertise in their disciplines and, together, they created a representative coalition from several sectors. The Steering Committee is charged with directing TP activities, managing the strategic planning process, implementing recommendations, and coordinating state and local TP efforts.

The following individuals constitute the TP Steering Committee:

Linda Holyfield, RN, MSN
Director of Mission and Community Health Improvement
St. Francis Medical Center
Chairman, Steering Committee
Co-Chair, Northeast Louisiana Partnership for Community Health

Anne Witmer, MPH
Executive Director
Louisiana Turning Point Partnership

Ann Anderson, PhD
Senior Associate Dean
Tulane School of Public Health and Tropical Medicine
Board Member, Louisiana Public Health Institute

Michael Andry
Chief Executive Officer
EXCELth, Incorporated
Co-Chair, Healthy New Orleans Turning Point Partnership
"The City That Cares"

Jim Brexler, MPA
Chief Executive Officer
Louisiana State University Medical Center, Health Care Services Division

Peter Conroy, MBA
Budget Analyst
House Committee on Health and Welfare

Patricia DeMichele, JD
Executive Director
Louisiana Health Care Campaign
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"The City That Cares"

Madeleine Wallace, PhD
Coordinator
Southwest Louisiana Turning Point Partnership

Valerie Wilson, PhD
Deputy Director
Center for Bioenvironmental Research,
Tulane University and Xavier University
Co-Chair, Environmental Advisory Group,
Louisiana Turning Point Partnership

STATEWIDE WORKGROUPS

Four statewide workgroups were established around the core functions of the public health system (health assessment, policy development, prevention and health promotion, and assurance) and charged with examining each function in depth. In addition, each workgroup was asked to develop recommendations and strategies for addressing health system shortcomings found during their assessment.

Two co-chairpersons lead each workgroup, one from the state Office of Public Health and one from a non-governmental agency. Groups also contain representatives from statewide and local organizations that play a role in the performance of each of the four core functions. For example, the Access Workgroup has representatives from major public and private health systems throughout the state. Each workgroup is responsible for contributing to the PHIP, outlining strategies for implementing change within their system, prioritizing activities, and communicating with other workgroups and the TP steering committee. It is also the responsibility of each workgroup to ensure that a diverse sample of partners is represented to contribute to the PHIP and serve as peer reviewers for assessment reports and document chapters (See Introduction).

PUBLIC HEALTH IMPROVEMENT PLAN DEVELOPMENT GROUP

This group is charged with developing the state PHIP. Membership includes co-chairpersons of each statewide workgroup, the chairperson from the Marketing and Communication Workgroup, TP staff, consultants, liaisons from each local TP initiative, and an ad hoc panel of advisors.

MARKETING AND COMMUNICATION WORKGROUP

The mission of this workgroup is to market the TP Partnership and PHIP. Group members include communication staff at OPH and one representative from each local TP Partnership who has expertise in marketing or communications. The Marketing and Communication Workgroup will develop a distribution plan for the PHIP and promote TP to constituents who will potentially support the program and implementation of the PHIP. This group also collaborates with each statewide workgroup to develop a public engagement plan to ensure public input in the assessment and strategy development phases.

ENVIRONMENTAL ADVISORY GROUP

This group brings an environmental perspective to the TP process since such implications are sometimes overlooked in public health assessments. Group members serve as PHIP peer reviewers to ensure that environmental issues are addressed where appropriate and are included in TP strategies. Most Environmental Advisory Group members are academic researchers, environmental advocates, and representatives from government agencies.

Local Turning Point Initiatives

In addition to the statewide TP initiative (funded by the RWJ Foundation), the W.K. Kellogg Foundation funded three local TP programs in Louisiana to perform the same activities but at the community level. These local initiatives share the same vision and goals as the statewide program and strive to build a local, collaborative, and multi-sectoral public health system. Local initiatives are located in the southwest region of Louisiana (DHH Region 5), the northeast corner (DHH Region 8), and the metropolitan region of New Orleans (See Glossary).

These three initiatives work closely with the state TP Partnership to communicate community needs and highlight community-based assets available to the state initiative that might otherwise be overlooked. Such collaboration is essential to restructuring public health delivery throughout the state and meeting health needs of diverse regions and communities. In addition, local TP Partners are vital to state TP activities in order to ensure that communication and learning is a reciprocal process. Local representatives are members of the Steering Committee, PHIP Development Group, Marketing and Communication Workgroup, and all statewide workgroups.

In addition, the three local Turning Point communities have also created public health improvement plans which include recommendations for systems change within their particular regions of the state (See Introduction). During the PHIP development process, the state and local partnerships collaborated on recommendations and assured that each of the four plans compliment one another. The state and local partnerships will continue to collaborate during the implementation phase to coordinate activities and maximize their effectiveness.

Tools for Change

The state TP Partnership has made extensive efforts to build capacity and competence among local-level TP Partners through a leadership and skill development program called Tools for Change (TFC). This program was designed by two key state partners, OPH and the Tulane University School of Public Health and Tropical Medicine and included interactive learning sessions and on-site technical assistance. Nationally renowned experts consulted with the local partners and provided them with tangible tools for use in their communities. Unlike many workshops that rely solely on didactic presentations, TFC forums included brainstorming and problem solving on real issues the partnerships were facing. These sessions allowed the three local partnerships to share ideas and experiences and learn from one another, thereby creating a statewide learning community.

An Explanation of the Public Health Improvement Plan

The TP Partnership permits public health partners to envision improved health for Louisianians and more efficient methods for service delivery. Program partners determined the means necessary to realize their visions and make them a reality for Louisiana's public health system. This, in short, constitutes the content of the PHIP: strategies for improving the state's public health system and service delivery to improve health outcomes for Louisianians.

The PHIP serves several purposes and may be regarded as a tool for improving the delivery of Louisiana's public health functions. As a tool, it may be used for:

- Facilitating communication among stakeholders
- Educating decision makers about public health system strengths and weaknesses
- Promoting legislative action to improve the status quo
- Soliciting "buy-in" from key stakeholders who are influential in implementing change
- Promoting TP initiatives to state and national decision makers
- Securing additional funding for TP activities and future public health programs

Contributors to the PHIP did not create this publication to be placed on a bookshelf and forgotten. Rather, they intend their recommendations to be used as steps in improving the public health delivery process and distributing responsibility for assuring health across organizations and sectors. The recommendations outlined in this document not only specify **what** must be accomplished but also **who** must take responsibility for those actions and **how** activities are to be financed.

This document outlines partner roles and relationships, describes alternative financing mechanisms, suggests means for reallocating resources, and identifies lead agencies for implementation. The PHIP includes the following items:

- Rationale for the need for statewide change in the current public health system
- Assessments of Louisiana's current capacity to perform broadly defined public health functions, including a description of current assets and shortcomings
- Outlines of needed changes based on assessment results
- Descriptions of strategies for implementing and sustaining needed changes including policy, financing, legal, technical, and organizational changes
- Descriptions of key players, their roles, responsibilities, and accountability
- Strategies for monitoring progress in health system improvement

This document does not represent a final product in the public health improvement process. Rather, contributors intend this document to serve as the first of many tools to enhance collaboration between stakeholders and establish new communication channels for sharing lessons learned and documenting successes. During program implementation, TP will continue to convene organizations and key individuals to discuss methods for improving health in Louisiana. The PHIP will continue to evolve as the TP Partnership addresses new challenges and opportunities.

Along with its utility as a tool for improving public health, the PHIP serves as an example of effective collaboration and shared vision between sectors. Its creation demonstrates the advantage of encouraging different organizations to reach common ground, formulate partnerships, benefit from each other's strengths, share common goals, and agree on effective methods for change within the public health system.

PHIP

Louisiana Turning Point Successes

Although the TP Partnership has been active in Louisiana for only two years, several successes can be attributed to its activities. The participation of motivated health agents and sector leaders has contributed to the initiative's progress and moved the program closer to its vision of transforming Louisiana's public health system.

Achievements credited to the Louisiana TP Partnership include:

- Involving major stakeholders at the state and local level in system assessment and strategic planning. Representatives hail from governmental public health agencies, public and private hospitals, academia, the faith community, media, consumer advocacy groups, mental health providers, state legislature, federally funded health education centers, primary care organizations, and community groups.
- Encouraging multi-sector dialogue about key activities in the public health system, namely health assessment, policy development, prevention and health promotion and assuring access to care.

- Promoting leadership and developing skills for partners at the local level (i.e., the TFC program).
- Developing a cadre of local leaders with skills in collaboration, system assessment, and strategic planning.
- Improving communication and coordination between state and local public health efforts, particularly health systems planning.
- Establishing a vision and methodology for improving the health system through collaboration between health agents, communities, and sector leaders.
- Creating resource assessment tools (such as the Environmental Scan, See Access to Care) to assess the capacity and competence of a community health system and its process for incorporating public input into state and local planning efforts.
- Increasing national visibility for Louisiana success stories through publications and presentations at national conferences about TP efforts and changes in the health delivery system.
- Conducting innovative research that examines unique subjects of inquiry such as the policy development process.
- Collaborating with other states to benefit from their success stories and share lessons learned in the field.

As a result of Turning Point's success, several organizations have asked for advice and assistance in developing other collaborative efforts. For example, both the state partnership and the local New Orleans partnership have helped to shape a multi organizational planning process to improve access to care in New Orleans. The desire to replicate TP's successes is evident throughout the state and project achievements serve as models for other organizations to follow.

Turning Point: A Continuing Process

The TP program is an innovative process for changing the public health system because it addresses issues from a holistic perspective and includes input from leaders in diverse health fields across both public and private sectors. Organizations that once worked independently of one another are now partnering to enhance their productivity and minimize resource expenditures as well as duplications of effort. The TP process also creates a positive learning environment for organizations by creating and maintaining dialogue between care givers, policy makers, public health agents, and leaders in several different sectors. In addition, this process encourages respect and appreciation among contributing agencies, especially those that may not be readily recognized for their contribution to public health.

The TP program is an evolving process that will continue to respond to new public health challenges. In the coming months, the TP Partnership will work with organizations throughout the state to implement the recommendations outlined in this document. Together, TP and its partners have laid the foundation for innovative methods of collaboration and efficient and effective means of public health delivery.

The effort required to complete assessments and publish this document has proven to be a valuable learning process for all involved. Never before have so many organizations in Louisiana come together to engage in such strategic planning and analysis of public health activities. In its effort to promote a new framework for conceptualizing and delivering public health, the TP Partnership has refined traditional perspectives about health systems and encouraged organizations to appreciate the work undertaken by their colleagues in different health organizations and sectors. In addition, the TP process has strengthened communication between state and local organizations and allowed decision makers to recognize the contributions of both levels.

As we enter the 21st century, it is more evident than ever that a great need exists to improve health delivery systems and assure populations' health, especially given the challenge public health agents face in gaining the support of key decision makers and the public. As a result, agencies must gain strength from one another through collaborative efforts and a shared vision for improving the health system. Such processes represent important outcomes of the TP initiative. In addition, TP has helped foster dialogue on critical areas affecting health care delivery, including health assessment issues, policy development, prevention and health promotion activities, and access-to-care concerns. Each organization involved in the TP process contributes a unique and valuable perspective for improving Louisiana's public health system. Because no organization exists in a vacuum, there is a strong need for collaboration, establishing partnerships, sharing resources and ideas, and avoiding a replication of efforts. Through the TP program, organizations have a resource for support and a mechanism for working with others to provide efficient and effective responses to Louisianians' health needs.

In a period marked by a rapidly changing health care system, initiatives such as the Turning Point Partnership must lead the way in changing the perception and delivery of health care.

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Chapter 1

Health Assessment In Louisiana

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    1. Train individuals at the local level to undertake health assessment activities
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    3. Coordinate communication between state and local entities
    4. Support the development of technical assistance centers to help communities with health assessment activities

VIII. Conclusion

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Chapter 1-Health Assessment in Louisiana

The following chapter examines Louisianians' ability to access data and use health information systems to improve health outcomes. Effective information systems allow individuals, communities, and larger populations to make informed health decisions, utilize available services, prioritize strategies to improve health, or enact policy changes. Key findings of the Assessment Workgroup's statewide evaluation of health information systems are presented as well as recommendations and strategies to improve Louisianians' access to health information. The primary focus of this chapter is *systems improvement* and strategies are proposed to improve statewide health information systems, increase user access, and promote the use of information systems to make informed decisions about public health.

IN THIS CHAPTER

Introduction

"Health assessment," for the purposes of this document, is defined as "the evaluation of individuals', communities', and larger populations' ability to access and use health data." According to this definition, the structure of conducting a health assessment is three-tiered[1]:

- Data Availability – determining the type of data that exist and where they are housed
- Data Accessibility - determining the extent to which individuals are able to use existing data for their own needs
- Data Applicability – determining the capacity of the health information system to link data users' needs with existing data or respond to new data needs if such data do not exist

All three steps should be considered when examining the effectiveness of health assessment systems. The third tier of health assessment, data applicability, serves as an analysis of the first two. It is insufficient to describe only the existence of health data and the ability individuals and organizations have to access data. Health assessment activities must go one step further and examine whether or not specific health care needs are addressed by the existing health information system. Activities must also determine methods decision makers can use to improve health assessment systems to accommodate data gatherers and users.

Overall, health assessment activities link individuals', communities', and larger populations' health concerns with data systems and health information that can support change and, ultimately, improve health. For example, individual health assessment is vital for providing feedback to individual patients, their families, and caregivers. Such feedback educates individuals about their health options, necessary behavior change, and available medical interventions. Likewise, community health assessment, and that of parish or state populations, provides feedback to planners and policy makers. Such information establishes community standards, prioritization of action strategies, and development of fiscal policy. All of these activities are vital for planning and improving Louisianians' health.

1. The definition used for "Health Assessment" in this chapter reflects Turning Point's system-wide focus. Although this definition is similar to that used by the Agency for Toxic Substances and Disease Registry (ATSDR), it has been modified to include the concepts of data collection, analysis, and health information dissemination (ATSDR 1999).

The following definitions will be used in this chapter when discussing the data-to-information process:

- **Health Data – records about events or circumstances that affect or describe the health of an individual or population**
- **Health Information – refined and understandable data that, in aggregate form, describe health-related events, health care services, exposure to health risks, and perceived health status of individuals and/or populations**

Health Assessment Workgroup and Mission

The statewide Assessment Workgroup includes representation from academia, governmental public health, local Turning Point (TP) initiatives, schools of medicine, schools of public health, medical centers and hospitals, and community-based organizations (CBOs). These workgroup members developed strategies and recommendations to improve access to health care information for Louisianians, thereby empowering citizens to make informed health decisions.

The workgroup was charged with creating viable partnerships among Louisiana's health data collection groups and refining the process of accessing and using health information to make it useful to the public. Such an effort is expected to advance the health of Louisianians by allowing informed decision making to guide program planning and policy development. It is also intended to help individuals and communities make informed decisions about health care. The Assessment Workgroup seeks to increase accountability among public health agents and create a "learning community" in which decision makers help Louisianians improve their health and well-being through access to information. The key to realizing this future is to create sustainable coordination among data gatherers, analyzers, and disseminators, which requires a shared vision of improved public health in Louisiana and active participation by all parties.

Assessment Methodology

The workgroup review process focused on the "usefulness" of databases in terms of timeliness, geographic aggregations, reliability and limitations, confidentiality issues, and the possibility for linkage with other databases. The Assessment Workgroup and TP Partners hope that other database custodians throughout the state will adopt the tools described below when undertaking future assessment activities. Such standardization will provide potential users with a synopsis of available databases, their features, and potential applications.

The first assessment activity was a situational analysis that examined Strengths, Weaknesses, Opportunities, and Threats (SWOT) in the health system's capacity to gather, analyze, and disseminate health data and information. This process allowed workgroup members to understand data users' and collectors' perspectives concerning the state's health information system.

The workgroup's second assessment activity included informal interviews with local- and community-level individuals who require data access. These informants described their experience with the state's health information system and provided a non-academic perspective on **system** strengths and weaknesses. This activity, along with the SWOT analysis, allowed workgroup members to draw upon a broad range of resources and incorporate them into their recommendations for improving the state's data collection and dissemination processes.

The Assessment Workgroup also developed a worksheet to assist in their assessment activities (See Health Assessment Appendix). This worksheet lists database components and features to assist users in determining the utility of databases for their own needs. Some items on the worksheet include data variables (such as general demographic information and ethnicity criteria), the unit of data collection and analysis, and contact information for databases. The worksheet also provides a brief introduction to currently available databases; however, it should not be considered an exhaustive document, as it does not address all questions a potential user may have about data access and application.[2]

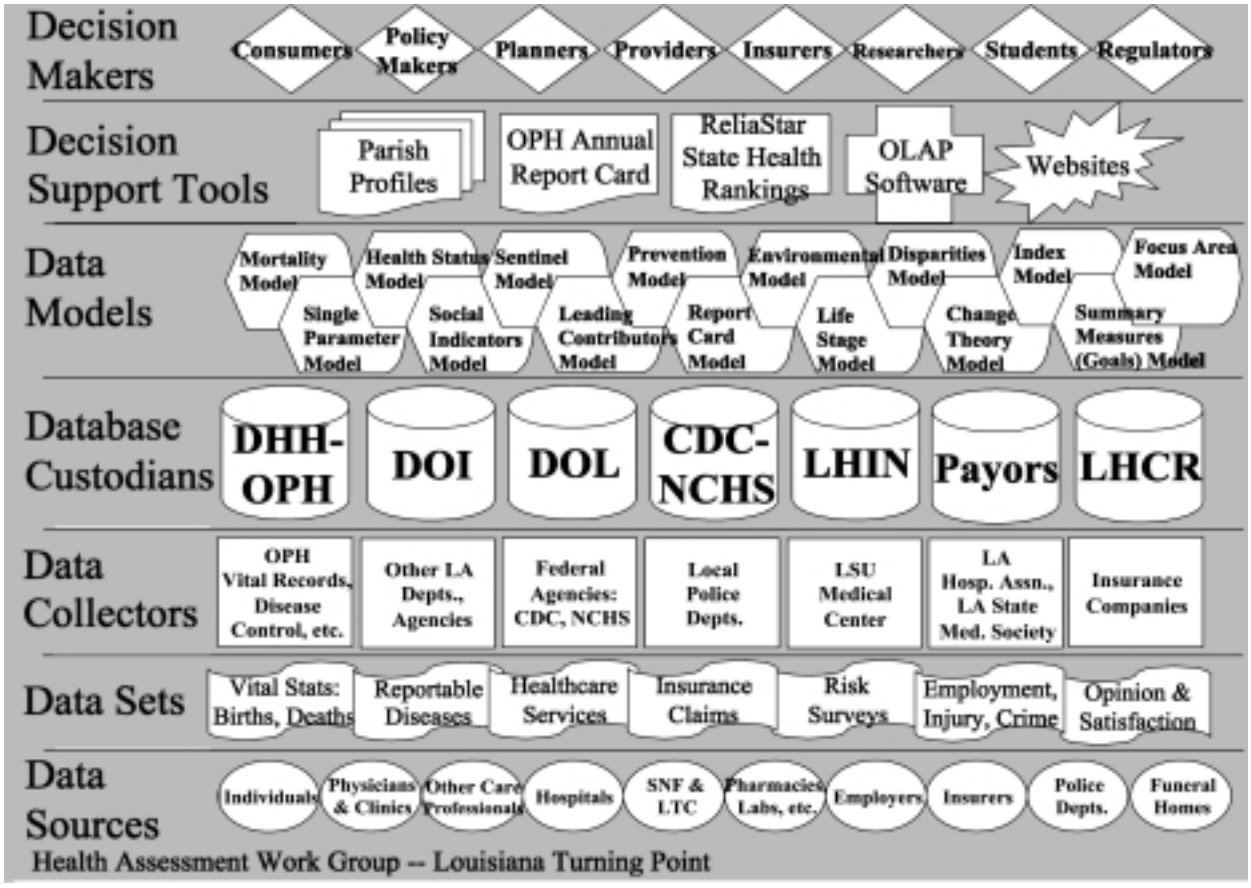
2. Due to limited time and resources, the workgroup was restricted to assessing major databases and members were unable to develop an exhaustive list of resources. The Assessment Workgroup and TP Partners felt that their time would be better spent reviewing major databases as resources for state users rather than conducting a full inventory of resources, the results of which would become quickly outdated. In addition, such an undertaking would replicate the efforts of the University of Louisiana at Monroe and the Office of the Database Commission that have already undertaken such an activity.

Health Assessment Framework

The Health Assessment Framework is a pictorial representation of the steps through which data progress in order to become health information. Workgroup members developed and used this framework to outline recommendations for improving Louisiana's health information system because it represents the process of data collection, analysis, and dissemination. The Information Value Chain Model served as the basis for this framework (For more information about the Information Value Chain, see the Health Assessment Appendix) and key players who are involved in data collection are depicted. In addition, the framework presents locations where data are stored, data analysis methods, and the capacity to which data are eventually used. "Entities" involved in this progression include individuals, institutions, or agencies that act as sources, collectors, custodians, and/or users of health information. "Relationships" among entities take the form of laws or regulations concerning health event reporting or circumstances and voluntary data submission for communities' common interests. "Objects" include raw data sets or refined information sources packaged through indices or written reports.

When examining this conceptual framework, the reader must realize that although the model is depicted vertically, it should be regarded as a loop where "decision makers" eventually influence "data sources," or the next health event, and the cycle begins again. In addition, it is important to note that similar responsibilities for data and information are shared across tiers so the relationships depicted in the model should not be considered as hierarchical.

Health Assessment: Gathering, Analyzing, and Disseminating Health Information



Framework Components

The Health Assessment Framework includes the following components:

- Data Sources: entities that provide data

  Sources of health data include individual patients and family members, all licensed health care providers and institutions, employers, government agencies, and industry associations. These entities are sometimes the first point of contact during a health event.

- Data Sets: how data are organized

  Data sets include information from "traditional" public health categories including vital statistics data, reportable diseases, health care service data, and health risk data. They also include data obtained from employment records, injury and crime statistics, opinion and satisfaction surveys, and health insurance claims.

- Data Collectors: agencies that gather data

  These entities include agencies or organizations that manage the acquisition of **data sets** from sources. The Office of Public Health (OPH), the Centers for Disease Control and Prevention (CDC), the National Center for Health Statistics (NCHS), and Louisiana State University Medical Center (LSUMC) are among the agencies identified in the Health Assessment Framework. In addition, it is important to note that many **data collectors** are also **database custodians**.

- Database Custodians: agencies that control data

  These entities include agencies or organizations that maintain one or more computerized or non-computerized information systems and databases associated with Louisiana's health information system. The Department of Health and Hospitals (DHH), the Department of Insurance (DOI), and the Department of Labor (DOL) are featured in the framework. However, other state agencies that fall within this category include the Department of Public Safety (DPS) and the Department of Education (DOE). The Louisiana Hospital Information Network (LHIN) is also included in the model and is operated by the Louisiana Hospital Association by Health Care Information Advantage (HCIA), an out-of-state contractor. "Payors" is a collective term used to refer to agencies that operate under insurance licenses issued by the Louisiana Insurance Commissioner. Finally, the Louisiana Health Care Review (LHCR) is the Peer Review Organization contracted by the Health Care Financing Administration for the oversight of practices by Medicare providers.

- Data Models: how conclusions are drawn from data

  Data models are objects that employ health indicators to an end purpose, such as public health program administration. Fifteen such data models were the focus of preliminary workgroup activities and were included in the Health Assessment Framework. Although these models satisfy the workgroup's assessment needs, readers should note that they do not represent **all** data models but are, rather, examples of those most commonly used. While such data models are useful for understanding trends in data, it should also be noted that they are not without their biases and shortcomings. To address this concern, additional models are under development to suit more specific analytical needs that remain unaddressed. The fifteen data models depicted in the Health Assessment Framework are more fully defined in the assessment appendices (See Health Assessment Appendix).

- Decision Support Tools: how information is distributed

  These tools are objects such as publications or refined health information systems. Such vehicles for investigation are in the hands of **decision makers**. On-Line Analytical Processing (OLAP) software is an example of one decision support tool that is used in manipulating stored data. Parish Profiles and the Annual Health Care Report Card represent decision support tools published as paper documents at OPH. Likewise, the annual ReliaStar State Health Rankings report and *Money Magazine's* annual review of best places to live could be considered decision support tools. Finally, internet websites that provide access to published information and databases serve as essential decision support tools for decision makers.

- Decision Makers: entities who use health information

  Decision makers include persons or organizations that have a vital interest in understanding health information and applying it to their personal, organizational, or community planning activities.

Framework Application

The following example illustrates the utility of the Health Assessment Framework and provides the reader with a method for understanding the nature of the relationships portrayed:

The bottom of the model (not included in the graphic) depicts the occurrence of a *health event*, such as sustaining a head injury from a biking accident. A *data source* records this health event (on a police accident report) and enters it into a *data set* (the police database). *Data collectors*, such as insurance companies (if the individual paid for his/her care with insurance) or the State Vital Records Bureau at OPH, acquire the data in order to create aggregate data sets. Next, *database custodians* control how these data are shared and may provide them for national, state, or local policy regulations. Custodians, such as DHH-OPH, often control more than one database. At this point, the original health event (the biking accident) has been recorded and sent to greater levels of aggregation. Eventually, some entity, perhaps the insurance company or OPH, will analyze the data and draw general conclusions about bicycle injuries (or injuries, in general) and pinpoint trends, with the use of *data models.* This process has taken a single health event (or piece of data) and generated useful health information. Such information is then published in written reports or *decision support tools* and disseminated to individuals who can make informed decisions that affect future health events. Policy makers and legislators (*decision makers*), for example, are able to use such health information to enact laws (such as mandatory use of bicycle helmets) that affect the next health event and, ultimately, health behavior.

APPLICATION

Louisiana's Current Data Reality

During the workgroup's assessment, members focused on the following sources of health data: health care providers, other service providers, employers, business associations, government agencies, and individuals (i.e. consumers). Currently, state or federal agencies collect the majority of health data that are available to the public at little or no charge. Collected data are generally housed in state or national agencies, or state-designated institutions. However, some private groups also provide data, usually in distilled form, such as general health indicators or sets of indicators.

When determining the utility of data sets, it is important that users consider data sources, collection methods, and collectors' and custodians' objectives in maintaining given databases. At the data source level, there is a strong potential for inaccurate data or entry error. For example, coroners, medical examiners, or funeral directors who complete death records may not have the same level of education or training and, therefore, may not list causes of death in a uniform manner. Likewise, the purpose of a source's initial data collection may be different than that of public health surveillance personnel or health planners who use it. For example, provider billing data are often the first sources of population-based morbidity statistics. However, billing codes are typically determined by standard reimbursement methods and may not reflect a physician's actual diagnosis or prescribed treatments.

In addition, data collectors and custodians may have ulterior motives, political agendas, or public relations protocol that influence their data model choices and ultimate data presentation. Intentionally, or unintentionally, data presentation directs users' attention to particular interpretation of data, which may or may not be appropriate. As a result, an important tenet of social research, which may or may not always be followed, is that one's data expectations should be identified as clearly as possible. It is imperative that data users consider these factors when examining distilled data, such as indices, "report cards," or other data reports.

Data users must also keep in mind that most public health databases have legally mandated confidentiality protections against releasing names or other identifiers of individual patients or records. Even when identifiers are not released, protection policies for individual privacy restrict data that may be disseminated in particular combinations if they could potentially reveal individuals' identity. Such a circumstance can delay the release of data; however, the state's responsibility to protect confidentiality is an important public health measure.

"Facts never speak for themselves...all research carries expectations about the nature of what is being investigated (Singleton, Straits, and Straits 1993)."

For routinely requested data sets, the solution is to develop automated approaches to censoring identifying variables. For example, members of OPH's Health Statistics Program are currently identifying standard data sets to be made publicly available on the World Wide Web. They are also developing nondisclosure rules that protect confidential information contained in these databases. Although developing rules and computer programs for accessing data is a time-consuming process, data users and providers will save time once these criteria are in place.

For ad hoc data requests, manual review by database custodians is necessary to guarantee that the release of requested data combinations will not result in a breach of confidentiality. However, some similar and even more personal data are freely collected, traded, and sold by insurance companies and others for whom confidentiality protections and data restrictions do not apply. Because there are no mechanisms in place to identify the misuse of privately held data, the public has little to no power in determining the scope and breadth of such misuse.

Conceptual Framework Analysis

The Health Assessment Framework serves as a useful tool for examining the relationship between data and health information in its **current capacity**. Conducting such an analysis allows evaluators to identify gaps within the system and steps at which the progression of data into health information is interrupted. This type of data-to-information system analysis, within the context of addressing data users' needs, is instrumental for determining appropriate methods to improve the system, enhancing data accessibility and availability while maintaining confidentiality. Conclusions from this analysis are listed below.

I. Local Level

When examining the Health Assessment Framework, it is unclear how and where local individuals impact the system or interface with it. Currently, individuals at the local level have little voice in the type of data collected or the mechanisms through which they are collected. Individuals are also portrayed as mere recipients of written reports, a point too late to determine the direction of data collection. This conclusion is also supported by interview results with local-level program planners.

The Health Assessment Framework also depicts data at various levels of refinement and aggregation. Program planners must determine at which point they should approach the data-to-information system in order to satisfy their data needs. They must determine whether data are most useful in raw form (at the level of data sets), in aggregate form (at the level of data custodians), or in refined/analyzed form (at the level of decision-making tools/reports). Establishing appropriate levels of access for program planners and their organizational needs will result in a more efficient use of data and health information.

Assessment results also revealed several local needs for information systems that remain unmet. Workgroup members determined that many individuals are unaware of existing databases, collection methods, and means of access. They are also sometimes denied access to certain tiers in the system due to database custodians' or collectors' organizational or legislative policies that restrict access to the point of being more detrimental than beneficial. In addition, some databases do not reflect local needs because communities were not involved in determining the type of data collected or analytical tests applied. Finally, some data models offered for analysis may not provide individuals with information relevant to their program planning needs and may ultimately decrease the "value" of data. Unmet data need, inaccessible databases, incomplete health information, and inappropriate data models hinder individuals' ability to use data and health information for effective program planning and informed decision making.

II. Process Shortcomings

A separate context within which to analyze the data-to-information system is to identify shortcomings or "disconnects" that prevent data from moving smoothly through the progression and becoming useful health information.

Some potential disconnects to consider are:

- Several organizations collect data independently of one another, resulting in a replication of efforts and duplicate data. In addition, such a process may result in decreased data reliability and validity if different organizations obtain conflicting results for the same measurement.

- Organizations often fail to use standardized operational definitions for data collection. This is true among different organizations and, sometimes, within the same agency when definitions are changed from one year to the next. As a result, comparing information across organizations can be problematic and comparing information from year-to-year may also be difficult.

- Although websites are an increasingly important source of health information, not all data can be included and agencies must decide which information is to be removed and which is to be presented. This process may result in users compromising the reliability and validity of their reports. Likewise, individuals may have difficulty determining how variables are defined or the original source of data, resulting in further misinterpretation.

- Internal organizational policies may restrict data sharing or coordination of data collection efforts. In addition, some organizational policies allow agencies to change operational definitions for data to suit their interests.

- Data models are usually developed for specific purposes and add value to raw data accordingly. Thus, using a specific data model may not yield the information sought by all organizations.

Major Findings

During its assessment of statewide health information systems, the Assessment Workgroup collected information on data access issues and database coordination. Workgroup members used the Health Assessment Framework during their assessment activities to determine system shortcomings and points at which individuals encounter difficulty accessing data and/or health information. These results were complemented by findings from informal interviews and the workgroup's SWOT analysis to provide a more complete picture of statewide access challenges. Results of the workgroup's assessment serve as a foundation for recommendations to improve Louisianians' access to health information. They are presented below.

- Data collection is uncoordinated among organizations, leading to problems of duplication of data and a replication of efforts.

  During its assessment, the workgroup determined that efforts related to gathering, analyzing, and disseminating health information were widespread but not necessarily well-coordinated among Louisiana's public agencies and private organizations. In addition, broad definitions determined what qualified as "health" information. The workgroup documented data systems of various state agencies including DHH-OPH, DOI, Social Services, Labor, Education, and Public Safety, none of which have coordinated their health information into one database, either centralized or distributed. As a result, the workgroup found many replications of effort, redundancy of data, lack of data integrity, and confusion among users about methods to obtain information specific to their needs, especially at the community level.

  The workgroup determined that legislative and administrative rule changes are necessary to allow health service data to be collected from private sources. In addition, they decided that an advisory panel (specifically, the Health Assessment Panel) should be created to increase coordination among agencies and improve data information systems. Finally, the Assessment Workgroup determined that particular health data management projects or initiatives should be used as "best practices" models to enhance Louisiana's health information system capacity.

- Local organizations lack access to data. [3]

  Results from informal interviews and discussions with local- and community-level program planners reinforce findings from the conceptual framework analysis. An apparent concern was that data are not always available or accessible to these organizations. In addition, local data users were unaware of locations where data are housed and methods of analysis that best suit their needs. Such shortcomings are detrimental to program planning capabilities, decision making, and policy development. Failure to address these fundamental issues fosters local dependency on larger agencies to fulfill organizations' data needs.

3. A "lack of access" to data may refer to data that are not collected in a useful manner or data analysis that does not meet local needs.

Likewise, collected data are often irrelevant to local community needs because they do not reflect unique local issues. Community issues are often specific to local areas and thus, it is imperative that communities are able to gather and analyze their own data. For example, the state is better placed to determine the total number of physicians in all parishes who treat children enrolled in Medicaid. However, it is not feasible for the state to determine how many of these physicians offer after-hours care. Such information is better collected and analyzed on a local level to address community needs and concerns.

In order for organizations to draw meaningful conclusions from data, the unit of collection should be the same as the unit of analysis (i.e., data collected on a population level should not be used to draw causal relationships within a specific community sub-group). In addition, one must recognize that data collected on a national level are usually inappropriate for local decision making. For example, Louisianian communities that wish to design teenage pregnancy prevention programs will not find data from a nationwide survey of teenagers entirely useful for their purposes, as they require information specific to their communities including risk factors for pregnancy and current sexual behavior.

- State disseminated health reports are sometimes out-of-date and contain inaccurate information.

  The political climate often determines how health initiatives are funded, resulting in inconsistent support for data collection and health information dissemination. Thus, legislators and other state decision makers must be educated about the importance of timely data and its role in creating successful and sustainable health programs. In addition, value must be placed on informed decision making and the necessity of data collection and information dissemination to foster this process (See Policy Chapter).

  A lack of timeliness in state-disseminated health reports affects several levels of program planning but is perhaps felt most significantly at the local level. Since many community members do not have the capacity to complete their own data collection and analysis, they rely on such reports for program planning. Informal interviews with local data users revealed frustrations about their inability to access accurate and timely health information upon which to design appropriate program activities. In addition, informants felt it would be a waste of local resources to collect and analyze data that are best collected at the state level. The example provided above supports this sentiment; although local organizations may want to know the number of physicians in their parish who offer after-hours care for children enrolled in Medicaid, it would **not** be in their best interest to determine how many providers in the **state** accept young Medicaid clients. While local data users wish to avoid duplicating data collection efforts, they also require relevant data and up-to-date health information to create successful programs that serve their needs.

Recommendations and Strategies

Two major recommendations resulted from assessment findings. Both address barriers faced by state and local organizations and methods for incorporating health information into programmatic activities. Each recommendation is presented below with supporting strategies and activities intended to improve statewide data access, collection, analysis, and dissemination.

I. Enhance state capacity to support data collection, gathering, and dissemination efforts at all levels, including local- and state-level efforts.

STRATEGY A: Create a Health Assessment Panel.

Health Assessment Panel members will be drawn from the Assessment Workgroup and statewide organizations that fall within all levels of the Health Assessment framework, such as data sources, data collectors, and database custodians. The panel will also include representation from local groups that will be represented in decision making processes and will contribute community

insight to statewide discussions. Much can be gained from the inclusion of both state and local perspectives in discussions about data and health information needs. The Health Assessment Panel, with the help of TP staff and the Louisiana Public Health Institute (LPHI), will expand its role as an advisory board to one that undertakes the activities listed below.

Activities of Health Assessment Panel.

Activity 1: Advocate policy recommendations

Several improvements that are necessary for state health information systems are best accomplished through legislative support. A standing panel that meets quarterly will provide such support, as members will recommend and advocate legislative change that improves health information systems. In addition, such a panel will advocate organizational procedures that facilitate sharing data between agencies and improving access.

- Support standardization of operational definitions for data collection.

  The panel will support the use of standard definitions that allow data to be compared across agency databases and over time. Standardized data fields (such as names, addresses, and other identifiers) will improve linkages between separate databases and create standards for database design and implementation. Standardization is best accomplished through policy changes and the Health Assessment Panel will be well positioned to raise awareness and advocate for such changes.

- Advocate policies that encourage the development and use of new and existing electronic infrastructure, including the use of emerging technologies and programs such as telemedicine and distance learning.

  Innovative solutions are required to address health information system barriers in rural communities and, because the majority of Louisiana is rural, addressing this issue will constitute a priority for the panel. Enhancing existing medical capacity for rural areas through strategies such as telemedicine and distance learning will address health system challenges such as a lack of access to care. Telemedicine will allow for the creation of networks between rural and urban hospitals and allow medical care to be "delivered" by health specialists via "real-time" video. Such instant access to physicians by rural residents will result in decreased morbidity and mortality throughout the state. However, since only a small percentage of rural hospitals have access to information technology, it is imperative that grant opportunities be identified and pursued that support equipping rural facilities with computers and creating capacity for telemedicine activities. The U.S. Department of Agriculture (USDA) provides grants that assist in the development of electronic infrastructure and health information systems. Such funds allow rural residents and facilities to find unique solutions to health information system barriers, namely telemedicine and its distance learning counterpart.

Activity 2: Facilitate communication and information sharing across agencies in order to coordinate data collection and prevent replicated efforts and duplicate data.

Because the Health Assessment Panel will be a statewide entity with representatives from several sectors, it will serve as the best avenue through which to facilitate inter-agency communication. Such a task will be accomplished through regular statewide forums with key decision makers who hail from local- and state-level organizations.

- Develop local capacity to conduct health assessment activities through training opportunities.

  The Health Assessment Panel will work with local technical assistance centers to develop effective training programs in communities. These centers are able to provide effective training programs because they benefit from sufficient financial resources, personnel, and expertise such as guest speakers that enable the export of training programs to local communities. In addition, the Health Assessment Panel will set agendas for training because it will remain in constant contact with state and local organizations and will incorporate their perspectives in training sessions.

STRATEGY B: Hold statewide agencies more accountable to local communities for effective health information systems.

A great need exists for open communication between state and local organizations since the actions of one directly affect the work of the other. Local communities can assist state organizations in setting their agendas. Moreover, state organizations can facilitate and support community efforts by creating a positive policy environment for local activity.

Activity 1: Facilitate communication between state and local organizations and enhance the state's responsiveness to local needs.

The Health Assessment Panel will serve as primary facilitator for these discussions as well as statewide forums where representatives will discuss the unique data and health information needs and resources of different regions. Such communication will prove invaluable since local organizations will be granted a voice in the type of information collected and its level of analysis. Likewise, state agencies will assist local organizations with data collection and provide training in innovative techniques developed for information technology.

Activity 2: Encourage timely dissemination of statewide written reports and other tools to assist local decision making.

The Health Assessment Panel will encourage the dissemination of up-to-date health information by coordinating discussions among statewide agencies responsible for these reports. As it stands, the dissemination of some reports lags by several years and by the time they are released, their information is no longer current or relevant to programmatic planning. This serves as a detriment to program decision makers, especially if they are unaware of additional health information sources.

STRATEGY C: Coordinate central and local data collection and information dissemination.

A final charge for the Health Assessment Panel is to coordinate data that are collected by state and local-level organizations to determine the types of data available and avoid a replication of efforts and/or duplicate data. The processes used to coordinate data collection can then be used to disseminate information quickly between local data users and central data repositories as well as between local information repositories and central data users.

II. Enhance local capacity and competence to conduct health assessments and health assessment activities.

Many of Louisiana's local organizations lack the large intellectual, financial, and knowledge resources that most state agencies have at their disposal. As a result, local groups become dependent upon state agencies for resources and are unable to provide feedback. In addition, because local organizations are often dependent upon state organizations for health information, they are unable to hold state agencies accountable should the needed information be unavailable.

STRATEGY A: Train individuals at the local level to undertake health assessment activities.

The most effective method for enhancing local capacity and competence is to train individuals to undertake health assessment activities. Effective training programs will provide local communities with skills for data collection, analysis, and dissemination. Such a process will ultimately provide some measure of autonomy from state agencies and decrease reliance upon the state for health information.

Activity 1: Coordinate key partners to identify, collect, and analyze data.

The Health Assessment Panel, in conjunction with TP staff and LPHI, will coordinate local-level training and contract agencies and key individuals to provide resources. Technical assistance centers (See Strategy D) will support periodic training throughout the state and provide technical assistance.

Such training are a key method for increasing local capacity and competence. In order to design effective health programs, planners must determine health information issues upon which to concentrate, determine information needed to address them, and develop appropriate indicators for data. In addition, planners must be familiar with methods of data collection and analysis that ensure statistical integrity and correct data interpretation.

Activity 2: Coordinate local training on innovations in information technology.

Several methodologies such as Geographic Information Systems (GIS) mapping, distance learning, and telemedicine offer promising solutions for local communities to expand their capacity and competence to gather, analyze, and disseminate health information. For example, GIS mapping will permit local organizations to collect data at a localized level, resulting in improved data analysis and relevant results for local communities. Partnership opportunities must be explored with Louisiana's universities who lead the state in information technology such as Louisiana State University (LSU) which is currently field testing these new strategies. In addition, the University of Louisiana at Lafayette (ULL) and Louisiana Technical University (LTU) are training a new cadre of informed leadership that will be capable of linking expertise in information systems with local organizations' needs.

STRATEGY B: Identify potential resources and employ them to help local communities develop their own infrastructure.

The Health Assessment Panel will assist local communities in identifying monetary resources and policies to support infrastructure development. The USDA is one source that sponsors grants to assist rural areas in electronic infrastructure development and updating health information systems. Funds may be obtained for purchasing equipment, hiring consultants, and/or designing training sessions for organizations wishing to use new health information systems.

STRATEGY C: Coordinate communication between state and local organizations.

This recommendation is an important step toward providing local organizations the autonomy and resources needed to access statewide data and improve health information systems.

Activity 1: Develop Regional Data Liaisons in each state region to facilitate data access for local organizations.

The primary function of Regional Liaisons will be to provide human contact for individuals and organizations wishing to access statewide data. Liaisons will feel comfortable working with data and be capable of explaining access and analysis procedures to organization personnel. Local organizations will call liaisons when they have questions about accessing data resources and determining which data are most applicable to their program needs. In addition, liaisons will conduct outreach activities in their regions to provide training and prepare personnel for working with data. Finally, liaisons will serve as intermediaries between state agencies and local communities to relay organizations' concerns and needs. Potential liaisons may be OPH employees, such as a regional epidemiologist or Healthy Communities Coordinator (see Glossary), or individuals occupying positions created especially for this service.

Activity 2: Create quick reference tools that contain data resources to distribute to organizations.

The Health Assessment Panel, along with TP staff and LPHI, will create quick reference tools (such as a laminated bookmark) of resources that state and local organizations may use when accessing data or health information. These tools will list statewide databases, their custodians, and unique features of each database.

STRATEGY D: Support the development of local technical assistance centers (Centers for Excellence) to help communities with health assessment activities.

An excellent example of a technical assistance center is the Health Informatics Center of Acadiana (HICA) at ULL. This center was created in Spring 1999 to complement health-related university missions, including health education and research. This program was also created to link traditional public health agencies with Louisiana's health care industry.

Future Centers for Excellence will serve as laboratories for reengineering the collection, analysis, and dissemination of health status information in Louisiana. Centers will also utilize academic, industry, and governmental partnerships to collect and analyze health information to benefit Louisianians' health. Thus, Centers for Excellence will serve as agents to establish prototype programs and deploy several of the recommendations outlined in this chapter. Such an investment in health information systems and infrastructure development will accelerate movement toward improved health assessment in Louisiana.

Conclusion

Effective health information systems are critical to the success and sustainability of public health programs. Reliable data and health information are necessary for informed decision making by program planners and timely data support the creation of appropriate public health programs in the future. Likewise, effective information systems allow individuals and communities to make informed health decisions, utilize available services, and prioritize strategies to improve health. Although the short-term benefit of improved health information systems may not be readily apparent, increasing the availability and accessibility to data has long-term implications for improving the health and well-being of Louisianians.

Up-to-date and relevant health information is also critical to program planners and individual data users across Louisiana. Unfortunately, funding agencies often overlook program proposals that target health assessment activities and increase user access and data availability. This predicament becomes apparent when examining the larger picture of improving health services; programs that directly impact health are given highest priority because the **need** for such programs is evident. The urgency of improving access to health care or ensuring the delivery of prevention and health promotion activities is usually more evident than the importance of increasing the availability and accessibility of data. However, upon closer examination, the indirect impact of data on public health programs becomes apparent. Timely, accessible, and usable data are critical to all phases of program planning including design, implementation, monitoring, and evaluation.

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For more information about the Agency for Toxic Substances and Disease Registry (ATSDR), call:
Division of Toxicology 404-639-6300
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Chapter 2

Health Policy in Louisiana

Chapter 2-Health Policy in Louisiana

The following chapter provides information on Louisiana's public health policy environment and development and it describes methods used by the Policy Workgroup to assess the state policy-making process. However, the primary focus of this chapter is recommending change, evaluating existing policy, proposing strategies for improving policy, expanding constituent involvement in policy making and, ultimately, providing better health programs for Louisianians.

IN THIS CHAPTER

Introduction

"Public health policy," for the purposes of this document, is defined as "practices and procedures that outline the responsibilities of individuals or organizations, either by prohibiting certain actions or by providing incentives for others." Public policy also refers to the regulation of the behavior of public officials and their employees, especially in their interactions with citizens and with one other. However, as Walt (1996) explains, "Health policy goes beyond health services and includes actions or intended action by public, private, and voluntary organizations that have an impact on health." Therefore, public health policy making encompasses a number of activities and involves several key players. However, it need not be an enigma and the Policy Workgroup has made an effort to provide concrete examples of public health policy, along with its development and implementation, throughout this chapter.

Public health policy comes in many shapes and sizes and its formation and realization come through several different avenues. For example, twenty years ago individuals did not wear seat belts in vehicles and, for the most part, no one worried about driving after having a couple of drinks. Now, for most individuals, buckling up is a habit and encouraging this practice is supported by legislation. In addition, most people think twice about how much alcohol they consume and whether or not it is appropriate to drive afterwards. Americans have changed their opinion of these issues, and change has been a result of community action, public education, and legislation.

Common forms of public policy include:

- Constitutions, both federal and state
- Statutes or other legislative procedures that affect the public on the federal, state, parish, or neighborhood level
- Regulations written by public managers and governed by the State Administrative Procedures Act – Such regulations implement broad statutes and must face public scrutiny before they are enacted
- Executive Orders (at all levels) that mandate policy within an executive branch
- Court decisions that interpret laws or apply laws to specific situations
- Management interpretation decisions whereby those who implement laws and regulations decide to act or not act based on managerial discretion and authority

Although the term "public policy" refers to decisions made by governments and methods used by governments to achieve their goals, one should also credit private sector activities with having broad public impact. Most importantly, the most effective public

policy is that which is informed by consumer needs and formulated along with community efforts. Such a grassroots approach to policy making is the only method that ensures community needs are met and local voices heard.

Public policy interventions may take several forms including one or more of the following:

- Creating mechanisms or avenues for public input into policy development
- Changing government funding of programs
- Changing government management of programs
- Creating or funding new programs
- Interpreting existing laws or regulations differently
- Enacting new laws
- Enabling state or parish officials to make decisions as a result of devolution

Policy Workgroup and Mission

The Policy Workgroup was charged with examining the capacity and competence of the public health system to formulate, advocate, and implement policies that positively impact Louisianians' health status. The workgroup is comprised of members who represent public and private sectors, governmental state and local agencies, and advocates. The focus of this chapter is to demonstrate how communities can contribute to healthy public policy by collaborating with policy makers. In addition, workgroup members believe that public policy issues must be addressed at all levels of government, including parish and community levels. Finally, the goal of this chapter is to make thinking about health policy and its impact a natural and obvious way to improve the lives of Louisianians.

Early in the assessment process, the workgroup decided that studying an area as broad as policy required a practical approach, one focused on improving the health and well-being of Louisianians. In addition, the workgroup committed to defining a practical scope of work that would result in tangible, workable recommendations and strategies.

In order to assess Louisiana's policy environment and provide communities with details about the policy-making process, the workgroup incorporated qualitative research methods into their assessment activities, namely discussions and in-depth interviews with policy developers and Turning Point (TP) Partners who are active at all levels around the state.

The Policy Workgroup undertook the following activities:

- Experienced workgroup members described essential elements for effective policy development, key activities of the policy development process, and structural and situational analysis of factors that drive policy making in Louisiana.
- Workgroup members completed an assessment of Louisiana's successes and shortcomings in policy development.
- Other TP workgroups shared the policy implications of their efforts for inclusion in this proposal.
- Assessment interviewees served as peer reviewers for the Public Health Improvement Plan (PHIP) policy recommendations.

- Workgroup members assessed major health activity areas and development in other public health arenas with implications for policy development in Louisiana.

The Policy Workgroup used these activities to examine Louisiana's general policy environment and the context in which policy making is conducted. Next, the workgroup collaborated with the Access, Assessment, and Prevention Workgroups to prioritize policy issues in support of their efforts and change within the public health system.

Existing Programs for Effective Policy Development

While the Policy Workgroup's assessment and recommendations highlight several shortcomings in Louisiana's policy-making process, it is important to acknowledge existing programs that contribute to informed policy development. The following activities have had a significant impact on the competence and capacity of Louisiana to develop sound public health policy and they serve as tools for effective policy development.

- Parish Health Profiles

  These documents provide information on over 130 health and quality of life indicators for communities around the state. The redesign and delivery of Parish Health Profiles has improved their utility and community accessibility. Data are presented in a user-friendly format and, after redesign by the state public health system, reports include suggested tools and strategies that communities can use to translate information into action at the local level. These health profiles have policy implications since they represent the only such publication developed in conjunction with other state agencies whose work impacts overall quality of life and health issues.

- South Central Partnership for Workforce Development

  This program, of which Louisiana is a member, focuses on developing a comprehensive regional approach to building and maintaining a professional public health workforce in four states. The Partnership emphasizes curriculum development to create a public health workforce that understands the utility of information for local decision making and policy development. Participants also learn to apply new skills at the local level and work effectively with communities. The Partnership will introduce this curriculum statewide in the year 2000.

- Healthy People 2010

  Louisiana is one of few states that recently passed legislation mandating the development and implementation of a statewide Healthy People 2010 (HP 2010) process. This legislation, with support from the Governor's office, places implementation responsibility in the state public health system. An important attribute of the HP 2010 process is the engagement and participation of community members in health indicator selection, tracking, and monitoring. Work completed by the Louisiana TP Partnership, Parish Health Profile teams, and the South Central Partnership for Workforce Development established a model for HP 2010 implementation in Louisiana.

Assessment Methodology

The Policy Workgroup used a combination of data collection methods to assess Louisiana's public health policy environment and recommend changes to improve the policy-making process. Workgroup members collected all data and synthesized results for this chapter.

First, workgroup members conducted in-depth telephone interviews with each of the 14 TP state coordinators across the nation. These discussions centered on their experiences organizing TP initiatives and state workgroup activities. A report was distributed to all interviewees, Louisiana TP members, and all workgroup chairs who use the information in their work (See Policy Appendix).

Second, workgroup members surveyed key Louisiana policy developers in the health and environment fields through telephone interviews. Areas of inquiry included policy development, drivers of policy, models for policy development, and successful (and unsuccessful) approaches to assessment (See Policy Appendix).

Concurrently, the workgroup reviewed four key policy models, developed a matrix of model attributes, and incorporated the most useful contributions into their list of recommendations and strategies. Models from Walt (1996), Kingdon (1984), Hogwood and Gunn (1984), and Gil (1992) and their implementation phases served as guides during the workgroup's assessment (See Policy Appendix).

Major Findings

The Policy Workgroup's assessment led to the following conclusions:

I. Many participants stated that Louisianians feel disenfranchised from the health system and are not included in the public policy-making process. For example:

- Community perspectives as "gold standards"

  Most participants stated that the community "knows best" and if policies reflect community needs, then they are good policies.

- The value of information

  Most interviewees agreed that information is "powerful" and that valid, reliable, and clearly presented data could "clean up the backroom policy-making process." Participants also agreed that not enough information is currently available and much of the information that is available is presented in difficult-to-understand formats. Finally, several interviewees stated that, if information were made available to communities in an understandable format, they could use it to affect policy priorities and implement change (See Health Assessment Chapter).

- The necessity of collaboration and diversity

  Many interviewees stated that it takes the power of several "strong voices" to bring about change. They added that advocates working to influence policy decisions are more effective when organized and applying a common agenda that represents diverse concerns.

II. **Many interviewees pointed out that consumers feel there is little government accountability for laws and policies. For example:**

- The utility of surveillance activities

  Many participants stated that if leaders and elected officials knew that their constituents were observing them, they would better heed their needs. They added that since communities' needs are considered the "gold standard," keeping leaders and elected officials true to them would make better policy and government and, eventually, better living circumstances for the public.

- Leaders' roles

  Most interviewees felt that leaders are "custodians" of the public trust and their responsibility is to remain true to the public's needs, to whom they are ultimately accountable. Agencies, elected bodies, and civil service should maintain the public good as their highest priority.

- The importance of accountability

  Participants spoke of accountability on several levels and stated that communities must take responsibility for their own welfare and, likewise, elected officials for their constituents. Public health systems must provide good and understandable information and agencies should value public input.

III. **None of the participants could identify official or unofficial methods of evaluating public health policy in Louisiana, either by key government figures, other policy makers, or constituents themselves.**

These findings, as simplistic as they may seem, were not surprising. Workgroup members identified a lack of community and public involvement in policy making as a key issue in developing sound public policy. The assessment process and its findings laid the groundwork for the development of the following concrete recommendations.

Recommendations and Strategies

This section includes policy recommendations at both state and local levels and appropriate strategies for their realization. Key findings and quotes from in-depth interviews support the recommendations and rationale behind their creation. In addition, a matrix located toward the end of this chapter consolidates proposed strategies and outlines implementation resources for each effort.

I. **Develop community capacity so individuals are empowered to participate in health care debates and decision making. Important activities include identifying community health needs, establishing health priorities, and crafting solutions, in addition to having the resources to do so. Individuals most affected by issues or deficiencies identified by workgroups must be involved as partners in implementing the PHIP.**

STRATEGIES:

- Develop a curriculum to identify, recruit, train, and support community health leaders, including a curriculum for Training of Trainers (TOT) and participants. Supporting materials must also be provided during training sessions.

- Identify communities and their health concerns using other TP workgroup issues and priorities, as well as structures already in place.

- Develop TP and the Louisiana Public Health Institute's (LPHI) capacity to deliver community health leader training through the statewide TP program as well as through state and local partnerships.

RATIONALE:

Those surveyed during the assessment phase identified a lack of community participation and engagement as one of the chief barriers to development and implementation of successful health policy. Community members often have valuable information to contribute to the policy-making process, but a lack of infrastructure and resources to draw upon leads to under-participation by these individuals.

"Policy falls between 'police' and 'politicians' in the dictionary. Maybe we need to learn something from that."

Public health decision makers must learn to value the resources, information, and insights that community members contribute to policy development, prioritization, and implementation. Moreover, the public health system must include identifying, recruiting, training, and supporting community members to play an active and ongoing role in policy development and implementation; thus a structure for this to occur must be developed and supported.

"For the vast majority of agencies that provide services, their minds are already made up...(even if)... they hold a public hearing."

Public health agents must develop an array of tools to identify, recruit, train, and support communities and develop staff competence to fulfill roles required in a comprehensive community capacity-building program. Tools may include conducting community needs assessments/prioritizations, defining "health" within individual communities, identifying barriers to access to care, or building relationships between individuals and organizations.

The proposed strategies represent a combination of short- and long-term goals. Short-term strategies include developing training programs to increase community capacity to affect public policy. Long-term goals must address competence to react to and sustain policy changes over time and encourage community involvement in policy enactment and evaluation.

Significant changes must be made in the public health system at policy, organizational, and structural levels. Financing and legal issues may need to be addressed based on specific strategies employed to fulfill this recommendation.

As a result of changes implemented in the public health system to support community involvement, individuals will feel an increased sense of control over health policy design, implementation, and evaluation. They will also experience a greater sense of ownership over health policy decisions and feel inclined to accept greater responsibility for their individual health decisions.

The development of community capacity and avenues for community involvement in policy making will create a broader base of support through a shared sense of responsibility for community health outcomes. Individuals must "own" their health and constituents must take responsibility for the health of their communities in order to improve. This finding has been demonstrated nationally through such initiatives as the Healthy Communities movement (See Glossary).

"...private health care needs to involve consumers...The general public needs to know more about health policy to understand it better."

II. Develop or change mechanisms to bring elected and government officials together with community members

STRATEGIES:

- Provide communities a forum to improve communication with legislators and make government officials accountable for responding to their health needs.
- Sponsor forums for local policy makers, community members, and health leaders to prioritize community health issues and facilitate communication to implement change.
- Develop "healthier" campaign models for use in city, parish, state legislative, statewide, and federal political campaigns to make health an electoral issue - Such a process allows constituents to obtain candidates' commitments and ensure accountability.

RATIONALE:

> **"It is clear to me that the decisions are made in the back room (and) that (our) discussion is only the icing on the cake. The legislators have already made up their minds."**

Key policy makers identified a lack of public accountability as a barrier to successful policy change. They felt that this factor contributes to distrust and disaffection with the health system.

An improved public health system must value public accountability as part of its mission. Public accountability is a useful tool for strengthening the capacity of communities to participate in the design, development, implementation, and evaluation of health policies. It is a viable method for strengthening the public health system's ability to respond appropriately to community needs.

The public health system must develop tools to facilitate public accountability. For example, individuals should participate directly in identifying issues and community priorities, developing solutions, implementing change, and monitoring the effects of change as well as updating and refining priorities. Likewise, the public should also review policy recommendations formulated by institutional and community representatives. To rebuild the trust between the government and public that has been broken, more decision-making meetings should include the public and be scheduled at times and places accessible to community members. Policy making procedures must incorporate the input received at such levels: that is, suggestions should not "fall on deaf ears."

> **"You have to have people, in my opinion, who can make decisions. Sometimes they send someone (to a meeting) ...but the people (who were sent) aren't able to make any decisions so they can't make change..."**

Strategies for accomplishing accountability are both short- and long-term. In the short-term, accountability strategies should be employed to publicize the PHIP and efforts should be initiated to develop community-government relationships that will eventually lead to ownership of the PHIP, commitment to its implementation, and ongoing evaluation. In the long-term, accountability strategies must be incorporated into community planning and implementation activities in order to create an ongoing system of government-community partnership, or a form of checks and balances.

Significant changes must be made to current structures that convene government and community members. Priority should be given to establishing mechanisms for organizational structures that support communities that work with legislators to impact policy. Financing and legal changes may be necessary to implement specific strategies, and constituents must be supported in their efforts to take part in policy making. Along with the ability to lobby, meet with legislators, and attend legislative sessions, citizens must be provided a place at policy-setting tables within health agencies and ensured mechanisms for policy development and evaluation input.

Public accountability increases the level of faith and trust individuals have in elected and administrative officials. More importantly, individuals feel an increased sense of power to affect change in health decisions and will be more inclined to accept greater responsibility for their individual health decisions when they are held accountable. This result will have significant consequences for improving health outcomes in priority areas identified by the Prevention Workgroup (See Prevention Chapter).

Success at this level will create improved support for health policies and promote a shared sense of responsibility for the public health system.

III. Develop a community-driven system of statewide multi-sector forums focused on policy issues and their evaluation based on community measurements of success. Each strategy must include a plan for periodic use that is sustainable over time.

STRATEGIES:

- Develop a system of public hearings, held periodically across the state, designed to take place at all phases of policy making, planning, implementation, and evaluation. This system should include health-related decisions that are of major concern to communities or issues that substantially impact constituents and communities. Finally, when possible, link with existing community groups to provide a channel into the policy-making process.

- Develop a plan for using and supporting focus groups, with community members across the state, to identify and prioritize local issues, identify additional community groups and members to involve, and test strategies for addressing issues and evaluating policy results once they are enacted.

- Develop survey tools that can be used to test community responses to issue identification and prioritization, proposed strategies, and the effectiveness of implemented policies. From these responses, develop mechanisms to incorporate into policy-making processes.

- Develop a system for ensuring automatic periodic review of statutes, regulations, and other policies to measure their effectiveness, the need for continued application, and suggestions for modifications. Where appropriate, provide mechanisms to institute sunset provisions on policies to ensure subsequent reviews of continued need.[1]

RATIONALE:

Key policy makers identified a lack of community engagement, public accountability, and policy evaluation as barriers to successful health policy change. They explained that even when constituents become involved in early stages of advocating policies and/or policy change, mechanisms must be put in place to encourage individuals to continue evaluating the impact policy has had on health.

Public health decision makers must recognize the value of continued information exchange, collaboration to identify problems and solutions, and shared experiences across sectors as they relate to specific policy implementations.

In order to evaluate policy outcomes, the public health system must include tools that facilitate multi-sector forums. Personnel must be in place to implement such tools and gather information to suggest and make recommended changes. These tools will improve sustainability and allow for systematic data collection. Tools should be simple to apply and communities must be provided timely feedback or witness change as a result of their participation in the data collection process.

1. "Sunset provisions" are time-limited policies that are reviewed before an expiration date to examine their appropriateness for renewal.

Strategies and tactics for accomplishing this recommendation are both short- and long-term. An important short-term goal is to publicize the existence of the PHIP and hold public hearings to solicit feedback. Developing multiple strategies for enhancing community-government partnerships in policy design, implementation, and evaluation serves as a long-term goal. Specific evaluation methodologies tied to recommendations in the PHIP must also be developed and monitored.

Significant changes must be made in the public health system at policy, organizational, and structural levels. Financing and legal changes may be necessary depending on the strategy chosen to implement this recommendation. Once again, structures must be developed and supported in order for policy evaluation and changes to become institutionalized. Financial considerations must support local community involvement while mechanisms for integrating evaluation information into future policy decisions are developed and sustained.

Individuals will feel an increased sense of power in health policy discussions, leading to increased ownership of health policy decisions and a heightened sense of individual responsibility for health behavior. The ability to evaluate key public health policies and follow their outcomes will provide communities with information needed to sustain change and improve health outcomes.

"The community has to have more control. I keep saying is that there is so much fear in the community because they have no control over the process. And when they feel that they have no control, then there is elevated fear."

IV. Develop measurement tools for systematic policy planning and evaluation (data) using community measurements of success and engage community members in shaping questions and variables.

STRATEGIES:

- Develop a sustainable process to identify community measurements of success and provide community members several opportunities to contribute to the design of evaluation tools.
- Develop a sustainable mechanism to ensure community members' participation in determining and prioritizing factors they feel are important to include in the policy evaluation process.
- Develop tools that will produce statistically reliable data and address factors identified by community members.

RATIONALE:

Key policy makers identified a lack of systematic tools for planning and evaluation as a barrier to successful health policy change.

Public health decision makers must develop simple mechanisms for public health service users to evaluate services they receive as well as newly enacted policies.

Personnel must be in place to support and analyze results of constituent evaluations as well as integrate results into system improvements.

Strategies for accomplishing this recommendation are both short- and long-term. Before any long-term implications for evaluating policy can be successful, short-term mechanisms must be developed and field-tested. In addition, evaluation methods must include built-in mechanisms to ensure that data are collected systematically.

Significant changes must be made in the public health system at policy, organizational, and structural levels. Financing and legal changes will be necessary depending on the specific strategies employed to fulfill this recommendation and evaluation methods must be built into policy development.

Systematic planning and evaluation will identify successful policies for replication and replace those that are ineffective or obsolete, leading to more successful health outcomes. In addition to establishing evaluation mechanisms in Louisiana's program, health policies in other states and localities should be examined to determine their role in promoting change and improving health outcomes.

Systematic planning and evaluation will encourage members of the public health system to become more strategic during policy development and focus on outcomes of policy implementation. It should no longer be accepted that public health policy will be developed without community input and without mechanisms for continued outcome monitoring and evaluation.

Strategy Implementation Matrix

The following matrix elaborates the strategies outlined in this chapter and indicates required resources and activities for implementation. In addition, pilot programs are described to demonstrate how strategies will be applied in the field.

Strategy	Key Players	Roles & Responsibilities	Accountability	Resources	Financing	Structures	Pilot
Develop a curriculum to identify, recruit, train, & support community health leaders, including a curriculum for TOT & participants.	Community members, organizations, coalitions, TP Partners, academicians, consultants, OPH staff, & TP/LPHI staff.	Collaborators & staff will design a Request for Proposal (RFP) for curriculum design & development.	Performance indicators will include the involvement of community members & organizations in policy making.	Staff with expertise in designing community engagement models & developing curricula.	Funding may be secured as part of the TP implementation grant, matching funds from Louisiana funding sources, & in-kind contributions from TP Partners.	Public health system decision makers must ensure that sufficient staff & resources are in place to support this strategy. Developed structures must value community engagement & principles of popular education.	The TOT will be tested on an initial group of trainers, including community coalition leaders, OPH staff, & TP/LPHI staff. Subsequent trainings will be replicated across the state.
Identify communities & their health concerns using other TP workgroup issues & priorities.	Community members, organizations, coalitions, TP Partners, statewide partners, community health leaders, consultants, & TP/LPHI staff.	Community members, organizations, & coalitions must set priorities from the PHIP & identify communities. Other collaborators will perform support activities.	Success will be measured by community participation. Decision makers in the public health system must develop & support structures to sustain community participation.	Community members, organizations, & coalitions contribute insight & information. The public health system must devote staff & other resources.	Funding may be secured as part of the TP implementation grant, matching funds from Louisiana funding sources, & in-kind contributions from TP Partners.	Public health system decision-makers must go beyond simply obtaining community "input": they must involve members in finding solutions to problems.	An initial group will identify strategies to implement at the community level. Strategies will be tested for efficacy in different locales.

Strategy Implementation Matrix *(continued)*

Strategy	Key Players	Roles & Responsibilities	Accountability	Resources	Financing	Structures	Pilot
Develop TP's capacity to deliver community health leader training.	Community health leaders, state & local TP Partners, consultants, OPH staff, & TP/LPHI staff.	Key players will design a workplan to deliver trainings. This may include securing needed resources, recruiting & hiring additional staff with expertise in community outreach & popular education.	Performance indicators will include a collaborative workplan for training delivery & successful completion of milestones.	Individuals with expertise in designing & implementing the workplan (most likely consultants).	Funding may be secured as part of the TP implementation grant, matching funds from Louisiana funding sources, & in-kind contributions from TP Partners.	The public health system must devote sufficient staff & other resources to this effort to ensure that capacity within the TP project is successfully developed & sustained.	None
Provide communities a forum to improve communication with legislators & make government officials accountable for responding to their health needs.	Community members, organizations, coalitions, community health leaders, policy makers, experts, TP/LPHI staff.	Community members, organizations, & coalitions will identify issues & set priorities for each workshop. Other key players will facilitate the planning process, coordinate workshops, & disseminate results.	Performance indicators will include collaborative efforts between community members, organizations, coalitions, & other key players to plan & deliver workshops.	Staff with expertise in community outreach, coordinating workshops, & facilitating community issue identification & problem solving.	Funding may be secured as part of the TP implementation grant, matching funds from Louisiana funding sources, & in-kind contributions from TP Partners.	Public health system decision-makers must devote sufficient staff & other resources to this effort to ensure that workshops are supported & design made sustainable.	The workshop design will be tested on a small group of legislators & committee staff to evaluate the plan & offer suggestions.

Strategy Implementation Matrix *(continued)*

Strategy	Key Players	Roles & Responsibilities	Accountability	Resources	Financing	Structures	Pilot
Sponsor forums for local policy makers, community members, & health leaders to prioritize community health issues & facilitate communication to implement change.	Community members, organizations, coalitions, community health leaders, policy makers, local & state TP Partners, OPH staff, & TP/LPHI staff.	Community members, organizations, & coalitions must identify issues addressed at forums & develop forum agendas. OPH staff will support this process.	Performance indicators include collaborative efforts between community members, organizations, coalitions, & other key players to plan & deliver community forums.	Staff members with experience in community outreach, collaborative planning, & forum coordination. Local resources & needs will vary among communities requiring several different methods.	Funding may be secured as part of the TP implementation grant, matching funds from Louisiana funding sources, & in-kind contributions from TP Partners.	Public health system decision-makers must ensure that sufficient staff & resources are in place & developed structures must value community engagement & popular education.	Various community forum techniques should be tested in several locales to determine the most appropriate format.
Develop "healthier campaign" models for use in city, parish, state legislative, statewide, & federal campaigns to make health an electoral issue.	Community members, organizations, coalitions, community health leaders, local and state TP Partners, OPH staff, & TP/LPHI staff.	Community members, organizations, and coalitions must identify candidates and issues upon which to educate them. In addition, these groups will develop forums and materials to inform candidates.	Performance indicators include collaborative efforts to develop, plan, and deliver healthier campaign activities.	Individuals with expertise in designing and implementing candidate education campaigns.	Funding may be secured as part of the TP implementation grant, matching funds from Louisiana funding sources, & in-kind contributions from TP Partners.	Public health system decision makers must devote sufficient staff and other resources to ensure the success of this effort.	Various candidate education techniques and materials should be tested in several locations and in various types of campaigns to determine the most appropriate methodologies.

Strategy Implementation Matrix *(continued)*

Strategy	Key Players	Roles & Responsibilities	Accountability	Resources	Financing	Structures	Pilot
Develop a system of public hearings to take place at all phases of policy making, planning, implementation, & evaluation.	Community members, organizations, coalitions, community health leaders, policy makers, local & state TP Partners, OPH staff, & TP/LPHI staff.	Key players will design a long-term plan for periodic hearing format, dates, & locale. Community members, organizations, & coalitions will identify issues, participants, & locations & develop forum agendas. OPH staff will facilitate & support the process.	Performance indicators will include workplan development, criteria for forum location, criteria for reporting community participation & level of community participation.	Staff with experience in community outreach, collaborative planning, & coordinating public hearings.	Funding may be secured as part of the TP implementation grant, matching funds from Louisiana funding sources, & in-kind contributions from TP Partners.	Public health system decision-makers must ensure that sufficient staff & resources are dedicated to this effort & community engagement & popular education are valued.	Key players will identify & test models for hearing formats, agendas, location selection, & participant recruitment. Strategies will be tested for efficacy in different locales & around different issues until an array of methodologies are developed that can be used & modified over time.
Develop a plan for using focus groups to identify & prioritize local issues, identify potential community groups & participants, & test strategies for addressing issues & evaluating policy results.	Community members, organizations, coalitions, community health leaders, policy makers, local & state TP Partners, OPH staff, & TP/LPHI staff.	Key players will design a long-term plan for focus group use. Community members, organizations, & coalitions will identify issues & recruit other key participants. OPH staff will facilitate & support the process.	Performance indicators will include production of a long-term plan & the extent to which communities participate in issue identification, participant, recruitment, & focus group design.	Staff with experience in community outreach, collaborative planning, & the design & coordination of focus groups.	Funding may be secured as part of the TP implementation grant, matching funds from Louisiana funding sources, & in-kind contributions from TP Partners.	Public health system decision makers must ensure that sufficient staff & resources are dedicated to this effort & community engagement & popular education are valued.	Key players will identify & test models for convening groups & recruiting participants as well as focus group format & question design.

Strategy Implementation Matrix *(continued)*

Strategy	Key Players	Roles & Responsibilities	Accountability	Resources	Financing	Structures	Pilot
Develop survey tools to test community responses to issue identification & prioritization, proposed strategies, & the effectiveness of implemented policies.	Community members, organizations, coalitions, community health leaders, policy makers, local & state TP Partners, OPH staff, & TP/LPHI staff.	Key players will determine parameters for developing survey tools. Community members, organizations, & coalitions will identify issues, priorities, solutions, & evaluation measures. OPH staff will facilitate & support the process.	Performance indicators will include the development of survey tools & the extent of community participation in their design. Additional indicators will be the application of survey data & analysis to health policy development.	Staff with experience in community survey & evaluation techniques & survey administration.	Funding may be secured as part of the TP implementation grant, matching funds from Louisiana funding sources, & in-kind contributions from TP Partners.	Public health system decision-makers must ensure that sufficient staff & resources are dedicated to this effort & community engagement & popular education are valued.	Survey tools will be tested & evaluated as they are designed.
Develop a system for ensuring automatic periodic review of statutes, regulations & other policies to measure their effectiveness, the need for continued application, & suggestions for modifications.	Members of the legislature & executive branches of state government, community members, organizations, coalitions, consultants, OPH staff, & TP/LPHI staff.	Staff & consultants must identify legislative, regulatory, or other changes needed to create a system of sunset provisions.	Key players will develop a collaborative advocacy plan to implement changes in statutes, rules, & management practices needed to create the sunset system.	Access to experts who can identify legislative & administrative changes or other interventions needed to implement the sunset system.	Funding may be secured as part of the TP implementation grant, matching funds from Louisiana funding sources, & in-kind contributions from TP Partners.	System decision-makers must institutionalize periodic review of statutes, & regulations to ensure that sunset requirements are met. Structures in other states that have undertaken similar work will be studied & analyzed.	None

Strategy Implementation Matrix *(continued)*

Strategy	Key Players	Roles & Responsibilities	Accountability	Resources	Financing	Structures	Pilot
Develop a sustainable process to identify community measurements of success & provide community members several opportunities to contribute to the design of evaluation tools.	Community members, organizations, coalitions, local & state TP Partners, consultants in evaluation design, academicians, OPH staff, & TP/LPHI staff.	Key players will help community members identify measurements of success for both health services & health policies.	Performance indicators will include the extent to which community measures are integrated into tool design.	Necessary resources include staff & consultants with expertise in designing models for identifying community measurements of success.	Funding may be secured as part of the TP implementation grant, matching funds from Louisiana funding sources, & in-kind contributions from TP Partners.	Public health system decision makers must ensure that sufficient staff & resources are dedicated to this effort & community engagement & popular education are valued.	An initial group of key players will identify & test one or more models for convening community members, organizations, & coalitions to identify community measurements of success.
Develop a sustainable mechanism to ensure community members' participation in determining & prioritizing factors they feel important to include in the policy evaluation process.	Community members, organizations, coalitions, local & state TP Partners, consultants in evaluation design, OPH staff, & TP/LPHI staff.	A collaboration of key players, led by community groups & members will guide model design & enable communities to identify & prioritize factors they consider important in evaluating services & policies.	Performance indicators will include the extent to which factors identified by community members & groups are included in tool design.	Necessary resources include staff & consultants with expertise in model design for identifying & prioritizing key community factors.	Funding may be secured as part of the TP implementation grant, matching funds from Louisiana funding sources, & in-kind contributions from TP Partners.	OPH decision makers must ensure that sufficient staff & resources are dedicated to this effort & that community involvement is valued.	An initial group of key players will identify & test one or more models for convening community members, organizations, & coalitions to identify & prioritize evaluation factors.

Strategy Implementation Matrix *(continued)*

Strategy	Key Players	Roles & Responsibilities	Accountability	Resources	Financing	Structures	Pilot
Develop tools that will produce statistically reliable data & address factors/ measurements identified by community members.	Community members, organizations, coalitions, local & state TP Partners, consultants in evaluation design, academicians, OPH staff, & TP/LPHI staff.	Key players will design, test, & implement measurements.	Performance indicators will include tools designed for this process.	Access to experts who can develop measurement tools that accurately evaluate health services & policies & analyze evaluation results.	Funding may be secured as part of the TP implementation grant, matching funds from Louisiana funding sources, & in-kind contributions from TP Partners.	OPH decision makers must ensure that sufficient staff & resources are dedicated to this effort & that community engagement & popular education are valued.	Various evaluation tools should be tested for an array of services & policies to determine the most useful tools for determining success.

Conclusion

Change in public health policy requires public input and involvement, but more importantly, it requires that the public health system value true community engagement. Louisianians' health will not improve until community members are active, educated, empowered, and engaged in health policy debate and decisions. As determined by an assessment of the state's policy-making environment, individuals feel that the community "knows best" and, therefore, health policies must reflect community needs and values to positively influence health status. Likewise, information is power and information in the hands of community members is an effective tool for expanding the base of health policy debate and decisions. Community members must have adequate and understandable information available to them to enable meaningful participation in decisions that affect their health and well-being. In addition, they require opportunities for questioning and holding those who have been entrusted with community health decision making accountable for their actions. Finally, support for community involvement will provide members with an increased sense of control over health policy decisions and their willingness to accept greater responsibility for individual health decisions.

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Chapter 3

Prevention and Health Promotion in Louisiana

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F. Blood pressure screening

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VII. Major Findings

A. Louisiana must address actual causes of death that are behavioral or environmental in nature.
B. Louisiana is performing fairly well in delivering clinical preventive services to individuals, but is still short of HP 2000 objectives.
C. African-Americans demonstrate disproportionately higher levels of behavioral risk factors and are less likely to receive evidence-based clinical preventive services than whites.
D. State prevention efforts are not coordinated across sectors or agencies resulting in replicated efforts and poor use of meager resources.

VIII. Recommendations and Strategies

A. Current prevention and health promotion efforts should be coordinated across agencies.
B. Prevention and health promotion efforts should be multifaceted, addressing policy, environmental, attitudinal, and behavioral factors that impact health.
C. Prevention priorities should be established according to perceived need within communities and supported by sound data.
D. Statewide prevention efforts should target actual causes of death and prioritize eliminating health disparities among sub-populations.
E. Statewide efforts should promote the delivery of evidence-based clinical preventive services and programs that emphasize eliminating health disparities among sub-populations.

IX. Implementation Priorities

A. Peer forums on actual causes of death
B. Pilot programs in local communities

IX. Conclusion

X. Contact Information

XI. References

Chapter 3-Prevention and Health Promotion in Louisiana

The following chapter discusses how Louisiana's current public health system can be strengthened through effective and efficient prevention activities. Highlights from the Prevention Workgroup's statewide assessment are included as well as specific recommendations for promoting healthier behaviors and lifestyle choices throughout the state. This chapter offers several suggestions for improving existing programs, prioritizing prevention efforts, and promoting collaboration between health agencies and diverse sectors to create innovative health programs for Louisianians.

IN THIS CHAPTER

Introduction

"Prevention," for the purposes of this chapter, is defined as "any action directed toward preventing illness and promoting health to avoid the need for secondary or tertiary health care (Anderson 1994)." The U.S. Preventive Services Taskforce (USPSTF) describes three levels of prevention: 1) primary measures that prevent the onset of a targeted condition (such as immunizations); 2) secondary measures to identify and treat asymptomatic individuals who may have risk factors or pre-clinical disease (such as cancer screening); and 3) tertiary services that include the treatment and management of persons with clinical illness (such as reducing cholesterol levels in patients with coronary heart disease) (USPSTF 1996). Although the delivery of these services is important for preventing the onset of disease, most health programs overlook non-obvious determinants of health such as levels of poverty, educational attainment, and cultural practices.

Human behavior and, subsequently, health decision-making processes are complex matters wherein several factors play a significant role. The seemingly disparate components of health, such as physical, mental, social, cultural, biological, and environmental components, are interrelated and continuously impact one another. As a result, it is imperative that prevention program planners recognize that several agencies and organizations are implicated in non-obvious determinants of health. In addition, health interventions should not be concentrated uniquely on health care settings, but should also target individuals' physical environment, work environment, home environment, and perceptions of group norms. For example, rather than encouraging smokers to join cessation programs, more effective interventions would promote smoke-free zones in office buildings, provide improved air quality in public areas (such as restaurants), or convey to teenagers that smoking is not an acceptable or "normal" behavior for individuals their age.

Multifaceted interventions, such as those described above, require program planners to collaborate with different health organizations and agencies from various sectors. Such multi-sector collaboration allows for a complete approach to program planning and a unified health system that is more responsive to individuals' and communities' needs. In addition, programs that include input from several sectors benefit from diverse perspectives and creative approaches, providing for more successful health prevention and promotion efforts.

Prevention Workgroup and Mission

The Prevention Workgroup was charged with integrating health prevention and promotion activities at different levels within the public health system to secure individual health as well as the general health of Louisianians. Workgroup members hail from several statewide organizations and partner agencies including the Louisiana State Legislature, Louisiana State University Medical Center (LSUMC), League of Women Voters, Ochsner Health Plan, Daughters of Charity Health System, Franciscan Missionaries of Our Lady Health System (FMOLHS), Louisiana Healthcare Alliance, New Orleans Department of Health, Tulane University School of Public Health and Tropical Medicine, and the Louisiana Office of Public Health (OPH).

When first presented their assignment, the workgroup decided to narrow their assessment activities and concentrate on the most critical health issues at hand rather than attempting to address all prevention perspectives. As a result, the workgroup identified three priority areas to address prevention issues and recommend appropriate action for improving prevention and health promotion activities. These issues are actual causes of death, clinical preventive services, and health disparities. The Prevention Workgroup used this focus to develop a complete approach to prevention efforts that will, ultimately, make a significant impact on adverse health outcomes and improve Louisianians' well-being.

Healthy People Initiatives

The Healthy People (HP) Initiative is a national program managed by the U.S. Department of Health and Human Services (DHHS) that uses health promotion and disease prevention objectives to monitor and improve the health of Americans. The HP initiative began in 1979, with the publication of *Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention.* This document outlined health goals for all age groups to be achieved by 1990. By then, public health agencies across the country had made improved health outcomes a reality for several populations when they met HP goals for all age groups, except adolescents and older adults.

Healthy People 2000 built upon lessons learned from previous HP efforts but it employed a broader perspective for examining health promotion and disease prevention. Unlike initial HP efforts, HP 2000 included collaboration from many individuals and organizations that outlined program goals and objectives. These entities included government agencies, voluntary and professional organizations, businesses, and individuals from local communities. The three key HP 2000 goals were to: 1) increase the span of healthy life for Americans; 2) reduce health disparities among Americans; and 3) achieve access to preventive services for all Americans. Healthy People 2000 goals were more extensive than initial HP initiatives and included more than 300 national objectives in 22 priority areas. States, communities, and the private sector currently use Healthy People 2000 objectives to design and support their own prevention work.

Likewise, HP 2010 outlines even more ambitious objectives than the original initiatives. This prevention agenda relies heavily upon input from users of HP 2000 goals as well as information from nationwide meetings that solicited feedback about the program. Goals and objectives outlined for HP 2010 respond to changing factors that impact individual and public health including changes in population demographics, disease spread, and environmental issues. In addition, these projections incorporate advances made in information technology and preventive therapies and encourage their application in future public health and medical practice (DHHS 1998) (See Glossary).

Assessment Methodology

The workgroup used a combination of activities to complete their assessment of Louisiana's health prevention and promotion programs, including data analysis and documenting "best practices" (See Prevention Appendix). Workgroup members continue to evaluate state prevention activities and will use assessment results in conjunction with new information to develop appropriate activities for Turning Point's (TP) implementation phase.

Workgroup members completed data analysis on information obtained from the Behavioral Risk Factor Surveillance System for 1992 to 1997 (OPH, BRFSS 1999) and Youth Risk Behavior Surveys from 1993 and 1997 (DOE 1997). In addition, the workgroup compared actual causes of death and clinical preventive services for Louisiana to national rates. State rates were then compared among sub-populations to determine the extent to which disparities exist among race, gender, and age groups. Finally, the workgroup compared Louisiana's overall and ethnic sub-population rates to HP 2000 objectives since HP 2010 objectives were still under review during the workgroup's assessment. However, when determining new goals and objectives for Louisiana, workgroup members used HP 2010 rates as standards by which to measure progress.

In addition to data analysis, the workgroup compiled a menu of best (evidenced-based) and promising (theory-based) practices that address actual causes of death and effective delivery of clinical preventive services. Workgroup members compiled a list of best practices after reviewing national programs and used this reference tool when evaluating Louisiana's programs. Examples of such best practices include those from the California Center for Health Improvement (1999) and the DHHS 1994 *Guidelines for School Health Programs.* Workgroup members then evaluated the extent to which these best practices employed a holistic approach when addressing health problems. During implementation, the menu of best practices will be expanded. The workgroup will create opportunities for programs across the state to share their own best practices through the convening of forums on actual causes of death (See Implementation Chapter).

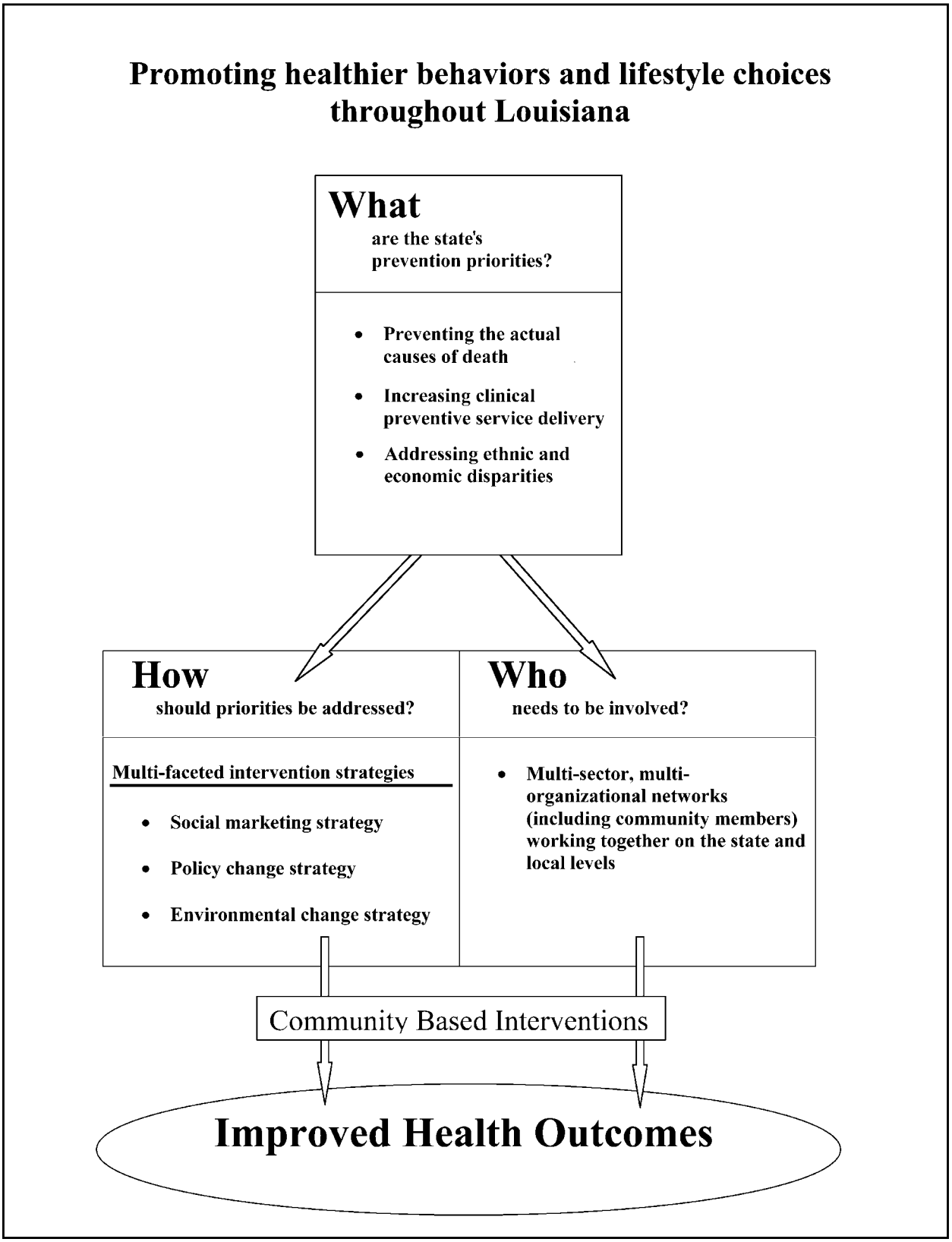
Prevention Priority Areas

The Prevention Workgroup developed the following framework to focus assessment activities and shape data analysis. This framework consists of three components: actual causes of death, clinical preventive services, and health disparities. The first component, actual causes of death, is based on McGinnis and Foege's 1993 article, *Actual Causes of Death in the United States*. The second element is derived from a set of evidence-based recommendations for clinical preventive services as set forth by the USPSTF. Finally, the third framework component, health disparities, is included to address health discrepancies that exist between Louisiana's ethnic and economic subgroups.

I. Actual Causes of Death

McGinnis and Foege conducted a meta-analysis of health articles, government reports, surveillance data, and vital statistics data that included a quantitative assessment of major, non-genetic, external factors that contribute to mortality in the U.S. Results revealed that approximately half of all deaths in any given year are attributed to identified lifestyle, environmental, and behavioral factors. In their article, McGinnis and Foege went beyond describing primary pathophysiological conditions identified at the time of death and examined root causes of death. Such causes of morbidity and mortality are those that are considered "upstream" causes of illness and death; that is, they result from the interplay of internal and external factors such as individual knowledge, social environment, and physical surroundings. In addition, McGinnis and Foege recognized that behavioral and lifestyle changes are not based on individuals' level of knowledge alone, but rather, are the result of one's social and physical environment. The impact of this research was to set public health program priorities and draw attention to overlooked factors that affect health.

McGinnis and Foege identified ten leading causes of death in their article: tobacco, physical activity patterns/diet, alcohol, microbial agents, toxic agents, firearms, sexual behavior, motor vehicles, illicit drug use, and miscellaneous factors.


Promoting healthier behaviors and lifestyle choices throughout Louisiana
What
are the state's prevention priorities?
• Preventing the actual causes of death
• Increasing clinical preventive service delivery
• Addressing ethnic and economic disparities
How
should priorities be addressed?
Multi-faceted intervention strategies
• Social marketing strategy
• Policy change strategy
• Environmental change strategy
Who
needs to be involved?
• Multi-sector, multi-organizational networks (including community members) working together on the state and local levels
Community Based Interventions
Improved Health Outcomes

However, the Prevention Workgroup decided to focus on five of the causes during their 1999 platform: tobacco, physical inactivity/poor dietary patterns, microbes, injuries due to firearms and motor vehicles[1] and toxins. The decision to include these factors was based on the workgroup's ability to examine their current role in state prevention efforts, the momentum of existing programs that address these factors, and Louisianians' receptivity to such programs. In addition, the workgroup was able to determine the level of support for existing programs provided by federal, state, and local governments. In the year 2000, the workgroup will expand its scope of work to include the remaining causes of death (alcohol, sexual behavior, and illicit drug use).

II. Clinical Preventive Services

The second component of the Prevention Framework addresses clinical preventive services. Guidelines set forth by the USPSTF provide the foundation for this component since they represent preventive services that have demonstrated a positive impact on health. As a result, they should be required at the minimum level of preventive services provided to the entire population. All are evidence-based recommendations and cover services for all age groups. Workgroup members reasoned that while other clinical preventive services may improve health outcomes, at minimum, all Louisianians should receive nine services for which improved health outcomes have been demonstrated. These services include screening for blood pressure, cholesterol, and mammography, providing pap smears, testing for stool occult blood, vaccinating adults against pneumococcus, tetanus, and influenza, and completing age-appropriate immunization for children.

III. Eliminating Health Disparities among Sub-Populations

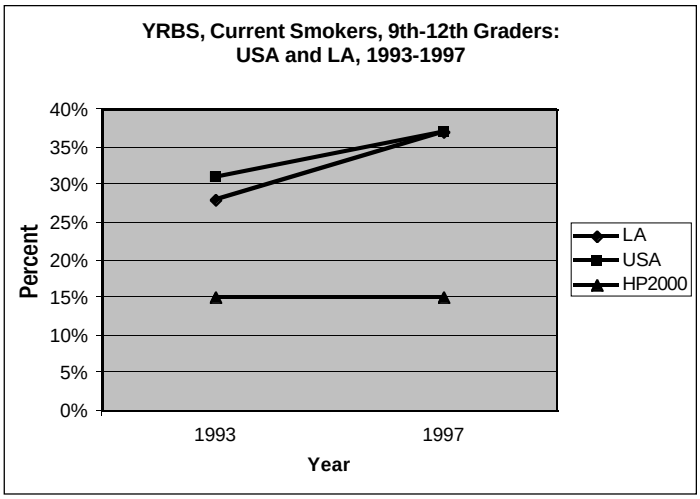
The Prevention Workgroup decided that bringing health disparities to the forefront of state public health discussions should receive priority during their evaluation and future implementation activities. Thus, the final assessment activity was to determine the extent to which discrepancies exist among Louisiana's sub-populations when examining leading causes of illness and clinical preventive services provided individuals. In order to improve state health indicators, it is imperative that health disparities be monitored and eliminated and actual causes of morbidity and mortality addressed. As a result of this effort, opportunities for prevention activities and culturally appropriate programs may be developed that target and improve the health of Louisiana's disparate sub-populations.

Louisiana's Current Health Status

I. Actual Causes of Death[2]

Tobacco

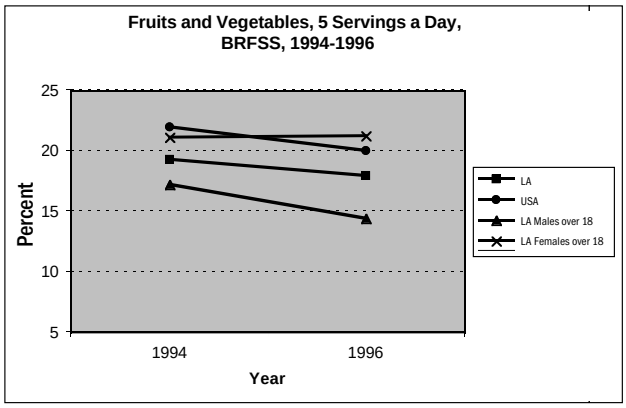
Tobacco is the number one killer in the U.S. (McGinnis and Foege 1993). In 1997, Reliastar State Health Rankings determined that Louisiana had the tenth highest rate of smoking in the nation. Likewise, Louisiana's current smoking rate exceeds the HP 2000 goal by 66% and is approximately 10% higher than the national average. In addition, between 1992 and 1997, Louisianian males smoked more than females, and the 25 to 44 year-old age group demonstrated the highest smoking rates in the state (OPH, BRFSS 1999). Finally, the graph demonstrates a startling trend for the youth of Louisiana.



1. Injuries due to firearms and motor vehicles are collapsed into one category for the purposes of this chapter.
2. The Prevention Workgroup has not yet collected data on toxins but will include levels of air pollution, toxic output from Superfund sites, pesticide exposure, the presence of mercury in surface waters and fish, and rates of childhood and adult lead poisoning in future assessment activities.

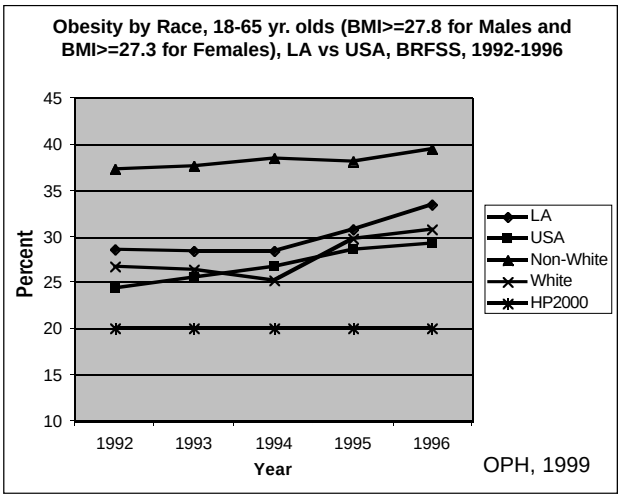
Physical Activity and Dietary Patterns

In their study, McGinnis and Foege found it impossible to separate physical activity from dietary patterns. Consequently, indicators used to examine this combined problem are physical inactivity, five-a-day fruit and vegetable consumption, and measures of obesity. These researchers determined that such a combination of physical inactivity and dietary patterns constitutes the second most common actual cause of death in the U.S. and accounts for 14% of all deaths (McGinnis and Foege 1993).



Louisiana is ranked higher than the national average for no leisure time physical activity and this trend appears to be increasing within all age groups. In addition, Louisiana is approximately two times below the HP 2000 goal for leisure time physical activity and younger cohorts are even less physically active than older age groups (OPH, BRFSS 1999).

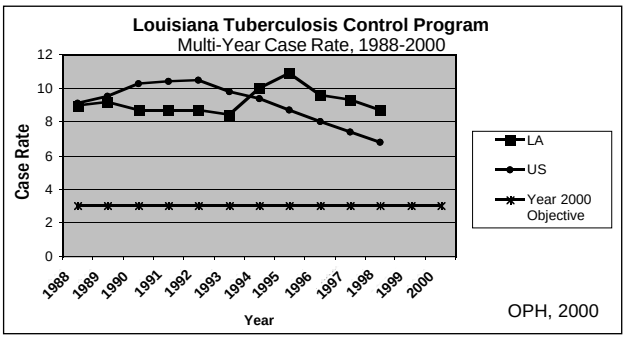
In 1996, consumption rates for five servings of fruits and vegetables each day were lower in Louisiana than in the rest of the nation and rates continue to decrease. In addition, men eat fewer servings of fruits and vegetables than do women. These trends are evident in the graph. In 1997, 14.4% of Louisianian males reported consuming at least five servings of fruits and vegetables each day while 21.2% of females reported the same (OPH, BRFSS 1999).



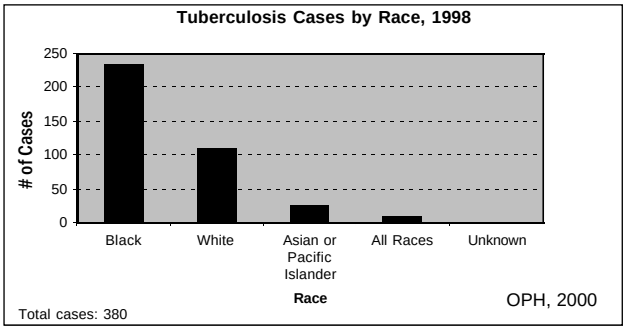
Most available data for the combined physical inactivity/dietary patterns indicator concern obesity. In terms of obesity rates, Louisiana is above the national average (33.4% versus 20.0%) and 50% above HP 2000 objectives (OPH, BRFSS 1999). In addition, Louisianians are becoming more obese over time with non-whites more likely to display signs of obesity than whites and females more likely than males. Rates of obesity increase with age until they level off in the 45 to 64 year-old cohort due to higher rates of death among obese individuals at younger ages. A representation of obesity and race show not only wide disparities, but also increasing rates since 1992.

Microbial Agents

McGinnis and Foege (1993) determined that microbes account for four percent of all deaths in the U.S., and categories of microbes that are of major concern nationwide include emerging infections, bioterrorism, and pandemic influenza. Most of Louisiana's antibiotic resistance patterns illustrate the presence of emerging infectious diseases at rates similar to national averages. However, tuberculosis, an airborne infection, occurs in Louisiana at somewhat higher rates than the rest of the nation with 9.3 cases per 100,000. This can be seen in the graph below. It should also be noted that African-Americans suffer disproportionately from this potentially debilitating disease. Rates for foodborne diseases are slightly lower than national rates but vary widely within the state, perhaps as a result of under-reporting. In 1997, Louisiana had 14.3 cases of salmonella per 100,000 and 4.2 cases of shigella per 100,000 (DHH 1997). Finally, waterborne diseases remain

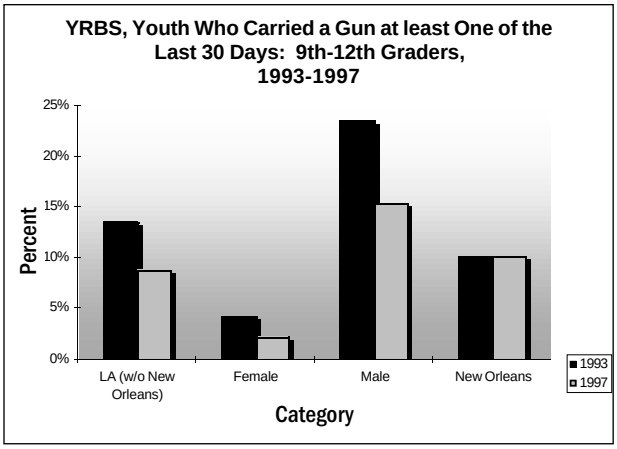


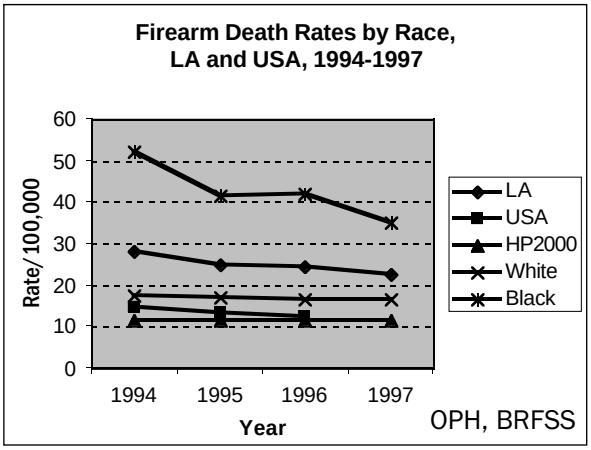
a threat in Louisiana. Between 1994 and 1997, three outbreaks of Norwalk virus infection (a gastrointestinal ailment) were recorded and associated with eating Louisiana oysters (DHH 1997).



Firearms

Firearms are responsible for two percent of all deaths in the U.S. (McGinnis and Foege 1993). In 1997, Reliastar ranked Louisiana as second worst in the country for firearm deaths and current firearm-related mortality rates are twice the HP 2000 goal of 11.5%. Likewise, in 1997, Louisiana ranked far above the national average for the percentage of ninth to twelfth graders who stated that they had carried a gun one or more times within the last month. Nationwide, 5.9% of all ninth to twelfth graders reported carrying a gun while 8.7% of Louisiana's ninth to twelfth graders reported the same. In addition, young males in Louisiana report higher rates than females. In 1997, 15.3% of male students reported carrying a gun while only 2.2% of female students reported the same (CDC 1998). Finally, mortality rates due to firearms were highest for African-Americans in Louisiana with 35 cases per 100,000 while whites demonstrated a rate of 16.8 per 100,000. Likewise, rates are four to six times higher for males than females (OPH 1997).

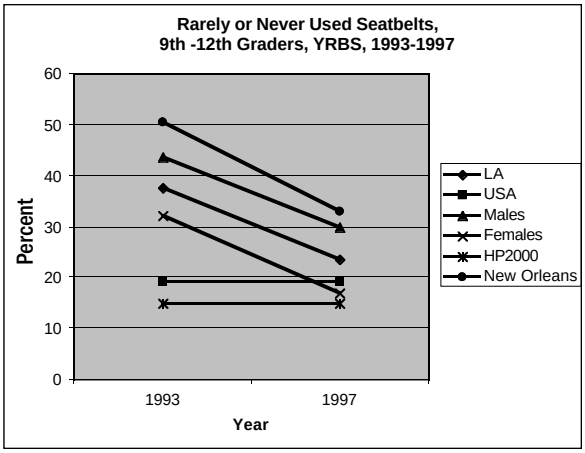




Motor Vehicles

Motor vehicles account for one percent of deaths in the nation (McGinnis and Foege 1993). In 1997, Reliastar ranked Louisiana within the top 12 states in the U.S. for injuries due to motor vehicles. Likewise, mortality rates due to motor vehicles were approximately 25% above the national average and they exceeded HP 2000 objectives by 66% (OPH 1997).

Adults in Louisiana report failure to consistently wear seatbelts at rates similar to the rest of the nation, but these rates are declining, most likely due to changes in state law and fines for failure to use seatbelts. Between 1992 and 1997, non-whites and males reported that they fail to consistently wear seatbelts more often than whites and females (OPH, BRFSS 1999). Failure to consistently use seatbelts was high among Louisianian youth in 1997 with 23.5% of ninth to twelfth grade students reporting that they rarely or never wear seatbelts (DOE 1997).



Rates for helmet utilization are lower in Louisiana than the national average, in part due to a lack of stringent laws requiring helmets. These rates are particularly low for youth. Twenty-five percent more of Louisiana's high school students report that they rarely or never use motorcycle helmets than other teens in the U.S. Males more frequently report such behavior than females and rates for failure to use helmets are more than twice the HP 2000 objective (CDC 1998).

II. Clinical Preventive Services

Several workgroup assessment findings are outlined below that fall within the second Prevention Framework component, clinical preventive services. Information is presented for blood pressure screening, cholesterol screening, mammography, pap smears, pneumococcal vaccination, and childhood immunizations. However, no data are yet available for stool occult blood testing or tetanus vaccination because the Prevention Workgroup is in the process of acquiring this information. Please refer to the Prevention Appendix for illustrative graphs.

Blood Pressure Screening

Blood pressure screening is an important preventive measure for detecting chronic illness such as hypertension or risks for heart failure. Between 1992 and 1997, approximately 95% of Louisiana's adults reported that they had received blood pressure screening within the last two years (OPH, BRFSS 1999).

Cholesterol Screening

The USPSTF (1996) recommends cholesterol screening every five years for persons over age 35 in order to monitor dietary patterns and reduce the risk of heart failure. Between 1992 and 1997, approximately 65% of all adults in Louisiana (18 years and older) reported having had their cholesterol checked within the last five years. In addition, approximately 70% of 35 to 64 year olds, the most important age group for this test, reported having been screened within the last five years. Such rates come close to the HP 2000 goal of 75% (OPH, BRFSS 1999).

Mammography Screening and Breast Exams

Routine screening for breast cancer is recommended every one to two years for women aged 50 to 69 years using a mammogram alone or a mammogram and annual clinical breast examination (USPSTF 1996). In 1996, screening rates for women in Louisiana fell well below the national average (54% versus 64%) and remained short of the HP 2000 goal of 60% (OPH, BRFSS 1999).

Pap Smears

Pap smears are recommended every one to three years for all sexually active females, all women over 18 years old, and women who have no history of having had a hysterectomy (USPSTF 1996). Between 1992 and 1997, 85 to 90% of women in Louisiana (over 18 years old) reported having had a pap smear within the last three years. These rates are comparable with the national average and they meet the HP 2000 goal of 85% (OPH, BRFSS 1999).

Pneumococcal Vaccination

Pneumococcal vaccinations are recommended for all individuals over age 65, persons with chronic diseases, or individuals with compromised immune systems (USPSTF 1996). Between 1992 and 1997, Louisiana is ranked far below the HP 2000 goal (60%) with only 25.0% of these sub-populations having ever received an inoculation. In addition, vaccination rates are lower in non-white populations than whites. In 1996, 20.2% of non-white seniors (non-institutionalized) reported ever having received a vaccination while 27.3% of white seniors stated that they had been inoculated. However, one should note that the gap in vaccination rates between these populations is shrinking (OPH, BRFSS 1999). Because the cost for procuring this vaccination is covered by Medicare, low inoculation rates appear to be an issue of delivery rather than cost or insurance coverage.

Influenza Vaccination

Yearly influenza vaccinations are recommended for several sub-populations including everyone over age 65, persons with chronic conditions, individuals with compromised immune systems, and health providers for high-risk populations (USPSTF 1996). Between 1992 and 1997, Louisiana demonstrated an influenza vaccination rate of approximately 50% for these sub-populations, slightly below the national average and well below the HP 2000 goal of 60%. In addition, vaccination rates are lower in non-white populations than whites. In 1996, 37.1% of non-white seniors (non-institutionalized) reported having received a vaccination within the last year, while 55.9% of white seniors reported the same (OPH, BRFSS 1999).

Childhood Immunization

Vaccination rates for children (a complete series by age two) continue to increase in Louisiana. In 1996, approximately 77% of all children in Louisiana had received a complete series of vaccinations by age two (CDC 1997).[3] Such a rate approaches the HP 2000 goal of 90% and is comparable with national averages (Shots for Tots 1997, CDC 1997).

Major Findings

The Prevention Workgroup derived four major conclusions from their assessment activities.

I. **Louisiana must address actual causes of death that are behavioral or environmental in nature. In some cases, trends must be reversed since Louisiana exceeds national averages and remains short of HP 2000 objectives.**

II. **Louisiana is performing fairly well in delivering clinical preventive services to individuals, but is still short of HP 2000 objectives.**

III. **African-Americans demonstrate disproportionately higher levels of behavioral risk factors and are less likely to receive evidence-based clinical preventive services than whites.**

IV. **State prevention efforts are not coordinated across sectors or agencies resulting in replicated efforts and poor use of meager resources.**

Recommendations and Strategies

The Prevention Workgroup found that most statewide prevention efforts are fragmented and uncoordinated. As a result, solutions do not entail increasing the number of agencies that provide prevention programs; rather, the appropriate focus is to mobilize existing prevention efforts to work together more efficiently and provide more effective programs. Such an endeavor requires that health agencies and organizations from other sectors enter into collaborative efforts to develop coordinated health prevention and promotion campaigns.

The Coalition for a Tobacco Free Louisiana serves as a model for coordinated prevention efforts and highlights effective collaboration between several statewide health agencies and sectors. This program is the most comprehensive state tobacco prevention effort to date, with public and private organizations working together to determine how tobacco settlement money will be distributed and utilized. The Coalition will also develop appropriate prevention programs to identify and address Louisianians' use of tobacco products. Not only does this program represent a comprehensive and coordinated model for delivering public health services, but it also shifts the focus away from personal responsibility for tobacco use and utilizes environmental and social ecology approaches. The Coalition consists of over 450 partners from diverse organizations such as the Department of Education (DOE), OPH, Metropolitan Hospital Council, American Lung Association, and Area Health Education Centers (AHEC).

3. This national survey provides data on children aged 19-35 months.

Several resources and activities are required to create additional collaborative efforts and effective prevention campaigns. The Prevention Workgroup developed the following recommendations and strategies to embark upon this endeavor.

I. Current prevention and health promotion efforts should be coordinated across agencies.

Current state prevention efforts are often so fragmented and uncoordinated that it is difficult to ascertain community capacity for additional prevention activities. Local-level program planners must recognize resources or programs that exist in their community since coordination among health agencies and across sectors will reduce replicated efforts and conserve valuable human and monetary resources. In addition, coordination must occur at the state level among statewide agencies and between state and local agencies.

This coordination process entails several steps. First, local-level planners, with input from community members, must identify existing activities and resources that can support and sustain new prevention efforts. Planners must identify resources needed to develop a coordinated social ecology approach for addressing the health concern. Once this assessment is complete and data are analyzed, program planners must then identify gaps in the current system or duplicate efforts and determine the most effective method for coordinating agencies and maximizing efforts. Finally, assessment activities must be thorough and planners must identify all organizations that impact the community health concern including outreach agencies, hospital programs, and worksite health promotion programs.

II. Prevention and health promotion efforts should be multifaceted, addressing policy, environmental, attitudinal, and behavioral factors that impact health.

The Prevention Workgroup determined that effective prevention activities must be multifaceted and address the many factors that impact health status. In 1974, the Lalonde Report established today's recognition of the role of environmental, biological, cultural, and social factors in individuals' overall health. This report, commissioned by Health Canada, was intended to set priorities for improving the health of all Canadians. It described relationships between access to health care services, human biology, environment, and individual behaviors and presented estimates for their relative contributions to improving health outcomes if progress was made in each of these fields. One of the Lalonde Report's most important conclusions was that individuals' health status would significantly improve by increasing their understanding of human biology, improving the environment, and modifying personal risk behavior in lieu of improving the medical care system's quality and efficiency.

The workgroup determined that appropriate prevention strategies must include policy changes, environmental changes, and social marketing efforts.

- Policy change strategies

  Policy strategies target laws, regulations, operational rules, and organizational directives and can aim to change work, academic, or social behavior. State or local strategies may promote new laws or regulations, or urge stronger enforcement of those already on the books. For example, an anti-smoking campaign might support legislation to prohibit smoking in buildings where it is currently permitted, or it may highlight existing laws that are only haphazardly enforced (See Policy Chapter).

- Environmental change strategies

  Environmental change strategies include factors that affect individuals' physical and social environments to impact their health positively. The Prevention Workgroup recognizes that physical, social, and cultural environments play a major role in individuals' health and present opportunities for prevention efforts. For example, creating bicycle lanes along streets encourages more individuals to ride their bicycles due to the avail-

ability of "safe zones." In addition, clearly defined bicycle lanes will help reduce traffic accidents between motorists and bicyclists by indicating appropriate areas for the operation of each.

- Social marketing strategies

  Social marketing is an important tool for targeting health behavior and changing social norms. Such programs go beyond increasing health knowledge and are directed at changing individual health behavior and attitudes. To effectively persuade individuals to adopt healthier behaviors, campaigns are often needed that target individual and organizational levels since healthier lifestyle changes are not readily adopted based on the appropriateness of change, but may instead be heavily influenced by perceived group norms.

III. Prevention priorities should be established according to perceived need within communities and supported by sound data.

When program planners design community health interventions without obtaining community perspectives, efforts are vulnerable to failure due to a lack of community support. Often, large entities at the state or federal level believe they know the most appropriate programs for communities. However, no matter their level of funding or planning, they are doomed to fail due to a lack of community support, an asset critical to the success of any effort. To resolve this issue, funding agencies must ask communities to describe health issues they consider to be of utmost priority. Sometimes these community priorities may coincide with agencies' preconceived programs while others may not. However, it is critical to engage communities in all levels of priority setting and adapt efforts accordingly so programs will benefit from broader support. Once communities have set their own priorities, they are more likely to collaborate with agencies to develop prevention programs and contribute to their success.

Likewise, communities must contribute to prevention program planning and implementation. Not only are they valuable resources for determining local health priorities, but they can also identify health disparities among sub-populations in their area. Community members experience firsthand problems caused by unequal access to health care services. In order to ensure that program planners address disparity issues, it is essential that local individuals and organizations have an opportunity to shape prevention efforts and appropriate program audiences in their communities.

Program priorities must also be supported by data analysis, the results of which can indicate health issues specific to communities. This may be primary data gathered by local program planners or secondary data from other sources, such as vital statistics information gathered by OPH that are relevant to implicated communities. In order to determine appropriate health concerns, there should be a balance between community perceptions and data results. Reliance upon one source exclusive of the other paints an inaccurate picture of community health needs and robs future programs of valuable community buy-in.

IV. Statewide prevention efforts should target actual causes of death (rather than disease-specific causes of morbidity and mortality) and prioritize eliminating health disparities among sub-populations.

The Lalonde Report and McGinnis and Foege's article both point to the importance of examining lifestyle and behavioral risk factors that lead to disease-specific morbidity and mortality. In order to impact Louisianians' health status, prevention efforts must promote changing social norms that encourage negative health behaviors and unhealthy lifestyles. For example, rather than concentrate statewide prevention efforts on reducing death due to heart disease, program developers should target obesity and poor dietary patterns, the root causes of several diseases including heart disease and diabetes.

In addition, this recommendation argues for the elimination of health disparities among Louisiana's sub-populations. Health service utilization rates differ according to ethnicity, levels of poverty, and geographic region, requiring program planners to identify patterns and specific causes for under-utilization of services during statewide prevention efforts. Since the existence of health disparities cannot be addressed by examining one aspect of the problem alone, such as

lack of access to health care, it is crucial to understand the larger environmental and policy factors that enable and sustain health disparities. Results of the Lalonde Report and McGinnis and Foege's work underscore the value of examining such systemic factors and the impact they have on individual health.

The Prevention Workgroup developed several statewide goals and objectives for the actual causes of death to be addressed during their first implementation phase. These goals and objectives were developed after analyzing health data and identifying the length to which statewide efforts will have to go to meet HP 2010 objectives. Although the following goals are aimed at improving health status throughout the state, local communities or sub-populations may need to modify them in order to reflect their unique health needs and realities.

- Tobacco

  Goals

  a. Reduce the initiation of tobacco use by children and young adults
  b. Promote cessation of smoking

  Objectives

  a. Reduce the current smoking rate among ninth to twelfth graders to 15% by 2002
  b. Reduce the current smoking rate among 18 to 24 year olds to 20% by 2002

- Physical Activity and Dietary Patterns

  Goals

  a. Increase the percentage of Louisianians who meet the Surgeon General's recommendation for moderate physical activity
  b. Increase the percentage of Louisianians who eat at least five servings of fruits and vegetables daily
  c. Reduce the percentage of Louisianians who are obese

  Objectives

  a. Reduce the percentage of Louisianians who report no leisure time physical activity from 33 to 15% by 2005
  b. Increase the percentage of Louisianians who eat two fruits and three vegetables per day from 18 to 30% by 2005
  c. Reduce the percentage of Louisianians who are obese from 33 to 20% by 2005

- Microbes

  Goals

  a. Reduce antibiotic resistance among all Louisianians
  b. Reduce the number of Louisianians who experience infectious diseases

  Objectives

  a. Decrease inappropriate prescription and over-prescription of antibiotics by physicians by 25% by 2005
  b. Decrease the incidence of new Hepatitis B cases by 50% by 2005
  c. Increase the proportion of Louisiana residents 65 and older who receive influenza vaccinations annually to more than 90% by 2002
  d. Increase the proportion of Louisiana residents 65 years and older who have received pneumococcal vaccinations to more than 90% by 2002

- Injuries

  Goals

  a. Reduce the number of deaths in Louisiana due to firearms
  b. Reduce the number of deaths in Louisiana from motor vehicles

  Objectives

  a. Reduce the number of handgun injuries among adolescents and young adults by 40% by 2005
  b. Increase seatbelt use to 90% of all motor vehicle occupants by 2005

V. Statewide efforts should promote the delivery of evidence-based clinical preventive services and programs that emphasize eliminating health disparities among sub-populations. Individual communities will need to modify these activities to meet their health needs and realities.

In addition to promoting prevention efforts that address actual causes of death, prevention efforts that ensure all Louisianians access to evidence-based clinical preventive services are needed. Programs should adopt services recommended by the USPSTF that have a positive impact on health status.

The Prevention Workgroup developed several goals and objectives that address needed preventive services for Louisianians. Although objectives are aimed at improving the health status for the general population, they may require modification in order to reach specific sub-populations.

- Clinical Preventive Services

  Goal

  a. Assure delivery of clinical preventive services recommended by USPSTF guidelines to Louisianians

  Objectives

  a. Increase pediatric immunization rates (using guidelines from the American Academy of Pediatrics - AAP and Advisory Committee on Immunization Practices) to 90% of all children by 2005
  b. Increase adolescent immunization rates (using AAP & ACIP guidelines) to 50% by 2005
  c. Increase senior immunization rates (flu and pneumococcal) to 80% by 2005
  d. Increase the number of mammograms coupled with breast exams (every two years) performed on women 50 years and older to 90% by 2005
  e. Increase the proportion of women 18 years and older who receive pap smears (within the last three years) to 90% by 2005
  f. Increase the proportion of adults 50 years and older who are screened for colorectal cancer either by stool occult blood testing (within the last two years) or with sigmoidoscopy (within the last five years) to 85% by 2005
  g. Increase the number of dental care checks performed on children one to six years old by 50% by 2005
  h. Increase the number of health care training programs that teach clinical preventive care services to 100% of all programs by 2005
  i. Maintain the rate of blood pressure checks (at least every two years) for individuals aged 18 years and older at more than 95% by 2005
  j. Increase the use of Hormone Replacement Therapy by women aged 45 to 65 years to 50% by 2005
  k. Increase rates of screening for elevated cholesterol levels for individuals aged 35 to 65 years to 75% by 2005

Implementation Priorities

Workgroup implementation priorities include both local- and state-level activities. Both levels of effort are recognized as vital to the delivery of effective prevention and health promotion programs.

Statewide Learning Forums

At the state level, priority is given to promoting leading causes of death to statewide agencies and assuring clinical preventive services. Thus, the Prevention Workgroup will conduct Peer Forums that focus on actual causes of death as outlined by McGinnis and Foege and evidence-based clinical preventive services recommended by the USPSTF. These forums will result in a statewide learning community that shares best practices, conducts joint problem solving, and promotes collaboration as a means of planning and implementing prevention and health promotion activities. Forums will be designed by a team of TP Partners with one agency occupying the lead role in developing the content of each forum according to the issues addressed. Ultimately, the workgroup plans to share information taken from these forums and develop publications that will document a menu of best practices and strategies for multi-agency intervention.

Local Capacity Building Pilot Programs

In addition, workgroup members will work with communities to develop pilot programs at the local level to test the efficacy of their comprehensive methodology. These pilot programs will build upon existing community resources and collaborative efforts in the region, such as local TP Partnerships and Healthy Communities initiatives. Local program planners will help determine community health priorities based on community perceptions and available data. In addition, planners will conduct assets analysis to identify existing prevention efforts and resources that address particular health issues; such a process will avoid a duplication of efforts. Results from this initial analysis will guide program planners in developing a multi-layered intervention that includes factors that impact health such as policy, environmental, attitudinal, and behavioral factors. In addition, results will be used to develop training that promote policy development and data utilization. Pilot programs will also include skills training for program planners to provide them with the necessary skills to implement future community health programs. Turning Point will promote this comprehensive methodology throughout the state and document lessons learned in order to share program findings with larger statewide and national communities.

Conclusion

The goal of this chapter has been to determine appropriate methods for improving prevention efforts throughout the state. "Improving" prevention activities is a complex process since it entails increasing program effectiveness and efficiency. This must also ensure that new measures are responsive to individual health issues and accommodate the varied needs of local communities. Planners must engage in collaborative efforts and consider prevention in terms of system-wide challenges and local community needs. Effective collaboration includes cooperation between "non-obvious" entities that impact health since their perspectives allow for a broader view of prevention. Likewise, state- and local-level individuals must incorporate this new approach into prevention efforts because their collaboration is essential to the success of future programs. Finally, program planners must shift the design of prevention efforts away from disease-specific themes and create campaigns that target unhealthy behaviors and lifestyle choices that ultimately result in disease. It is the Prevention Workgroup's hope that the recommendations contained in this chapter provide for a more collaborative, responsive, and effective delivery of activities, as well as a new method for thinking about preventive services.

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Chapter 4

Access to Care in Louisiana

I. Introduction

II. Access Workgroup and Mission

III. Current Efforts in Louisiana to Improve Access to Care

A. Educational loan reimbursements
B. Louisiana Rural Health Access Program
C. Mobile health units
D. Telemedicine

IV. Assessment Methodology

A. The Access Data Matrix
B. The Environmental Scan
C. Assessments among communities, patients, and providers

V. Major Findings

A. Louisiana has one of the highest percentages of uninsured individuals in the country.
B. Insurance can be a financial burden for individuals who are self-employed, work part-time, or have very little income.
C. There has been a reduction in the amount of insurance coverage provided by employers.
D. Cost is a major obstacle to accessing health care for uninsured and insured individuals.
E. Several cultural, financial, and resource-related barriers are associated with an inability to access health care.
F. In many areas of Louisiana there are too few primary health care providers who serve the uninsured and Medicaid recipients.
G. Emergency rooms are overused as primary care sites.
H. Existing services for the uninsured and underinsured are fragmented and uncoordinated.

VI. Recommendations and Strategies

A. Develop collaborative community planning processes to improve access-to-care issues and address service needs through the creation of public and private alliances at the local level across the state.
B. Continue assessment activities to increase understanding of access-related issues and develop strategies to procure necessary resources and infrastructure to support data collection, analysis, and dissemination at the local level.
C. Promote communication among local access-to-care initiatives throughout the state to share experiences, tools, information, and support.
D. Promote public awareness about the access-to-care challenge in Louisiana and its implications for local communities.

VII. Policy Recommendations

A. Increase enrollment of eligible individuals in public insurance programs such as Medicaid and LaCHIP.
B. Develop mechanisms to assist individuals with the cost of purchasing health care coverage.
C. Increase the percentage of employers who provide adequate and affordable health care coverage to their employees and dependents.
D. Create mechanisms for employers and individual consumers to compare insurance plans based on their scope of services, cost, and provider choice.
E. Increase the number of primary care providers and facilities that serve the indigent uninsured, underinsured, and Medicaid populations.
F. Assure the appropriate geographical distribution and utilization of primary care facilities and providers.
G. Decrease non-emergency utilization of emergency rooms by increasing the availability of primary care services and educate consumers about appropriate service utilization.
H. Encourage the development of local provider networks to serve the uninsured in a comprehensive and coordinated manner.
I. Enhance community outreach and education about existing services for the uninsured including enrollment information for health coverage.
J. Develop health literacy campaigns to promote the appropriate use of services and compliance with prescribed treatment regimens.
K. Build capacity to identify, train, and support community members to play an active role in policy development and decision making about the design and delivery of health care services.
L. Develop a strategy and infrastructure for the ongoing monitoring of access to care.

VIII. Strategy Implementation Matrix

IX. Conclusion

X. Contact Information

XI. References

Chapter 4-Access to Care in Louisiana

The following chapter provides information on access to health care in Louisiana and identifies barriers facing individuals and communities when seeking health care services or adopting prevention efforts. Highlights from the Access Workgroup's statewide assessment are presented as well as recommendations and strategies to implement change and improve Louisianians' access to health care. The purpose of this chapter is to recommend change to the public health system, promote local community ownership of access issues and solutions, and propose strategies for improving access to care that will ultimately improve the health and well-being of Louisianians.

IN THIS CHAPTER

Introduction

"Access to care," for the purposes of this document, is defined as "the timely use of personal health services to achieve the best possible health outcomes including preventive care and care for ongoing health problems or emergencies (Millman 1993)." In a public health system's efforts to promote and maintain wellness, one of its key responsibilities is to assure that all individuals have access to basic preventive and primary care services. State and local Turning Point (TP) Partnerships identified the inability of individuals to access health services in a timely manner as one of the most critical challenges facing Louisiana's health system. Although many factors contribute to an inability to access care, the most significant barriers are cost and a lack of health insurance. Infrastructure factors that limit access include too few care providers, maldistribution of providers, lack of transportation, and too little information available to the public.

The state of access to care in Louisiana is profiled in the 1997 Health Resources and Services Administration (HRSA) report, U.S. Department of Health and Human Services (DHHS) draft objectives for Healthy People 2010 (HP 2010), U.S. Census Bureau estimates, and Medicaid records:

- Just over one third (33.4%) of the state's population is without access to a primary care provider compared to 16.3% of the general population (HRSA 1997).
- Approximately 19% of the state's population was without any form of public or private health insurance in 1998 while 16.3% of the general population was without health insurance that same year (U.S. Census Bureau 1999).
- Surveyed individuals were most likely to state that a lack of health care coverage and lack of a regular source of care are the two biggest obstacles to accessing care. As a result, most were unable to obtain health care services when needed (DHHS 1998).
- In 1997, 47.9% of Louisianians had private health insurance (Louisiana Medicaid Program 1998).
- In 1997, 17.3% of Louisianians were enrolled in Medicaid and most eligible individuals (96%) were enrolled in the program (Louisiana Medicaid Program 1998).
- In 1997, 26.2% of Louisianians who lived below the federal poverty level[1] were not eligible for Medicaid coverage. (Louisiana Medicaid Program 1998).

1. The 1997 federal poverty level for a family of four was $16,400 (U.S. Census Bureau 1997).

After reviewing these findings, the workgroup agreed that access to care is a multi-dimensional issue that can be broken down into three primary components :

- **Service Availability** – the physical existence of services, clinics, or human resources
- **Service Usability** – access to services regardless of insurance status, available methods of transportation, and convenient hours of operation
- **Service Acceptability** – culturally competent service delivery that does not discourage use, perceived quality of services, and services available in languages other than English

This chapter examines these access issues and presents recommendations to improve them. Several methods for involving communities in identifying problems and implementing solutions are also presented. A close examination of access-to-care issues and community-based solutions is essential to improving Louisianians' access to health care and, ultimately, providing communities with tools to improve their health and well-being.

Access Workgroup and Mission

The statewide TP Access-to-Care Workgroup (Access Workgroup) includes representation from public and private provider organizations, consumer advocacy groups, social service agencies, universities, state governmental health care agencies, and several other major statewide and regional organizations. These workgroup members have developed strategies and recommendations for improving access to care for all Louisianians, particularly the indigent uninsured and underinsured.[2]

Workgroup Mission Statement

To bring together representatives from an array of statewide agencies to develop policy recommendations (legislative and organizational) that improve access to care throughout the state and enhance the capacity of local communities to develop innovative strategies for eliminating access barriers.

Workgroup members recognized very early that "access to care" is a complicated measure extending beyond the health system infrastructure. Although access to health care is a very important component of maintaining good health, access to services alone does not **create** good health. Assuring access is a critical role of a well-functioning health system. However, if services are not provided in conjunction with efforts to improve communities' overall health and quality of life, available services will have limited impact. Therefore, the workgroup incorporated prevention into their definition of access and promoted access to care as part of an overall commitment to creating healthy communities throughout the state.

Once this broader notion of "access" was recognized, it became apparent that innovative strategies would be most successful if developed on a local level, ensuring that communities themselves define and address unique aspects of their access problems and are involved in actively implementing solutions. Workgroup members also felt that strategies to address this issue would be most effective if they built upon existing organizational and community assets and benefited from collaborative community partnerships. Recommendations were then developed to enhance the ability of local communities to bring public and private providers and community members together to create innovative solutions for improving access barriers.

2. The "underinsured" include individuals with insurance coverage but inadequate benefits to cover some preventive services and secondary and tertiary care.

Current Efforts in Louisiana to Improve Access to Care

In an effort to increase Louisianians' health service utilization, some model programs are attempting to reduce the number of areas around the state that experience provider shortages and render preventive and primary care services available to more communities. Outlined below are just a few examples of current local and statewide efforts to improve these access-to-care issues.

I. Educational Loan Reimbursements

Louisiana's State Loan Repayment Program is an excellent example of improving access-to-care issues by encouraging dentists and physicians to work in under-served areas. In exchange for a two- or three-year commitment, the state agrees to repay a portion of providers' educational loans. Providers who make a two-year commitment receive up to $13,333 a year in loan repayment and those who agree to work in under-served communities for three years receive up to $20,000 a year in loan repayment (mid-level medical professionals receive somewhat less for their commitments). Several other programs, including the National Health Service Corps (NHSC) Scholarship and Loan Repayment Program and the J-1 Visa Waiver program, also place physicians in under-served areas in exchange for loan repayment or residency status (Health Policy Tracking Service 1998).

II. Louisiana Rural Health Access Program

The Louisiana State University Medical School Center (LSUMC) has partnered with the Department of Health and Hospitals (DHH) to lead the Louisiana Rural Health Access Program (LRHAP). The Robert Wood Johnson (RWJ) Foundation has sponsored this initiative since 1998 and programs focus on the development of a rural health care network, community-based "chambers of health," and loans for health-related businesses (Southeast Louisiana AHEC, 1999). In addition, LRHAP Program implementers place a high priority on recruiting and training medical students, pre-medical students (in college), and high school students to provide health services in under-served communities. An effort is made to recruit trainees from diverse cultural backgrounds and individuals from rural and under-served areas who would like to serve their communities in the future (Health Policy Tracking Service 1998).

III. Mobile Health Units

Of major benefit to communities without ready access to health services are mobile health units (i.e. vans) that provide health care in their areas. Such mobile units may provide urban and rural areas with preventive services, primary care, and, health screenings and tests. Both private and public groups in Louisiana have supported mobile health units and provided health services for under-served communities.

IV. Telemedicine

The Louisiana State University Medical Center established a telemedicine program in 1992 to improve access to care in rural areas. This program provides rural communities with an opportunity to receive health information and conduct some physical examinations via "real-time" video. Another statewide program is the Community Hospital Telemedicine Consortium, a network of seven tertiary hospitals and approximately 90 to 100 rural hospitals. In 1997, the state legislature supported such efforts through approval of Medicaid reimbursement for telemedical services (Health Policy Tracking Service 1998).

Assessment Methodology

Most health care professionals in the state readily acknowledge the large proportion of individuals in Louisiana without access to care. However, the Access Workgroup had a unique opportunity to study this issue and examine barriers that impede individuals' use of preventive and primary care services. Group members were eager to develop innovative methods for assessing both the resources and gaps in the existing state health care infrastructure.

THE ACCESS DATA MATRIX

One of the first steps in the assessment process was to compile a matrix of health care infrastructure information and health resources in each region of the state as well as data on each region's disease rates, demographics, and population risk factors. Compiling this information into one database will allow the workgroup to study the interaction of existing resources, or lack there of, along with a sampling of disease patterns and compare their effect across each region of the state. The matrix will also serve as an invaluable tool for intervention planning at the local level by providing an accessible compilation of existing data that highlights health resources and gaps for each parish. Throughout the past year, the TP Partnership has provided matrix information to several organizations to assist them in health activity planning and implementation (See Appendices).

Data were collected using a variety of existing databases from public and private agencies. In addition, statewide organizations, primarily DHH – Office of Public Health (OPH), contributed data to complete the matrix. The Access Data Matrix includes nine broad categories of information:

- Demographics
- Population risk factors
- Insurance status for populations
- Number of health care providers in each area
- Number of provider practice settings in each region
- Available transportation to consumers (or potential health care consumers)
- Social services
- Several health indicators including rates of alcohol and drug abuse, immunization rates, and the proportion of women who receive adequate prenatal care

This data collection process revealed the complicated nature of access-to-care issues and provided the workgroup with an opportunity to understand potential limitations of existing secondary and tertiary data sets. Upon completion of the Access Data Matrix, significant gaps in health care data collection were highlighted:

- Workgroup members discovered that several types of data were unavailable because they are not currently collected or calculated on a regular basis. This problem was especially evident when the workgroup wished to examine the number of uninsured Louisianians at the parish level.

- Time and financial constraints restrict some statewide data collection efforts to five-year periods. This process makes it difficult to understand current health care realities because data are sometimes too old to be of use to decision makers.

- Some data are limited in their utility because they do not provide an accurate portrayal of access barriers. This was the most striking finding for workgroup members because it revealed the incomplete nature of several existing databases. For example, although workgroup members were able to obtain information on the number of physicians per parish, data did not reveal whether or not physicians accept new clients or have limited hours of operation.

As a result of the above findings, the Access Workgroup decided to place a priority on collecting primary data at the parish level. In addition, workgroup members recognized the need for data collection activities that reveal current information about communities' health care needs and the system's capacity to deliver them.

THE ENVIRONMENTAL SCAN

During the assessment process, several TP Partners expressed interest in collecting data for their own program needs. Rather than duplicate efforts and resources, members of the Access Workgroup collaborated with individuals from OPH to design a tool known as the Environmental Scan (See Appendices). This assessment of health care infrastructure is a survey of regional community capacity in Louisiana that inventories providers, hospitals, community agencies, and dentists in terms of availability, types of payment accepted, and primary care services provided. The Office of Public Health assumed the role of primary data collector by utilizing staff at parish health units to coordinate collection efforts among service providers and agencies at the community level. However, in the local TP communities, TP Partnerships took the lead in organizing data collection efforts.

The Environmental Scan has been one of the most successful outgrowths of TP. Until now, such detailed information assessed in the scan has not been readily available from any central source. Since its debut, individuals and organizations across the state have demonstrated a piqued interest in this data collection process due to an urgent need for information that enables health service planning. Such data prove critical as they allow state-level agencies and local communities to identify gaps in their health care system infrastructure and help public and private alliances to address unmet needs. Data also provide a much-needed inventory of resources within local communities by mapping provider sites and available services.

The Environmental Scan is also an applied example of TP's vision of collaboration and partnership across agencies and projects, between the public and private sides of health care, and between state- and local-level agencies. For example, at the local level, data collection requires the cooperation of both public and private providers; thus strengthening relationships between these sectors. In addition, the environmental scan process has demonstrated collaboration between state- and local-level efforts, with individuals collecting data at the local level and the state (represented by OPH and the TP Partnership) providing necessary resources and infrastructure to create a database for analysis. The state will provide reports to local communities in a meaningful and useful format (See Health Assessment Chapter).

ASSESSMENTS AMONG COMMUNITIES, PATIENTS, AND PROVIDERS

Assessing communities', patients', and providers' perspectives on access-to-care issues also required cooperation between local and state-level agencies. As with the Environmental Scan, individuals at the local level collected data while state groups provided necessary resources and infrastructure for data analysis and dissemination.

Throughout the past year, the Access Workgroup held meetings with representatives from the three local TP initiatives in northeast Louisiana, the southwest region, and New Orleans. These meetings permitted workgroup members to obtain community members' perspectives on access issues in their respective regions of the state. These discussions resulted in an informal but valuable assessment of perceptions of access-to-care issues at local levels.

Research with uninsured individuals and providers is a work in progress with surveys planned for patients and focus groups with providers. Results from patient surveys will be used to refute or challenge findings from other data sources about barriers to care and patients' perspectives on the health delivery system. Focus group discussions with providers should reveal their needs and concerns about working with special groups, particularly the uninsured. Workgroups will examine the practicality of a delivery network and explore additional methods to support providers' efforts to serve populations such as the indigent uninsured.

Major Findings

Although many of the Access Workgroup's assessment activities are ongoing, some major findings from their efforts to date must be highlighted. Much of the information presented below was obtained once the Access Data Matrix was complete, and results are presented with supporting literature on general access-to-care issues. The following major findings are the result of collaboration between workgroup members (who collected data), colleagues from statewide organizations (who served as peer reviewers for this document), and communities that contributed health care data.

I. Louisiana has one of the highest percentages of uninsured individuals in the country.

Although insurance coverage does not **guarantee** access to care, it remains a major determinant in the ability of individuals to obtain needed health services. Uninsured patients are less than half as likely as insured consumers to have a primary care provider, receive appropriate preventive care, or completed a medical visit within the last year. In addition, a lack of health care coverage has been demonstrated to increase the risk of premature death (HRSA 1997).

Likewise, even though Louisiana demonstrates similar rates of disease as other states, morbidity rates are much higher due to irregular access to preventive and primary care. For example, the incidence of cervical cancer in Louisiana is similar to most other states but mortality rates among Louisianian women are higher (Meriwether 2000). This finding is particularly disturbing given that cervical cancer is easily detected and treatable if women receive regular and timely examinations.

Several factors contribute to individuals and their dependents remaining uninsured, namely cost, personal choice, and a lack of knowledge about available options. In addition, many low-income individuals lack coverage even though they are eligible for public insurance programs such as Medicaid. Such findings underscore the need for increasing insurance coverage and enhancing individuals' and employers' ability to purchase private insurance plans at lower cost. This is especially true for employers with small businesses.

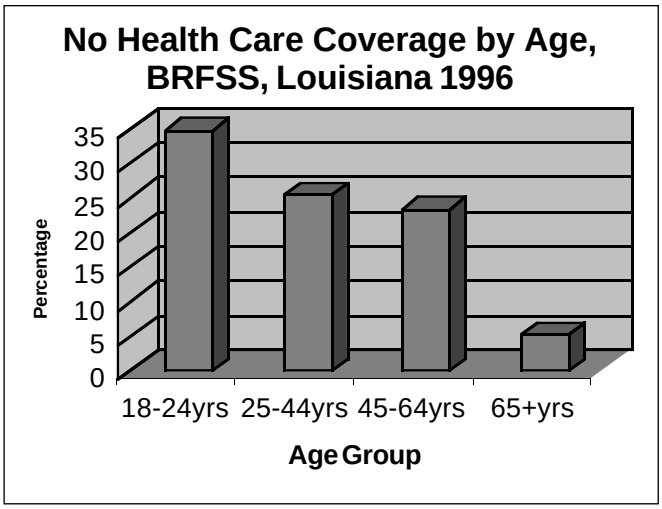
II. Insurance can be a financial burden for individuals who are self-employed, work part-time, or have very little income.

Individuals who earn the lowest wages or who work part-time are more likely than other employees to be uninsured. According to the U.S. Census Bureau, 47.5% of low-income, full-time employees did not receive health coverage of any kind in 1998 (U.S. Census Bureau 1999).

III. There has been a reduction in the amount of insurance coverage provided by employers.

Even workers who receive employer-sponsored health insurance are losing coverage. Employers who face rising costs are requiring higher premiums and reducing benefits, resulting in an increase among both the uninsured and underinsured (Brown 1999). Moreover, a reduction is visible in employer-sponsored retiree health insurance, leaving many elderly individuals without coverage when they least expect it (Duchon et al. 2000).

IV. Cost is a major obstacle to accessing health care for uninsured and insured individuals.



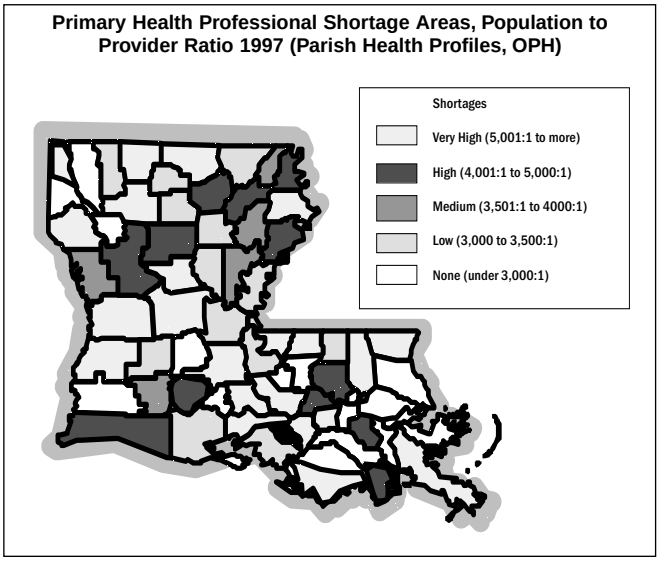
Cost is an especially heavy burden for individuals who have no health care coverage and whose income approaches poverty levels. Direct costs may serve as barriers to individuals who must pay premiums, co-payments, and deductibles even if an employer provides coverage. Other direct costs include testing, medications, and other forms of treatment. Too often, insurance coverage is presented in a vague format and consumers are confused about services included in their health plan such as lab work, medications, equipment, and supplies. In addition, consumers bear indirect costs such as time away from work, childcare, and transportation costs. (The graph depicts the disparities in age groups. It demonstrates the effects of Medicaid on an individual's ability to have health coverage).

V. Several cultural, financial, and resource-related barriers are associated with an inability to access health care.

Additional barriers to accessing care are factors that strain meager resources or address cultural issues. Such obstacles include not having a phone, moving frequently, or speaking a language other than English. In addition, having several children in one family, maintaining more than two jobs, and addressing competing medical needs (such as pregnancy and disability), can limit one's ability to seek preventive care in a timely manner. Likewise, vulnerable populations, such as children, the elderly, and the disabled must ask others to transport them to care services, making them dependent on others' schedules and capabilities. Because data concerning these obstacles are not readily available to state-level planners, communities must examine barriers to accessing care that may be unique to their location or population.

VI. In many areas of Louisiana there are too few primary health care providers who serve the uninsured and Medicaid recipients.

This problem is the result of several factors including too few providers, poor distribution of providers, and providers' unwillingness to treat Medicaid and uninsured patients. Providers also tend to cluster around urban centers where the majority of large tertiary care centers are located. As a result, some rural parishes may have as few as three or five primary care physicians (Board of Medical Examiners 1998). Likewise, 63 parishes in Louisiana are designated as "medically under-served" and, within these parishes, certain regions remain more under-served than others, particularly the delta region in northeast Louisiana (HRSA 1997).



Although many view the lack of adequate reimbursement for treating the uninsured or Medicaid clients as the primary reason physicians refuse to serve these populations, addi-

tional factors may hinder providers' ability and desire to treat these groups. For example, some physicians perceive the administrative responsibilities associated with being a Medicaid provider as more costly than actually treating patients free of charge (DeMichele 2000). Because uninsured patients rarely receive preventive services, they are typically sicker and in need of more extensive treatment. Many physicians become discouraged when they cannot effectively treat these patients because they are unable to refer them for testing or follow-up treatment, obtain needed prescriptions, or link clients with case management services.

VII. Emergency rooms are overused as primary care sites.

Several factors contribute to over-utilization or inappropriate use of emergency rooms, most notably a lack of primary care services. This problem is not only the result of a lack of providers or facilities in a given area, but also hours of operation and a willingness to serve uninsured and Medicaid patients. Often, emergency rooms are the only alternative for such clients since they are assured treatment in these facilities.

Another contributing factor to over-utilization or inappropriate use of emergency rooms is clients' lack of information about primary care services in their area and how to use them. Individuals without a regular source of care or access to services, such as nurse advice lines, resort to emergency room visits for treatment. Often, such visits constitute their first and only contact with the health system, regardless of whether or not their health needs require emergency treatment.

Such misuse of emergency rooms results in negative ramifications for both the patient and health system. Patients must commit more time and money to receive health services in emergency rooms, exceeding costs they would otherwise spend on primary care. Such visits may result in missed opportunities for receiving health education and preventive services. After an emergency room visit, clients often receive little or no follow-up care or the care they receive is disjointed. In addition, the high cost of providing care in emergency rooms forces facilities to shift their costs, resulting in higher insurance rates for consumers. Finally, over-utilization interferes with the timely and effective treatment of actual emergency cases and impedes the quality of care provided all clients.

VIII. Existing services for the uninsured and underinsured are fragmented and uncoordinated.

Unlike consumers with adequate insurance, uninsured and underinsured individuals are not part of a formalized system of care that includes all forms of treatment necessary for maintaining good health. Needed services include screenings, health education, referral systems for specialty care, home health services, and methods to monitor health status. Individuals without these resources tend to receive sporadic care and only when very sick. Likewise, patients may not receive follow-up treatments or drug regimens necessary for recovery, resulting in greater health costs. The health system also bears increased cost and providers may be unwilling to serve such clients when they foresee difficulty treating them effectively.

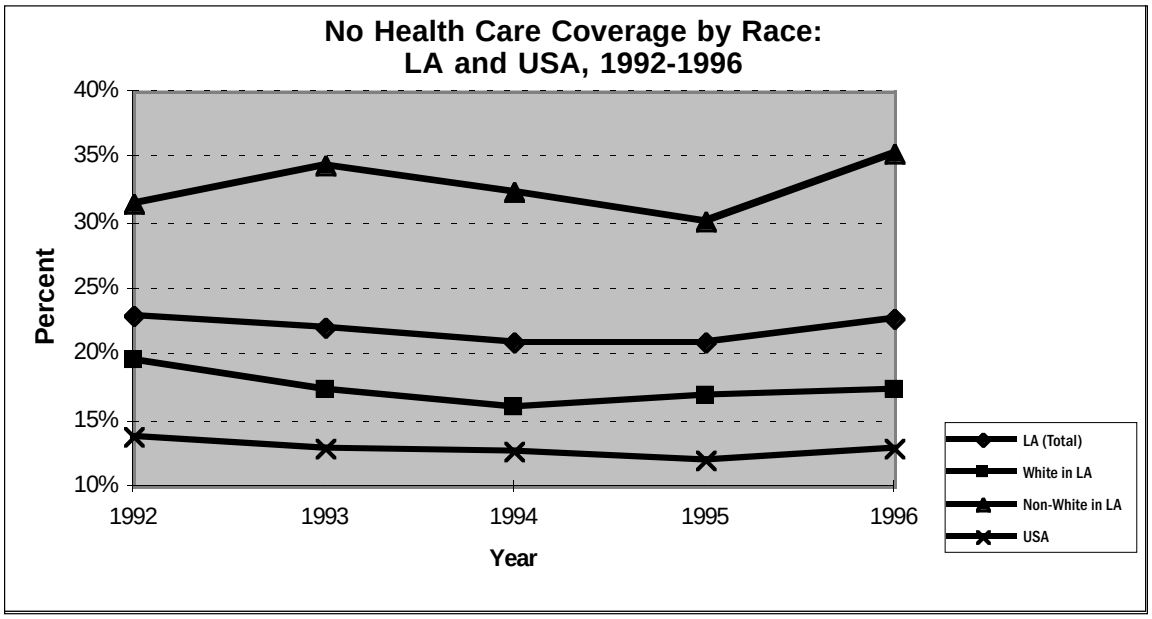
IX. Major disparities exist among economic and ethnic subgroups that hinder their ability to access needed care.

Several U.S. studies have demonstrated that significant disparities exist among economic and racial groups in their ability to access care. When compared to national averages, Louisiana demonstrates higher concentrations of ethnic minority populations, higher rates of poverty, and higher numbers of uninsured individuals (DHHS 2000). As a result, one can surmise that ethnic disparities in the ability to access to care are more pronounced than in most other states. For example, ethnic minorities are less likely than white populations to have health insurance, less likely to report a regular source of health care, and more likely to use hospital-based care (DHHS 2000).

Health disparities are most pronounced for Hispanic Americans (DHHS 2000) and this trend continues despite high rates of employment (Commonwealth Fund 2000). In 1996, reports indicated that 30% of Latinos were without a regular source of care while 20% of African-Americans and 16% of whites reported the same (Kaiser 1999).

Likewise, minority children receive less primary care than white children. Even when differences between coverage and income are controlled for, they are less likely to have a usual source of care, an available after-hours emergency source of care, or a physician they may see for needed care. Minority children are also more likely to travel long distances and experience long waits when seeking care (Kaiser 1999). In a 1999 study, African-Americans reported that they believe they are less likely than whites to receive the latest medications and treatments available and are more likely to be judged unfairly or treated with disrespect because of their race or ethnicity (Kaiser 1999).

Disparities in access to care also exist between different socioeconomic groups. In a survey by the Commonwealth Fund (2000) 32% of individuals with annual incomes below $35,000 (the bottom half of the income range) reported that they were uninsured while only 7% of those in the top half of the income range reported the same. Disparities in job-based insurance coverage are also associated with levels of income. Adults earning low wages are more likely to be uninsured than higher wage earners, even when working full time (Commonwealth 2000).



Recommendations and Strategies to Improve Access to Care

Community ownership of both the access problem and its solution is essential for changes to be successful. Collaboration is imperative at the local and statewide levels as well as at neighborhood and community levels where services are actually delivered.

Local efforts cannot sustain success without the support of statewide agencies and appropriate state policies. For example, in Louisiana, all public health, mental health, and social service agencies are part of larger statewide systems. All public hospitals belong to the State Charity Hospital System managed by the LSUMC - Health Care Services Division. In addition, many private hospitals are part of larger health organizations such as CHRISTUS, Franciscan Missionaries of Our Lady Health System (FMOLHS), and Daughters of Charity. Coordination between local provider sites and their central management offices are essential to assure the likelihood of success and improve access-to-care issues.

State-level players can support local communities' endeavors by implementing appropriate legislative and organizational policies and conducting research on access issues. State entities can provide meaningful information to communities, coordinate local activities throughout the state, develop channels of communication among local efforts, and provide technical support for developing local initiatives (See Policy Chapter).

Priority Recommendations

Enhance communities' capacity to design and implement innovative solutions to overcome barriers to health care access, fill resource gaps, and maximize the effective use and distribution of existing community resources to enhance delivery of care for the uninsured.

PRIORITIES

Implicit in all of the strategies listed below, is the need to document and address disparities that exist among economic and ethnic groups, making it more difficult for certain subpopulations to receive care when needed.

The following strategies are intended to enhance communities' capacity to solve access-related problems at the local level and these strategies serve as workgroup priorities for TP's implementation phase.

I. Develop collaborative community planning processes to improve access-to-care issues and address service needs through the creation of public and private alliances at the local level across the state.

Within the next four years, the Access Workgroup, along with partner organizations, will provide technical support to local communities in their efforts to:

- Convene stakeholders
- Create public/private alliances
- Assess strengths and gaps that exist in local health care infrastructure and resources
- Develop strategies that maximize the use and distribution of existing community resources
- Coordinate efforts across agencies and sectors
- Address disparities among subgroups

Some local initiatives supported by the Access Workgroup include:

- The Imperial Calcasieu Access-to-Care Initiative

  The Access Workgroup chose the southwest region of Louisiana to develop a pilot program for integrated systems of care. Workgroup members collaborated with the local Southwest TP Partnership to develop a preliminary plan for service delivery and financing for the uninsured known as the Imperial Calcasieu Access-to-Care Initiative. (See Access to Care Appendix).

- The New Orleans Partnership for the Care of the Uninsured

  The workgroup is collaborating with the New Orleans TP Partnership and the New Orleans Partnership for the Care of the Uninsured (NOPCU) to implement a community planning process to improve access issues in the New Orleans metropolitan area. The NOPCU is headed by four of Louisiana's major Catholic health systems (CHRISTUS, FMOLHS, Daughters of Charity, and Sisters of Mercy) and includes community partners and governmental agencies. This council approaches access issues from a holistic perspective in which all components of the health system are addressed: patients, providers, social service agencies, and community members. The objective of this program is to match communities' health needs with existing resources found among coalition partners and unrecognized assets found in the communities themselves.

- Louisiana Rural Health Access Project

  The TP Partnership collaborates with partners in LRHAP to develop a variety of interventions that improve access to care throughout the state. Activities include health professional recruitment, educational loan reimbursement, infrastructure development, community advisory panels, and the creation of partnerships among service providers. Turning Point is represented on the LRHAP Partners Technical Advisory Council where representatives work closely with program staff to share ideas, tools, and information to improve access-to-care issues.

- Louisiana Office of Public Health and St. Francis Medical Center Primary Care Partnership

  For the last three years, the local TP Partnership in the northeast region of the state has delivered primary care services at two parish health units with private providers' participation. These health units serve as "one-stop-shops" for poor and uninsured clients who might otherwise go without primary care. This partnership has developed and expanded its services since its debut and now includes diverse services, such as breast cancer screening clinics.

II. Continue assessment activities to increase understanding of access-related issues and develop strategies to procure necessary resources and infrastructure to support data collection, analysis, and dissemination at the local level.

Data from current assessment activities and future efforts will be made available to each of the nine DHH regions in Louisiana, OPH parish health units, and community-based organizations (CBOs) for resource planning in local communities. Aggregate data and database access are intended to empower local communities to generate results for report writing and enhance their activities to include identifying unmet health care needs in their area (See Health Assessment Chapter).

In Fall of 2000, the workgroup will also initiate new research activities including **a survey of uninsured consumers and focus groups with providers** who have traditionally served Medicaid and uninsured populations. Survey results will provide consumers' perspectives on access barriers and highlight methods to engage community members in developing solutions. Focus groups with providers will examine real and perceived barriers that limit their ability and desire to treat Medicaid patients and the uninsured. Discussion groups will also explore mechanisms for reducing these barriers. Pilot sites will be located in local TP regions. It is anticipated that, like the Environmental Scan, these activities will be easily replicated throughout the state. In all assessment activities, the workgroup will place a particular emphasis on documenting existing disparities among subpopulations.

The workgroup is considering additional assessment activities such as:

- Assessing the extent of employer-based insurance coverage.
- Tracking and monitoring improvements in access to care for newly enrolled members in the Louisiana Child Health Insurance Program (LaCHIP) (See Glossary).
- Developing a model that includes indicators and benchmarks that allow the state to evaluate access issues across state regions and measure improvements in access over time. Example models may include those from the Institute of Medicine - IOM (Millman 1993), HRSA (1997), and Kids Count (1999).
  Indicators will include:
  - Utilization indicators (i.e., individuals' contact with the health system and their number of appointments)
  - Outcome indicators (i.e., health status consequences such as successful birth outcomes or a reduction in heart disease)
  - Measures of health care resources (i.e., the number of existing hospitals and physicians)

III. Promote communication among local access-to-care initiatives throughout the state to share experiences, tools, information, and support. Joint problem solving will be encouraged to resolve common challenges faced by these programs.

Several collaborative community efforts currently exist to improve access to care, including LRHAP, the Bayou Teche Community Health Network (BYNET), the Imperial Calcasieu Access-to-Care Initiative, the Baton Rouge Virtual Clinic, Northstar, and the NOPCU. Many of these projects share a common goal of developing public and private alliances to address service delivery gaps, particularly for the indigent uninsured. Enhanced communication and coordination among these efforts will improve the quality and effectiveness of each endeavor.

In the coming year, TP will realize this goal by creating opportunities for local initiatives to convene and problem solve collectively. Regularly organized meetings and forums will be held to strengthen the following activities:

- Information sharing and communication
- Coordination of activities where appropriate
- Collaborative problem solving and monetary resource development for programs including:
    - Assessment activities that include data collection and monitoring
    - Financing strategies
    - Community/consumer engagement in planning the design and delivery of services
    - Organization and administration of coordinated activities
    - Disparities among subpopulations in ability to access care
- Advocacy strategies for common concerns
- Methods to increase awareness about access-to-care issues

IV. Promote public awareness about the access-to-care challenge in Louisiana and its implications for local communities.

The workgroup proposes several strategies to increase awareness of the large number of uninsured in the state and the impact this issue has on communities. Such activities will promote ownership of the health care access problem and solutions and serve as larger commitments to improving health and the quality of life for Louisianians.

At the state level, a statewide media campaign should be developed and disseminated to educate the public about Louisiana's large number of uninsured individuals and promote one or two priority solutions that initiate change. Such a social marketing campaign will serve as support for other recommendations outlined by the Access Workgroup and encourage audiences to participate in activities that improve access-to-care and impact local communities. Workgroup members recognize that effective social marketing campaigns are resource intensive and require preliminary steps to implement, including target audience identification, research on appropriate messages, clearly defined "calls-to-action," and assurance that supporting health structures will be in place to meet increased demand.

In addition, individuals at the state level who are able to change health infrastructure or allocate additional resources require more personalized forms of awareness building. These individuals include legislators and members of major health organizations. Effective methods include networking, medical society communications, selective promotional events, and public relation efforts.

Local efforts encompass several activities. While some support new efforts, others require calling on existing resources. Some examples follow:

- Utilize existing regional TP and Healthy Communities initiatives to promote access to care for the uninsured within the sectors they represent (health care, business, education, churches, media, etc.) and determine methods by which each sector may contribute to the solution.

- Coordinate outreach campaigns with key groups including employers, community leaders (such as elected officials or church leaders), and local private providers to educate them about the number of uninsured individuals in their region. Messages should also address the community impact of a large uninsured population, appropriate community efforts to improve the access-to-care issue, and community assets that can be mobilized to improve the status quo.

- Develop strategies to engage local communities in activities that improve access. Such efforts will be determined by community needs and priorities and may include Medicaid or LaCHIP enrollment campaigns or the provision of supportive services such as transportation.

Policy Recommendations (Legislative and Organizational)

The Access Workgroup, along with TP Partners, will continue to develop policy recommendations during assessment and implementation activities. Collaboration with partners is essential, as they will be responsible for fostering policy developments within their own organizations and promoting awareness of potential legislative issues among their constituencies (See Policy Chapter).

The following information is intended as a menu of ideas that targets different components of the access-to-care problem in Louisiana. Twelve policy recommendations are listed below and strategies, key players, and specific activities for implementation are presented in a matrix toward the end of this chapter. It is important to note that, at minimum, most of these recommendations require implementation at a local level. As part of TP's implementation, the workgroup will collaborate with local communities throughout the state to develop pilot programs for enacting strategies and assuring their sustainability.

I. Increase enrollment of eligible individuals in public insurance programs such as Medicaid and LaCHIP.

II. Develop mechanisms to assist individuals with the cost of purchasing health care coverage.

III. Increase the percentage of employers who provide adequate and affordable health care coverage to their employees and dependents.

IV. Create mechanisms for employers and individual consumers to compare insurance plans based on their scope of services, cost, and provider choice.

V. Increase the number of primary care providers and facilities that serve the indigent uninsured, underinsured, and Medicaid populations. This will expand the current "safety net" and increase shared responsibility between public and private sectors.

VI. Assure the appropriate geographical distribution and utilization of primary care facilities and providers.

VII. Decrease non-emergency utilization of emergency rooms by increasing the availability of primary care services and educate consumers about appropriate service utilization.

VIII. Encourage the development of local provider networks to serve the uninsured in a comprehensive and coordinated manner.

IX. Enhance community outreach and education about existing services for the uninsured including enrollment information for health coverage.

X. Develop health literacy campaigns to promote the appropriate use of services and compliance with prescribed treatment regimens.

XI. Build capacity to identify, train, and support community members to play an active role in policy development and decision making about the design and delivery of health care services (See Policy Chapter).

XII. Develop a strategy and infrastructure for the ongoing monitoring of access to care.

Strategy Implementation Matrix

The following matrix elaborates the recommendations outlined in the Policy Recommendations section & indicates strategies, key players & specific activities for implementation.

Recommendation	Key Players	Strategy	Specific Details (if applicable)
Increase enrollment of eligible individuals in public insurance programs such as Medicaid & LaCHIP	Medicaid, OPH (Covering Kids, Louisiana Health Care Campaign, Agenda for Children, & the Medicaid Workgroup), local communities, & local chambers of commerce	1. Assist local communities in documenting the number & geographic distribution of eligible individuals for Medicaid & LaCHIP	N/A
		2. Increase enrollment of eligible individuals into public insurance programs such as Medicaid & LaCHIP	Promote the development of community-level Medicaid & LaCHIP enrollment campaigns that include community education, marketing, & outreach to increase enrollment & assure access to & appropriate use of services • Create culturally sensitive communication strategies • Provide enrollment forms in multiple languages • Provide mail-in enrollment opportunities • Include working parents whose insurance does not cover dependents • Coordinate public, private, & nonprofit sectors • Train peer counselors to work directly with communities • Perform outreach activities in multiple sectors of communities • Train outreach agents (in New Orleans & central Louisiana) to work with local businesses & employers to educate them about LaCHIP • Ensure patient education & resource referral for preventive & primary care services • Determine necessary resources for clients, such as transportation & childcare, that facilitate service use Ensure that enrollment efforts throughout the state are collaborative & coordinated to enhance effectiveness
		3. Monitor program enrollment & its impact on service access & utilization	Perform program evaluation (such as surveys with state, local, public, & private organizations) to determine cultural sensitivity & consumer comprehension of campaigns Track enrollment & monitor program utilization with models like Halfon et al.'s (1999) Access Pathway Model Collect longitudinal data with consumers to determine how & where children receive services
Develop mechanisms to assist individuals with the cost of purchasing health care coverage	State Department of Insurance (DOI), consumer advocacy groups, employers, & insurance companies	1. Promote individual & employer purchasing pools through DOI pilot programs	N/A
		2. Explore policies, including tax incentives or subsidies, that encourage the uninsured to purchase coverage by making premiums more affordable	N/A

Strategy Implementation Matrix *(continued)*

Recommendation	Key Players	Strategy	Specific Details (if applicable)
Increase the percentage of employers who provide adequate & affordable health care coverage to their employees & dependents	DOI, the Louisiana Business Group on Health, local & statewide business communities, & local communities	1. Assess the extent to which employers provide health care coverage to employees & their dependents in each region	N/A
		2. Explore real & perceived barriers to providing coverage & potential incentives to increase the likelihood of providing coverage	N/A
		3. Examine coverage options for part-time workers or individuals seeking more affordable insurance	N/A
		4. Educate employers about the importance of adequate employee coverage (including affordability & scope of benefits) such as preventive services & prescriptions	N/A
		5. Promote the development of employer purchasing pools for small businesses in which employees become part of a purchasing pool that spreads risk & reduces cost	N/A
		6. Develop report cards of major plans & provide them to employers to assist in making cost-effective decisions	N/A
		7. Promote preventive health services to employers & the cost-effectiveness of circumventing illness among employees	N/A
Create mechanisms for employers & individual consumers to compare insurance plans based on their scope of services, cost, & provider choice	DOI, the Louisiana Business Group on Health, local & statewide business communities, & local communities	1. Articulate a model health plan in terms of coverage & cost against which to compare plans	N/A
		2. Collaborate with agencies (such as DOI & the Louisiana Business Group on Health) to determine approximately ten factors upon which to compare coverage programs	N/A
		3. Develop report cards for insurance plans outlining policy advantages & disadvantages	N/A
		4. Promote consumer education using these report cards	N/A

Strategy Implementation Matrix *(continued)*

Recommendation	Key Players	Strategy	Specific Details (if applicable)
Increase the number of primary care providers & facilities that serve the indigent uninsured, underinsured, & Medicaid populations	Clinical training programs, public & private providers, provider agencies/organizations, DHH-OPH, & medical associations	1. Create public/private partnerships that encourage agencies with more resources to provide care to the uninsured with reciprocal benefits in terms of decreased emergency room utilization, public relations, & a wider community presence	Encourage the mutual exchange of services between public health agencies & primary care providers Establish fixed rate reimbursement agreements among public & private providers
		2. Create a supportive environment in which primary care providers can more easily treat the uninsured and Medicaid populations	Develop agreements with physicians to provide services to a set & finite number of uninsured individuals, allowing practitioners to plan for treating the uninsured in a more predictable manner Limit physician liability for treating the uninsured Link physicians with supportive services such as nurse advice lines for their patients, case management, etc. Eliminate barriers that hinder providers' ability to refer uninsured clients to tertiary care centers for follow-up treatment & testing
		3. Collaborate with clinical training programs to expand the potential pool of primary care providers in exchange for an opportunity for students to train in community-based settings	N/A
		4. Increase the use of cost-effective providers such as nurse practitioners & clinical students as personnel	N/A
Assure the appropriate geographical distribution & utilization of primary care facilities & providers	Clinical training programs, public & private providers, provider agencies/organizations, DHH-OPH, & medical associations	1. Collaborate with clinical training programs to expand the potential pool of primary care providers in exchange for an opportunity for students to train in community-based settings	N/A
		2. Utilize public health facilities as prevention & primary care centers where existing facilities are minimal	N/A
		3. Expand the number of existing, cost-effective, prevention & primary care sites such as school-based clinics	N/A
Decrease non-emergency utilization of emergency rooms by increasing the availability of primary care services & educating consumers about appropriate service utilization	Clinical training programs, public & private providers, provider agencies/organizations, DHH-OPH, & medical associations	1. Increase the number of primary care sites (through the expansion of school-based clinics & utilization of parish health units) & expand hours of operation	N/A
		2. Promote the development of triage phone services & nurse advice lines - Some of the Charity Hospitals (within the State Public Hospital System) have created a "talk line" for patients where nurses provide medical advice based on national medical protocols	N/A

Strategy Implementation Matrix *(continued)*

Recommendation	Key Players	Strategy	Specific Details (if applicable)
Encourage the development of local provider networks to serve the uninsured in a comprehensive & coordinated manner	Clinical training programs, public & private providers, provider agencies/organizations, DHH-OPH, & medical associations	1. Convene stakeholders within a defined geographic area, including health and social service providers, CBOs, and consumers	N/A
		2. Catalog existing services provided by organizations for the uninsured, identify duplicated services and service gaps, and document existing collaborative relationships among organizations	
		3. Develop concrete strategies to reallocate existing resources and coordinate services through collaborative agreements among stakeholders	Establish contracts between member agencies for reciprocal service provision (i.e., clinical care in exchange for wrap-around services) Create capitated service arrangements to redistribute costs of tertiary care Share case managers and care coordinators to facilitate cross system referral Establish a system-wide program of wraparound and outreach services including transportation between sites and nurse advice/triage lines to direct patients to appropriate services
		4. Create shared information systems to track patients and monitor outcomes.	N/A
Enhance community outreach/education about existing services for the uninsured including enrollment information for health coverage	Groups involved in developing integrated systems of care, local community coalitions (such as TP & Healthy Communities), & the sectors each coalition represents (LSUMC & the Catholic Health System Coalition)	1. Establish a regional/parish resource clearing house that is published on the web	N/A
		2. Create 24-hour community resource telephone lines (that are housed in public or private hospitals or local CBOs) & refer consumers to appropriate services	N/A
		3. Provide community gatekeepers (such as public clinics, schools, or churches) with service resource information so they may assist individuals without telephone or computer access in obtaining this information	N/A
Develop health literacy campaigns to promote the appropriate use of services & compliance with prescribed treatment regimens	Service delivery agencies (such as parish health units), the Louisiana State Hospital System, public & private hospitals, community clinics, CBOs, gatekeepers, & consumers	1. Establish triage telephone line services that provide health education & referrals	N/A
		2. Collaborate with community gatekeepers to develop campaign messages & identify utilization issues (such as over-utilization of emergency rooms for primary care)	N/A
		3. Encourage the development of community-based case management programs that follow service delivery & ensure that clients adhere to treatment regimens	N/A

Strategy Implementation Matrix *(continued)*

Recommendation	Key Players	Strategy	Specific Details (if applicable)
Build capacity to identify, train, & support community members to play an active role in policy development & decision making about the design & delivery of health care services	Community members, CBOs, coalitions, TP Partners, OPH staff (including Healthy Communities staff), community health care providers, & consultants	1. Develop a Training of Trainers (TOT) program for local community leaders organizing around the access-to-care issue - TP Access & Policy Workgroups will work with local community collaboratives to develop this type of program	N/A
		2. Identify community leaders to organize forums/town meetings & engage community members in the design & delivery of health care	N/A
		3. Educate health care organizations & providers to support community members' active participation in policy development	N/A
		4. Create channels for community members to provide feedback to health care agencies about the design & quality of care	N/A
Develop a strategy & infrastructure for the on-going monitoring of access to care in the state	DHH-OPH, Medicaid, LSUMC, public & private health systems, & local communities	1. Create a plan for continuous regional & state monitoring that includes the development of indicators for monitoring access to personal health care services over time	Develop indicators that include: • Utilization indicators (i.e., individuals' contact with the health system & their number of appointments) • Outcome indicators (i.e., health status consequences such as successful birth outcomes or a reduction in heart disease) • Measures of health care resources (i.e., the number of existing hospitals & physicians)
		2. Improve existing data collection & elaborate matrices, scans & surveys developed by the Access Workgroup	
		3. Develop a data program for housing & analyzing information	
		4. Assure that data collection is available to local communities & presented in a usable & understandable format	
		5. Track children's access to care through LaCHIP enrollment	

Conclusion

The Access Workgroup addressed the challenge of improving state access-to-care issues during their assessment activities. Supporting literature, existing data, and information gathered by the workgroup demonstrate a need for health system improvements throughout Louisiana, particularly communities' capacity to improve access-to-care issues and appropriate policy structures to support this endeavor. Assessment activities revealed high rates of uninsured individuals throughout the state, provider shortages, and several infrastructure-related factors that impede individuals' access to needed health services. In addition, many individual and community-specific factors influence access-to-care constraints and can only be effectively addressed on the local level. Innovative solutions to access-to care issues can be successful with the support of state decision makers and health care agencies as well as policy implementation that enables change at the community level. It is the Access Workgroup's hope that the information and recommendations contained within this chapter will serve as a foundation for improving Louisianians' access to care.

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Chapter 5

Implementation Framework: Priorities and Process

Introduction

The recommendations in the four previous chapters are the Turning Point Partnership's attempt to clearly state what must occur to improve the delivery of public health activities in Louisiana and move towards its vision of a collaborative and competent public health system. These recommendations are to be used as a guiding framework for all the major organizations and sectors that share the mission of assuring and improving health for people in the state. Looking across the four areas, certain consistent themes emerge from the assessment findings and recommendations. This chapter is an attempt to lay out a holistic implementation framework that integrates all the state recommendations and takes into account the direction and agenda of the local TP partnerships.

From both our research efforts and through our partnership's collective experience, common themes emerged from the planning process which help to shape our implementation priorities:

- Louisiana is a state with limited resources. To maximize the effectiveness of existing resources and services, they must be coordinated and linked both within regional communities as well as across the state. In an era of decreased government spending and downsizing, efforts to link existing resources and services are just as important as trying to obtain new ones.

- Many health improvement efforts such as improving access to care need to be carried out at the local level where the service networks exist. Coordination with and support from state-level agencies and policy makers must also occur to assure that local communities have the support and resources they need for their efforts to succeed.

- State level agencies and policy makers need to be more responsive and accountable to the perspectives and concerns of local communities. Individuals from the local and state level need opportunities to dialogue together and be viewed as equal partners in health improvement efforts.

- Individuals and organizations at the local level need specific skill training opportunities particularly in regards to policy development and health assessment skills.

- Individuals in both local-and state-level organizations need specific leadership skills to develop and lead collaborative efforts.

- Information and data are not readily accessible to local decision makers in a timely and meaningful way.

In addition to the above themes, common change strategies exist that cut across all four workgroups:

- Collaborating across organizations for planning and interventions

- Examining problems systemically and holistically

- Testing ideas through on-going assessment and pilot models

- Building local capacity through skills training

- Developing leadership at both state-and local-levels

- Developing on-going learning and planning communities

- Linking state and local agencies and decision makers

- Holding organizations more accountable to the communities they serve
- Documenting best practices and lessons learned from innovative health improvement efforts
- Decreasing disparities in health and access to services among sub populations

Given the scope of these cross-cutting themes and overarching strategies, it was necessary to develop an implementation framework that would address all of the commonalities of the four workgroups in a concise, cohesive plan. The plan that the partnership developed weaves together the ideas of the previous four chapters and contains both state-and local-level components. This plan is outlined in the following boxes. The activities delineated at both the state-and local-levels address the common themes of the four workgroups (Health Assessment, Policy Development, Prevention and Health Promotion, and Access-to-Care) and use the overarching strategies that are universal to all the workgroups, creating a plan that is not only efficient, but also effective and holistic. Such a targeted approach to implementation will ensure that all of Turning Point's implementation priorities will not be addressed in a piecemeal fashion, but rather as vital parts of a whole plan. The implementation plan is as follows:

Implementation of State Level Activities

Our goal at the state level is to enhance capacity across the state and within state level organizations to perform public health activities through:

I. Development of statewide forums/learning communities in each of the four key areas that encourage

- **Coordination of efforts**
- **Enhanced communication among key agencies**
- **Joint problem solving**
- **Sharing best practices and lessons learned**
- **Development of policy recommendations**

II. Ongoing assessment efforts and assessment tool development

III. Documentation and promotion of public health best practices across the state

IV. Organizational collaborative leadership training

V. Development of a social marketing campaign to promote:

- **Multi-organization/multi-sector collaboration, public/private partnerships**
- **Community accountability**
- **Holistic, multilevel health improvement efforts**

Local Level Activities

Our goal at the local level is to enhance local community capacity to perform public health functions through:

I. Collaborative leadership training

II. Specific skill development and training (data usage, policy development)

III. Local initiative development to improve health through collaborative community problem solving and action (pilot programs- approximately four pilot programs)

IV. Specific technical assistance efforts including resource development

Anticipated Outcomes

Although many of the outcomes specific to each of the four areas were described in the previous chapters, below are examples of overall outcomes we expect to achieve:

- A more integrated public health system in which there is coordination and communication both within local communities as well as among state-level organizations.
- Enhanced communication and collaboration between community-level organizations and statewide agencies and policy makers.
- Effective state and local organizations that have the skills and capacity to engage in multi sector/organizational problem solving.
- Organizational leaders at the state and local level who can work together collaboratively and are responsive to the people they serve.
- Organizations that are receptive to and communicative with communities.
- Statewide multi-sector problem solving networks for health improvement (i.e. Health Assessment Panel).
- Networks of community organizations working together to solve problems and leverage existing community resources.
- Communities that mobilize to influence policy that will impact their health improvement efforts.
- Communities that have the information they need to make decisions, plan, solve problems, and evaluate their efforts.
- Community leaders that advocate for needed resources and policy changes at the local level.
- Individuals at the local level who know how to obtain, analyze, and use data and information appropriately.
- Local experts that serve as consultants to other communities.
- Enhanced capacity of LPHI and its partner organizations to provide technical assistance and consultation to community health improvement efforts.
- Development of a comprehensive training of trainers (TOT) curriculum to enhance health assessment and policy development skills at the local level.

- Promotion of the value of collaboration and multi-organizational problem solving among health and social services agencies throughout the state.
- Enhanced communication among similar health improvement initiatives across the state leading for sharing information, strategies, resources, and tools.
- Innovative, coordinated and multi-faceted health improvement interventions to improve access to care and prevention efforts
- Effective organizational and legislative policy changes to improve health.
- Documentation and promotion of best practices and lessons learned from the TP process.
- Development of tangible tools including: access to care assessment tools, policy development and evaluation tools, and program evaluation tools.

Implementation Process

GAINING COMMITMENT

Now that the TP partners have effectively described a plan of action to improve the health system, they must hold each other accountable for instituting change. Over the next year, the TP Partnership will seek commitments from organizations to participate in collaborative change strategies, as well as document what groups across the state are doing to forward the TP agenda. In addition, the TP Partnership must identify resources to institute and sustain their recommendations by locating new resources, reallocating existing ones, and coordinating allocation among partners. During implementation, the Partnership must further institutionalize the collaborative processes begun during the planning phase. For implementation to succeed, partners must continue to view themselves as part of a larger whole and remain committed to collective dialogue and innovative collaboration.

ROLE OF THE LOUISIANA PUBLIC HEALTH INSTITUTE

The Louisiana Public Health Institute (LPHI) housed and staffed the TP Program for the past two years and will continue to convene and coordinate its activities. The mission and the goals of LPHI-to foster collaborative, multi sector health improvement initiatives and serve as a impartial convener of a broad range of state and local groups make it uniquely positioned to serve in this role. The TP Public Health Improvement Plan (PHIP), sets an agenda for LPHI and helps shape the direction of its resource development efforts. The Louisiana Public Health Institute will help leverage grant resources to enable the TP Partnership to implement the recommendations in the PHIP.

ESTABLISHING INITIAL IMPLEMENTATION PRIORITIES

Given the scope of the PHIP, it is not feasible to implement all of the recommendations at once. Thus, key implementation priorities must be established to focus initial activities. Statewide implementation priorities will be determined through collaboration with the three local TP Partnerships in the first half of the year 2000. An agenda will be established by examining the consistencies in priorities across the four PHIPs and by determining how implementation efforts at the state-and local-level can enhance one another.

MONITORING PROGRESS

The Tulane School of Public Health led efforts to evaluate the TP process throughout the strategic planning phase. The evaluation focused on assessing the development and effectiveness of the state and local partnerships and examining indicators such as leadership, communication, and resource development. The partnerships will continue to be monitored as they evolve during implementation. During implementation, the evaluation will continue to examine the strengths and challenges of conducting collaborative public health activities, sustaining them, and methods to improve their effectiveness.

Monitoring Louisiana's progress toward developing a more competent and collaborative public health system now becomes the agenda of the TP Steering Committee. In the next phase, the TP Partnership will revisit PHIP recommendations and strategies to

pinpoint accomplishments across the state. Moreover, the TP Partnership will assess new opportunities and priorities for health improvement in the state and adopt the PHIP as appropriate. Progress on original recommendations, as well as evolving priorities, will be described in addendums to the PHIP and future documents.

SUSTAINABILITY OF PARTNERSHIP

The group of more than 200 state and local organizations comprising the TP Partnership will undoubtedly change and evolve during implementation. New organizations will be recruited, particularly from those sectors not represented in the traditional health system. The TP Partnership's organizational structure will adapt to meet the emerging needs of implementation. The Steering Committee will continue to govern the TP Partnership and its activities and adapt its composition to represent other constituencies assuming lead roles in implementation. The statewide workgroups that played a pivotal role in strategic planning will also adjust their roles to reflect new and different responsibilities. For example, the Health Assessment Workgroup will become the State Health Assessment Panel, with membership that includes appropriate state and local partners with a stake in developing effective health assessment policy. The Prevention and Access-to-Care workgroups will coordinate statewide activities through the Access-to-Care Congress and the Prevention Peer Forums. Finally, the Policy Workgroup will work with the TP Partnership to develop community participation strategies and train new community health leaders.

Conclusion

Throughout this document, TP partners have identified needed changes and described strategies to achieve them. The PHIP describes a shared vision and common goals and creates an opportunity for partners to collectively create a healthier Louisiana. The Partnership has generated the momentum for change which must now be turned into action. As we enter the 21st century, many industries are experiencing a financial upturn. However, the health care industry is reeling from the rapid and significant changes of the last decade. The healthcare system is fraught with problems and neither the public nor private sectors have sufficient resources to address them. As a result, health and social service organizations must work together to leverage scarce resources more efficiently. Such an effort requires increased communication, coordinated efforts, shared responsibility and resources, and collective accountability to the communities they serve. A failure to seize this opportunity to work together will have significant adverse effects economically and in terms of health outcomes.

Turning Point partners have witnessed first-hand the benefit of collaboration. They have formed new relationships and become accustomed to looking beyond their own agenda when facing a new challenge. In addition to cross sector collaboration, state entities have learned the importance of local input and cooperation as well as engaging in joint planning and problem solving. In turn, local groups are learning to view themselves as equal partners, with each segment playing a distinct but critical role. Finally, organizations at both levels now understand how crucial it is to involve their own constituencies in both the design and implementation of health improvement efforts.

The kind of changes suggested in this document requires a greater level of commitment than most organizations have provided in the past. Working collaboratively requires partners to share both power and "turf." It is hoped that as more agencies take part in Turning Point, collaboration will become a well-accepted method of engaging in health improvement efforts. As more agencies join collaborative ventures, the agencies themselves begin to change internally as they reshape their own priorities and operating principles. Working collaboratively, agencies must also redefine their role and relationship with respect to other organizations and sectors, and, eventually, with respect to the public health system as a whole. As a result, Turning Point is creating a public health system that is more collaborative, efficient, and ultimately, more effective and more responsive to the needs of the people of Louisiana.

Appendices