State Health Promotion Capacity

A DHPE Assessment Report

July 2003

Funded by the Directors of Health Promotion and Education (formerly ASTDHPHE) through a cooperative agreement with the Centers for Disease Control and Prevention

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Executive Summary

Purpose

The purpose of this project was three-fold:

(1) to assess the perceived health promotion capacities of those carrying out programs in state health agencies;

(2) to ascertain their priority needs for professional development; and

(3) to propose possible actions that might be undertaken to strengthen health promotion activities and programs carried out through state and local public health agencies.

Methods

The primary source of information used in the preparation of this report came from responses to structured interviews with: (1) a sample of members (15 of 54) of the Directors of Health Promotion and Education (DHPE) and, (2) 21 CDC staff members from 10 different Centers, Institutes, or Offices (CIOs) within CDC. NOTE: In several instances, comments or references made during the interviews required direct follow-up clarification either through additional interviews or reviews of published material and references.

Findings

The findings for this report have been framed around the three “themes” which surfaced from the analysis of information obtained during the interviews. Those three themes were:

- Health promotion organizational support in state health agencies and within CDC – operationally defined as perceived leadership and economic support for health promotion from leaders in state health departments

- Health promotion skill capacities within states – operationally defined as the perceived level of competencies within state health departments for the seven essential skills needed for effective health promotion practice (see Table 1.)

- Priority health issues being address by state health promotion programs – operationally defined as the priority health problems (e.g. diseases, risk factors, social/economic/environmental determinants) that were being addressed by health promotion programs in the respective states.
For the purposes of this executive summary, the findings are presented in the following question-and-answer format.

Q. Health promotion capacity can be assessed at two levels: (1) specific health promotion skills within the public health workforce, and (2) resource and administrative support. How should the health promotion skills of public health practitioners in state health agencies be rated?

A. With reference to the skills highlighted in Table 1, the state-level health promotion workforce is, on the whole, competent. Levels of competences tend to be stronger among those skills that relate to the understanding health problems and the overall planning of activities and programs. Furthermore, the level of competence appears to be improving. However, considerable variability in skill remains across and within states, and while substantial progress has been made, considerable room for improvement remains.

Q. What accounts for this level of competence and pattern of improvement?

A. Two factors stand out. First, although rooted in the rich tradition of public health education, health promotion continues to be a dynamic, emerging discipline. As new theories, strategies and methods are shown to be effective, they are disseminated through a wide range of channels including: (1) the professional literature, (2) professional education meetings like those sponsored by DHPE, APHA, and SOPHE, and (3) specific technical assistance and training programs sponsored by CDC (e.g., pre-application grant workshops, CDCynergy, MAPP, social marketing courses, OSH evaluation training).

A second factor is the cadre of health education and health promotion leadership that exists in states (nurtured by DHPE). This is a formidable network of experienced leaders whose commitment and advocacy has been critical to the on-going improvement of health education and health promotion in states and communities.

Q. What health promotion skills are in the greatest need of improvement?

A. The skills associated with the process of program evaluation surfaced as the area that was consistently reported in need of improvement. This distinction suggests that evaluation is a universal priority for training by CDC, schools of public health, and other institutions with a training and workforce development mission. However, given the variability in competence reported for all health promotion skills, it would seem appropriate to assign priority training status to other specific skill areas based on needs determined by the locally (by states in question).
Q. Why is evaluation so problematic for practitioners?

A. Clearly, many respondents attributed evaluation deficiencies to the lack of skills among practitioners and, therefore, to the need for specific, on-going evaluation training and technical support. However, sentiments were also expressed suggesting that the problem goes beyond the skills of practitioners in the field.

Specifically, among the various CDC categorical program grants, there appears to be little agreement on two critical aspects of the evaluation process: (1) the goal(s) of the evaluation and (2) what constitutes appropriate and realistic measures or indicators of progress toward those goals. Without clear and consistent evaluation goals and principles, even skilled practitioners will be confounded when they are asked to address ever-changing evaluation goals and expectations. This is especially problematic for state and local-level practitioners who wear the hats of multiple programs (e.g., cardiovascular disease, diabetes, injury, school health). In most states, this is the norm.

Q. Turning to the administrative and resource support aspect of health promotion capacity in state health agencies, how supportive of health promotion are the state level public health leaders?

A. Generally leaders in state health agencies are supportive of health promotion when they perceive, either from personal experience or from documented evidence indicating that health promotion contributes to the effectiveness of public health programs and policies.

Q. How do political leaders in states view health promotion?

A. Legislators tend to view “health” primarily in the context of health care and health services -- especially as those programs are tied to state funding mechanisms like Medicaid. Among political decision makers in states, a clear awareness of the merits of health promotion remains the exception rather than the rule.
Q. What is a fair assessment of the resource/fiscal support for health promotion programs in state health agencies?

A. From an historical perspective, economic resources to support health promotion activities in state health departments (and public schools) have never been higher. Direct program grant support to state health agencies through the National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) in 2002 was over $480 million – nearly 50 times greater than the amount awarded through the Health Education Risk Reduction Grants program in the early 1980’s.

It is estimated that about 75-80% of the health promotion budget in states comes from the federal government, almost all of which is through categorical grants and cooperative agreements with CDC. Most of the remaining amount comes from a variable combination of three sources: (1) state budgets, (2) the tobacco settlement, and (3) grants from philanthropies. Positive gains notwithstanding however, several respondents expressed concern over the continuing pattern of lower support for prevention compared with medical care. This perspective seems to be supported by the recent trend of tobacco settlement resources being shifted away from prevention and public health to non-health activities, especially public health and prevention.

Q. How has this infusion of support from CDC influenced health promotion activities and programs in states?

A. It has certainly led to an increase in the public’s exposure to health education and health promotion programs. Over the past 20 years, both within CDC and across state health agencies, health education and health promotion activities and programs have become ubiquitous and are embedded in a wide range of categorical health programs (e.g., chronic diseases, injury, environmental health, HIV/STD, etc.). Concurrently, the health promotion workforce in states has grown with these increases.

Q. Has this increase in exposure to health education and health promotion been accompanied by evidence that these programs are yielding health benefits or improvements?

A. Although there are reports showing that specific programs do achieve their intended goals and result in tangible health outcomes (e.g., tobacco Control, school health, injury prevention, teen pregnancy), evidence of the effectiveness of health education and health promotion remains sparse. In the absence of an effective system of evaluation, the effects of programs (positive and/or problematic) are going undetected. At present, there is no mechanism for
systematic compilation and reporting of health promotion program effects at either the state or national level.

**Q. Are there problems associated with the integration of health education and health promotion into categorical health areas?**

**A.** While the integration of health promotion into categorical health areas has expanded the reach of health education and health promotion, it has also been the source of problems. Categorical programs often come with restrictions that limit the ability of state and local practitioners to address unique local needs.

These restrictions can also lead to fragmentation that sometimes add to administrative costs and can negatively influence the quality of health promotion planning, implementation, and evaluation at the state and local levels. For example, each CDC/CIO (and sometimes categorical programs within each CIO) manages the health education/health promotion components of its respective programs independent of the approaches taken by other CIOs.

As a result, standards and expectations for program evaluation are frequently inconsistent among different CDC programs where health promotion is an integral component resulting in variability in the way health promotion is interpreted across the categorical programs within CDC. And, as was pointed out in the question of program evaluation, this kind of discontinuity is especially problematic when the same state-level staff person has the lead in preparing program grants for different categorical programs.

**Q. Is there a need for a CDC “focal point” for health promotion?**

**A.** In 1974, the Bureau of Health Education was established at CDC to create of governmental focal point for health education. One of the primary purposes for that action was to elevate health education as a visible public health priority. Since that time, programmatic and research activities in health education and health promotion have grown exponentially within CDC and among state health agencies to the point that health promotion programs and activities are ubiquitous. Input from those interviewed suggests that the time has come for establishing a coordinating focal point for health promotion within CDC to enhance program continuity within CDC, between CDC and the states, and among the states.
Recommendations

The central purpose of this project was to assess the professional development needs of health promotion practitioners in states. The following recommendations are based on the findings from that assessment process.

Recommendation 1 - Re-establish a Health Promotion Focal Point at CDC

Goal: Establish an official CDC focal point for health promotion with the responsibility of assuring that health promotion components of CDC health programs employ common guidelines, standards and terminology in their program grants and training programs.

Recommendation 2 - Create an Inventory of Health Promotion Programs That Work

Goal: Establish a single, easy-to-access source that describes the health benefits and (as appropriate) the cost effectiveness of public health promotion programs.

Recommendation 3 - Develop and Implement a Strategic Plan to Strengthen the Evaluation Capacities of State Practitioners

Goal: Improve the evaluation capacities of state health promotion practitioners.

Recommendation 4 - Refine and Expand the DHPE Peer Assistance Training Program

Goal: To provide practical, timely, peer-based health promotion technical assistance tailored to address local (state) needs.
Background

Following his address to Congress in 1971, in which he argued that a greater priority on prevention and health education would help stabilize rising health care costs, President Nixon appointed the President’s Committee on Health Education. The committee, comprised of leaders in medicine, the insurance industry, business, and academia, was charged with formulating recommendations based on their research and input from regional public hearings. One of the key recommendations in the committee’s final report to the President in 1973 was the establishment of a federal Bureau of Health Education.

As an extension of the National Health Planning and Resource Development act of 1974, the Bureau of Health Education was formally established at the Centers for Disease Control and Prevention (CDC) in 1974. Since that time, the disciplines of health education and health promotion have become integral to prevention research initiatives and public programs throughout the agency. Examples of these initiatives and programs include the Prevention Research Centers and the Prevention Research Initiative, the prevention and control of multiple chronic diseases, the promotion of integrated school health programs, injury/violence prevention and control, immunization, STDs, HIV/AIDS, environmental health, asthma, birth defects, and communicable disease control in international settings. Although some of these initiatives and programs are coordinated through academic centers and/or non-governmental organizations, the great majority are carried out in close collaboration with state health departments and through those state health departments to local public health agencies.

A temporal comparison of health promotion resource allocations by the National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) provides a measure of the growth of CDC’s support for, and commitment to, health promotion in states and localities. In 1982, the Health Education Risk Reduction (HERR) grant program was managed through the Center for Health Promotion and Education (CHPE), the predecessor to NCCDPHP. At that time, HERR was the only federal program that provided funds to states health
agencies specifically to support health education programs; the total budget for HERR was $10 million. By comparison, in 2002, the NCCDPHP extramural budget was just over $700 million, which includes support for national organizations and academic prevention research centers. It is estimated that over half of the NCCDPHP extramural budget ($478 million) goes to programs in states. Albeit less dramatic, similar increases in support for health promotion programs to states can also be seen in CIOs focusing on other key health issues including injury prevention, environmental health, HIV, STD, prevention, immunization, and birth defects.

It goes without saying that CDC has a vested interest in assuring that public health practitioners apply the latest and most relevant knowledge, using the most effective methodology in planning, implementing, and evaluating community and school-based health promotion programs. In a variety of categorical health areas, across different Centers, Institutes, and Offices (CIOs), there are numerous examples of CDC undertaking actions aimed at strengthening health promotion both within the agencies and with their counterparts in state health and local health departments.

These include:

- Establishing and maintaining an on-going national behavioral risk factor surveillance system (BRFSS) providing state-specific data for every state and some small area data in some states.

- Providing technical assistance to selected state health agencies in the application of categorically specific community-based health promotion programs (e.g., specific chronic diseases, injury, HIV, etc.)

- Providing technical assistance and support in the monitoring and evaluation of categorically specific community-based health promotion programs.

- Supporting research into the science, methodology, and process of community-based HE/HP.

- Disseminating documented “best practices” in tobacco prevention and control programs.

- Conducting training workshops (for categorical health issues) on specific aspects of community-based HE/HP.

- Developing and maintaining on-line websites with information relevant to community-based HE/HP.

- Supporting organizations promote professional development and support workforce development within CDC: the Behavioral Sciences Working Group and Public Health Education and Promotion Network (PHEP Net).
Unlike the way CDC coordinates technical support and training for the discipline of epidemiology through the Epidemiology Program Office (EPO), no official focal point has been designated to coordinate technical support and training for health promotion for either CDC staff or their counterparts in state health departments. Consequently, training and technical support for health education and health promotion has been, and continues to be, managed independently by the respective CIOs, often with minimal communication between them. While such independence has yielded the benefits of stimulating innovations and timely responses to categorical requests, in CDC's rapidly expanding and growing system, it has also become fragmented.

Failure to address the fragmentation of health promotion within CDC is especially problematic for two reasons. First, although rooted in the rich tradition of public health education, health promotion continues to be a dynamic, emerging discipline. Globally, academic research and development over the past two decades has contributed to a substantial increase in the body of knowledge related to health promotion; this has led to an expansion and strengthening of the theoretical and scientific foundations of health promotion practice. Within the United States, many of these advances have been stimulated by support from CDC. There can be little doubt that all CDC CIOs would benefit from a coordinated mechanism that promotes the timely sharing and integration of those on-going developments. In part, the emergence of organizations like the Behavioral Sciences Working Group and PHEP Net provides evidence of the need for CDC-wide sharing and coordination that is more than serendipitous.

Second, the effectiveness of public health programs supported by CDC resources is highly dependent upon the capacity of state and local practitioners to implement those programs in accordance to the unique conditions and circumstances in the locality where it is being applied. In most instances, state and local practitioners wear more than one “categorical hat;” thus, a state-level practitioner with responsibilities in tobacco control, may also have responsibilities in other programs such as asthma, physical activity, injury prevention, or school health. Even though all of these programs are likely to include a substantial health promotion component, each will be managed by a different CIO or program at CDC with no assurance that their health promotion perspectives are coordinated at least to the extent that they share common language related to common concepts and principles. The absence of coordinated, CDC-wide approach to health promotion increases the likelihood that the same state-level health practitioner may receive conflicting guidelines or feedback on aspects of health promotion, depending upon the orientation of a given CDC CIO, or program.
Purpose

The purpose of this project was three-fold: (1) to assess the perceived health promotion capacities of those carrying out programs in state health agencies, (2) ascertain their priority needs for professional development, and (3) to propose possible actions that might be undertaken to strengthen health promotion activities and programs carried out through state and local public health agencies.

Information Gathering Protocol

The primary source of information used in the preparation of this report came from responses to structured interview questions provided by health promotion staff from selected state health agencies and by health promotion staff representing different Centers, Institutes, or Offices (CIOs) within CDC. NOTE: In several instances, comments or references made during the interviews required direct follow-up clarification either through additional interviews or reviews of published material and references.

The protocol was as follows:

1. A short background paper, providing a brief historical account of the emergence of health education and health promotion at CDC, was developed. The paper highlighted key assumptions about health education and health promotion at CDC, especially in the context of working with state health agencies. (A portion of the content of that paper is included in the introductory “background” section of this report.)

2. Two panels of public health practitioners were identified. One panel represented the perspective of state-level health promotion experts and was comprised of 15 of the 54 members of Association of State and Territorial Directors of Health Promotion and Public Health (DHPE). Although they all shared common ground as members of DHPE, 10 of the 15 respondents were located in organizational entities or programs with a categorical focus (e.g., chronic disease, injury, etc.).

   The other panel consisted of 21 CDC staff members from 10 different Centers, Institutes, or Offices (CIOs) within CDC. Members of the CDC panel were selected because their assignments included substantial contact with grant programs or activities carried out by state health agencies where health education, health promotion and/or health communication are major components. The list of DHPE and CDC panelists are presented in Appendices A and B respectively.
3. DHPE panelists were interviewed by telephone using a structured interview guide sent to each panelist prior to the interviews. (See Appendix C.) Each person received a copy of the background paper and was asked to review it prior to the interview. The average length per call was 45 minutes. All interviews were audio taped with permission of the respondents.

4. Information from the CDC panelists was obtained through small group discussions. The groups ranged in size from 3 to 5 persons each. Each session lasted 1-1/2 hours. A structured interview guide was used to facilitate the group discussions. (See Appendix D.) All participants received a copy of the background paper and were asked to review it prior to their discussion session. All sessions were audio taped with permission of participants. The information gained through the interview and small group discussion process was not limited solely to health promotion in the context of chronic disease or chronic disease risk factors. CDC panelists represented 10 different CIOs. Consequently, their perceptions of health promotion capacity in states was from the perspective of a wide range of public health problems which included: birth defects, environmental health, injury, toxic exposure and superfund sites, school health, infectious disease, health communications, reproductive health, chronic diseases, and risk-factor specific problems. Members of the DHPE panel represented the state experience primarily from the perspective of those engaged with community health, health communications, chronic diseases, injuries, and their attending risk factors.

**Analysis and Themes**

Tapes of the small group sessions with CDC staff were transcribed into written summaries. The tape recording of each interview with a DHPE member was reviewed to augment data transcribed during the course of each interview. The analysis of information from both of these sources generated three “themes:”

- **Theme 1 – Health Promotion Capacity: Organizational Support** (A1, 2, 3, 4; C1, 2, A5)
- **Theme 2 – Health Promotion Capacity: Skills/Workforce Development** (A6; C3 A9, 10; C4, 5)
- **Theme 3 – Priority Health Issues Addressed by Health Promotion** (A7, 8)
Findings

The findings for this report are framed around the three themes, each of which consists of two components: (1) a narrative of the participants’ responses to the questions relevant to that theme, and (2) a brief summary of the salient issues in that theme.

1. Organizational Capacity and Support

For the purposes of this report, health promotion capacity (whether at the federal, state, or local level) was understood to require two interdependent components: (1) the organizational structures, resources and commitment needed to support effective health promotion programs and activities, and (2) the staff with the skills necessary to plan, implement, and evaluate those health programs and activities; both components are necessary and both are addressed in this section.

Within the Context of CDC

CDC panelists were asked: “to what extent do you think that CDC administrators understand and value the role that health promotion in public health programs? Respondents indicated that there is considerable variability among senior CDC administrators in their understanding of health promotion and the extent to which they value health promotion as a critical component of public health. Some key senior leaders in several CIOs are perceived to have a clear understanding of the benefits that can result from effective health promotion. Evidence of how those leaders value health promotion is manifest by the consistent efforts to provide leadership and budgetary support for sound health promotion programs. Some have played a major role in creating initiatives that have advanced the science and credibility of health promotion. However, such high level understanding and support for health promotion is not yet the norm at CDC.

Panelists offered several reasons why support for health promotion remains uneven. First, many of those in senior leadership roles come from the perspective of medical epidemiology, often within the context of communicable disease. Some with that orientation seem to be unclear about the scientific merits of health promotion. As a consequence, some tend to view health promotion, along with health education, health communication, and public information as relatively straightforward tasks that everyone with public health
training could and should do. Still others remain scientifically wary because researchers and practitioners describe the “effects” of health promotion without employing the traditional standards used for scientific assessment. One CDC panelists observed,

“Some CDC leaders view health promotion as a product rather than process. It is as if they think: I can buy it, (e.g., pamphlet, video, Web site, campaign) and get it off my plate. It is easier to do that than to adopt a process with ongoing investment in people, their qualifications, methodology, planning, and evaluation.”

Panelists generally agreed that high level support for health promotion at CDC is steadily, albeit slowly, becoming stronger. They indicated that this trend seems to parallel to two others: (1) health promotion becoming more predominant in public health policy and professional literature, and (2) mounting evidence that well-planned health promotion does yield documented health benefits. The following quote by one of the CDC respondents reveals what it took to create a shift in her Division Director’s support for health promotion:

“. . . it took about four years of applying health promotion principles, and going beyond the process to more emphasis on monitoring and evaluation, more training, and articulating problems, interventions, theories, outcomes.”

In State Health Agencies

DHPE participants were asked to respond to the question of organizational capacity and support from two perspectives: (1) that of their state health agency, and (2) that of state political decision-maker (e.g., office of the governor and state legislators).

Similar to findings above, support for health promotion in state health agencies is variable and seems to be influenced by a combination of at least four factors:

- The location of the state health agency within the organizational configuration of state government – Generally support for public health programs (and, therefore, health promotion) seems to be more forthcoming when the public health agency is situated as an independent agency and/or part of the governor’s cabinet. When it is positioned as a part of a larger organizational entity, the struggle for budgetary support is more problematic.

- The public health perspective or bias of the state health officer – State health officers differ in what they consider to be key policy, program and budget priorities. Obviously, those who are perceived to hold the view
that health promotion can contribute to the effectiveness of public health programs and policies are seen as more supportive. For example, when asked to explain why the state health department was judged to be “unequivocally supportive,” the DHPE respondent said, “He’s a physician with an MPH; he did a lot of missionary work in Africa and used the population-based community approach with great success there. He knows what we are trying to do is important.” When asked what they thought differentiated supportive from not-so-supportive health officers, respondents generally indicated that those less supportive remained unconvinced of the benefits that an investment in health promotion would yield.

- The frequency in turnover of public health leadership – There were two dimensions to the issue of leadership change. The first was that frequent change contributed a sense of instability in leadership. Because health promotion is frequently a component of programs addressing complicated public health problems, such programs require a sustained commitment over time. Respondents indicated that frequent leadership changes tend to confound the continuity of such efforts. The second dimension was related to the fact that frequent changes in leadership influenced both the morale within, and economic support for, the health promotion programs. However, this observation was acknowledged by respondents as being double-edged - in some instances a supportive health officer might be replaced by someone less supportive, or visa versa.

- The fiscal status of the state - Without exception, all ASTDPHPPE interviewees indicated that their respective state budgets were facing severe cutbacks due to the recent declines in the national economy. Some respondents expressed concern that a sustained economic decline, combined with the heightened concern for bio-terrorism, could threaten the existence of some health promotion programs.

With regard to their perception of the support given to health promotion by state political leaders (governor, state legislators), DHPE respondents generally agreed that legislators understand “health,” or at least have a heightened sensitivity to health, primarily the context health care and health services -- especially as those programs are tied to state funding mechanisms like Medicaid. While some exceptions were noted, it seems as if the majority legislators in states have only minimal awareness of public health in general and even less for health promotion. The following quotes capture the sentiments expressed by several DHPE panelists:

“They [legislators] don’t value what we do because when we do a good job, nothing happens! Our work prevents disease, injuries, and disability, and contributes to an improvement in quality of life – furthermore, those benefits don’t cost that much. But they [legislators] can’t see it! They seem to get lathered up about the
costs of Medicare and health insurance, and now bio-terrorism -- not public health.”

“They are kind of supportive but don’t know it. Take tobacco. Those who are against tobacco do support the budget for tobacco control. To the extent that health promotion is a part of the tobacco control effort, that’s the extent to which they support health promotion! The ability to use data from the BRFSS is especially helpful in getting their attention.”

DHPE respondents were asked to estimate what portion of the budget for health promotion programs in their state comes from: (1) federal sources, (2) their own state budget, or (3) other sources like grants from foundations, etc. With the exception of California, where the largest portion comes directly from categorical funding from the state budget, respondents indicated that about 75-80% of their health promotion budget comes from the federal government, almost all of which is through categorical grants and cooperative agreements with CDC. Most of the remaining amount comes from state funding; only a small portion of their health promotion budgets (1 or 2%) comes from other sources. The majority of states indicated that if the categorical grants (e.g., chronic diseases, HIV/STDs, injury, environmental health, birth defects, school health, BRFSS, etc.) were discontinued, there would be virtually no resources to support health promotion.

Summary of Salient Points: Organizational Capacity and Support

• Among senior leaders at CDC and in state health agencies, there is considerable variability in their understanding of health promotion and in the extent to which they value health promotion as a critical component of public health.

• Leaders who are perceived to be “more supportive” are those who have either had direct experience working with health promotion or see it as a necessary process or component for effective public health practice.

• Some leaders view health promotion, health education, health communication, and public information as relatively straightforward tasks that anyone with public health training could and should do. Others remain scientifically wary because researchers and practitioners describe the “effects” of health promotion without employing the traditional standards used for scientific assessment.

• Although high level understanding and support for health promotion is not yet the norm, it is steadily becoming stronger – this appears to be the case among state health agencies and CDC.

• The trend of increasing support parallels to two others: (1) health promotion becoming more predominant in public health policy and
professional literature, and (2) mounting evidence that well-planned health promotion does yield documented health benefits.

- Legislators understand health primarily in the context of health care and health services, especially as those programs are tied to state funding mechanisms like Medicaid. The majority legislators in states have only minimal awareness of public health, much less health promotion.

- With few exceptions, approximately 75-80% of health promotion budgets in states come the federal government, almost all of which is through categorical grants and cooperative agreements with CDC. Most of the remaining amount comes from state funding; only a small portion of their health promotion budgets comes from other sources.

- The majority of states indicated that if the categorical grants (e.g., chronic diseases, HIV/STDs, injury, environmental health, birth defects, school health, BRFSS, etc.) were discontinued, there would be virtually no resources to support health promotion.

## 2. Health Promotion Capacity: Skills

DHPE and CDC panelists generally agreed that the seven skills described in Table 1 represent a practical and valid interpretation of the essential skills needed to carry out effective health promotion programs. Respondents were asked to estimate state-level capacities for each of the seven skill areas, ranging from “extremely competent” to “needs substantial improvement.” Virtually all panelists qualified their responses indicating that a wide range of factors contributed to what they perceived to be considerable variability across and within states. Among other things, staff turnover at the state level, and to a lesser degree at CDC, made it difficult to provide an accurate assessment of capacity. Because of overlaps in the responses, skills 2, 3, and 4 are aggregated in the summaries below as well as skills 5 and 6.
Table 1. The Essential Skills of Community Health Promotion Practice

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<th>SKILL</th>
<th>GENERAL INDICATOR OF COMPETENCE</th>
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<td>1. Understanding the health problem (or problems) that constitute the focus of the health program</td>
<td>A working knowledge of a given health problem, including what is known about the factors and conditions known to influence the presence (or control) of the health issue in question and how that specific problem, and its multiple determinants, may be linked to other health and social issues.</td>
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<td>2. Conducting an appropriate health and social assessment</td>
<td>The ability to ascertain population health needs, taking into account cultural and historical idiosyncrasies of the area in question, and availability of economic and human resources, and the views and perceptions of multiple stakeholders.</td>
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<td>3. Planning theoretically sound health promotion programs</td>
<td>The ability to incorporate, where feasible, the application of the combination of strategies (shown to be effective in previous applications) to address the program needs based on evidence obtained in the health and social assessment.</td>
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<td>4. Applying appropriate health promotion strategies</td>
<td>The ability to implement and/or direct the effective implementation of health promotion strategies by others, including: (1) community development and community organization, (2) health education programs tailored to the needs of those in multiple settings (e.g. the community, schools, worksites, and clinical settings, (3) specific education of health care providers, (4) social marketing, (5) advocacy, (5) targeted health communication, and (6) the use of policies and the enforcement of existing regulations.</td>
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<td>5. Providing effective leadership and management to deliver programs and relevant services</td>
<td>The ability to: (1) promote a common vision and framework for the program in question, (2) call on skilled staff to carryout the program, (3) motivate staff at all levels (from top levels for funding to school level for implementation), (3) manage human and financial resources, and (4) work collaboratively with stakeholders from a wide range of sectors and interests.</td>
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<tr>
<td>6. Collaborating across sectors</td>
<td>The ability to: (1) identify common ground in priorities and unique contributions of different sectors and stakeholders, and (2) actively engage those stakeholders in aspects of the program relevant to them, and (3) maintain transparent communication with stakeholders.</td>
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<tr>
<td>7. Monitoring and evaluating processes and outcomes in health promotion</td>
<td>The ability to: (1) routinely monitor relevant health status indicators and their multiple determinants, (2) assess program progress including the effectiveness of intervention components, and (3) document, disseminate and use monitoring and evaluation results to publicize achievements and improve efforts.</td>
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Skills: Understanding health problems

State level practitioners appear to have a good working understanding of the specific health problems which constitute the focus of their programs. Respondents attributed this high level of competency to two factors: (1) CDC’s continuous investment of time and resources (pre-grant application workshops, periodic scientific updates and newsletters, annual meetings of the various CIOs, etc.), and (2) the reality that communicating knowledge about specific health problems is straightforward, and comparatively less complex than other aspects of public health practice.

Skills: Health/social assessment, planning and the application of appropriate strategies

Members of both panels found it unrealistic to respond independently to skills for assessment, planning, and application of intervention strategies because each element tends to be closely connected to others. Accordingly, the panelists’ comments regarding those three competencies are aggregated in this section. All respondents qualified their responses with this caveat: there is considerable variability in health promotion skills of practitioners across and within states, and across and within CDC. That variability is captured by the juxtaposition of these two comments:

“We are extremely competent in conducting health assessment and in planning. We have had an assessment plan in place for about nine years wherein we gather critical indicators at the local level - we have been at the forefront in looking at health disparities and we have a good handle on that.” [DHPE member]

“I was surprised by the number of people who were carrying out health promotion in regions with little or no training. Many had an experiential base, but it was like Swiss cheese - there were some big holes in the theories they used and most had limited assessment and evaluation skills.” [CDC Respondent involved in a state training program]

Several ASTDHPPE indicated that many practitioners working in states do not directly carry out the task of health and social assessment. Rather, their task is to provide some combination of training and technical support to their local counterparts who coordinate and/or conduct assessments in their respective
regions or communities.\footnote{The exceptions would include: (1) direct participation in state-level “demonstration” programs, or (2) participation in a review of health indicators, risk factors and social and economic determinants for the purpose of establishing state-level health goals and objectives as in the case of the \textit{Texas Declaration for Health} (December, 2002).} They also made the point that the same is true for planning. That is, for many state-level staff, the task of planning is often in the context of more macro-level strategic planning involving other state partners and community partners. The task of “program planning” per se is carried out at the local level.

While both state and CDC participants felt that the capacity in states to provide direction and support for the assessment process has been reasonably adequate, several acknowledged that the task of assessment was becoming increasingly more complex and challenging. One CDC respondent made this observation:

“To truly inform the planning process and, consequently the development of targeted strategies, there is a demand for expanding the range of indicators used in the assessment process . . . those related to quality of life, and a widening range of social, economic and cultural determinants. Which ones are feasible and reliable? What do they tell us? How do we use them? These are complex and important issues, and I don’t think we are well prepared for them at this time.”

Other respondents involved with health promotion programs addressing the needs of diverse populations commented that there was a growing need to enhance the level of stakeholder participation in all aspects of the assessment and planning process.

The general sentiment by both panels with respect to program planning may be summarized as follows: while the knowledge of how to plan programs at the state-level is very sound, they do not do enough of it. Respondents indicated that administrative duties, frequent changes in the organizational configuration of the health department, restrictive and unrealistic timelines, and limited economic and personnel resources are the major factors that tend to compromise effective planning. Sometimes, staff changes at CDC can interfere with or break up the continuity of state programs. One state respondent commented:

“We had a CDC program manager who knew our state inside/out and was incredibly helpful to us. That person took a new position and was replaced by someone with no experience in [topic area] and zero familiarity with our part of the country!”
Several DHPE panelists commented that CDC’s use of planning grants was a big help in overcoming many of the aforementioned barriers. One respondent said:

“Injury prevention gave us a one-year planning grant and that set us up for success. We ended up with a fabulous strategic plan that subsequently enabled us to do all of the little things that make a difference.”

State respondents made numerous references to initiatives undertaken by CDC that have been sources for enhancing their health promotion program planning and implementation capacities. Those initiatives included: (1) the Planned Approach to Community Health (PATCH), (2) Behavioral Risk Factor Surveillance System (BRFSS), (3) Mobilizing for Action through Planning and Partnerships or MAPP (supported jointly by the Public Health Practice Program Office at CDC and the National Association of City and County Health Officers - NACCHO), (4) a training course in “Evidenced-based Chronic Disease Prevention” offered by the School of Public Health in St. Louis, with funding from the NCCDPHP at CDC, and (5) the Assessment Initiative (Epidemiology Program Office). Also mentioned was IBIS, an innovative data system being employed by the Utah State Health Department in tracking health promotion activities in local health agencies.

Both CDC and DHPE respondents identified CDCynergy, a multi-media CD-Rom used to assist the design of health communications within a public health context, as a promising training tool. CDCynergy was developed by the Office of Health Communication at CDC in coordination with several CIOs and is currently being disseminated by the Society for Public Health Education (SOPHE). Although respondents indicated that they were aware of considerable training activity in states associated with CDCynergy, they were not able to comment on how that training has influenced practitioners’ capacities related to planning or implementation of health promotion programs.

In spite of the variability, most CDC panelists indicated that they could see a steady pattern of improvement in the process of planning and the application of intervention strategies. This improvement was reflected by the increased use of policy, regulatory and environmental change strategies, especially in the areas of injury prevention, tobacco prevention and control, school health programs, birth defects (folic acid), physical activity and cardiovascular disease prevention. Several state respondents indicated that the “social marketing” training course offered to state-level health promotion staff by the University of South Florida was very helpful in strengthening their planning and intervention capacities.

The examples of training and technical assistance described above are incomplete - more initiatives of that kind exist and are available as a service to health promotion practitioners both at the state and local level. The availability of these opportunities may give the appearance that state and local practitioners routinely take advantage of them. This is not the case. For example, some respondents, including those from CDC, were not aware of MAPP or the
Assessment Initiative; only two persons from either panel had ever heard of the Utah IBIS project. It is evident that innovations and training in health promotion at CDC are ubiquitous and appear to be of high quality. However, the potential impact of these efforts appears to be diminished because they have not been well-coordinated within CDC or across its CIOs.3

Skills: Provide effective leadership and promote collaboration across sectors

While CDC panelists indicated that some states appeared to have stronger leadership than others, “competent,” “dedicated,” and “professional,” were the terms most frequently used to describe those holding health promotion leadership positions in state health agencies. Some CDC respondents characterized some of the state health promotion leaders as professional entrepreneurs, because they used creative means to overcome conflicting political priorities and resource restrictions. In some states, creative health promotion leadership is a tradition. One CDC respondent stated:

“In [4 states named], they have had a tradition of strong health promotion leaders who nurture and maintain on-going relationships with advocacy groups, the health voluntary agencies, and universities, as well as other state health agencies like education, social services, and law enforcement. They are terrific coalition builders.”

CDC panelists commented that the most effective state health promotion leaders were those who have made a strong commitment to collaboration both within their respective health agencies and with organizations and groups from other sectors. For example, Utah uses what they call “cross-health work group teams” to encourage collaboration among staff from different categorical programs. For example, physical activity and nutrition staff work with pedestrian safety staff on a program called “Walk Your Kids to School Day.” Respondents from Kansas and Maine indicated that their programs have gotten strong support from close collaboration with health foundations in their states. To a question on collaboration, one DHPE respondent said:

“Collaboration? That is everything my office does. We work with local health departments and across other departments in the agency. Early on, because we started small, we saw the need to go outside of our office and create other resources with partners

3 Most of the technical support initiatives sited have very strong collaborative relationships with professional health organization outside CDC (MAPP with NACCHO and CDCynergy with SOPHE). The reference to the problem of coordination is primarily one within CDC and through the multiple CIOs within CDC to state health agencies.
who could help us. We had 4 or 5 people on the staff then, we have 40 now.”

Earlier in this report the point was made that California is one of the few states (perhaps the only state) where funds from the state legislature constitute the major source of budgetary support for health promotion programs. Historically, leaders in the California State Department of Health have maintained close contact with advocacy groups (voluntary health organizations, schools of public health, research institutes, and grassroots community groups) committed to the principles of public health. In regard to maintaining resources to support health promotion, the California DHPE said, “Frankly, it is the work of those advocacy groups that keeps us afloat.”

Comments from both panels suggest that state-level health promotion leaders who were deemed effective tend to share several common characteristics. One is “readiness.” That is, some seem to have the insight and ability to anticipate issues, or problems that were emerging and were likely to be priorities for future funding. Leaders with “readiness” were those who could find the means to secure local resources to generate community “pilot” programs or demonstrations. Later, when funding became available, they would have evidence of their state’s credibility and “readiness” to undertake larger, more robust efforts.

Several ASTDPHHE members pointed out that they had gained important leadership insights from formal and informal sources of “training.” Annual Professional meetings are examples of informal training. For example, the National ASDHPPHE Conference affords state leaders the opportunity to share their experiences and exchange ideas with colleagues from other states. An example of formal training is the Health Education Leadership Institute, which is coordinated by faculty at the St. Louis University and sponsored by DHPE, the Society for Public Health Education (SOPHE), and the National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP).

**Skills: Monitor and evaluate processes and outcomes in health promotion**

Respondents from both panels were consistent in their perceptions about two things related to the skills of monitoring and evaluation: (1) they constitute a critically important dimension of health promotion, and (2) at all levels of the public health system, they are in greatest need of clarity and improvement. The underlying factors perceived to be of greatest concern seemed to cluster into four general, but interrelated, categories: evaluation anxiety, confusion about the purpose of evaluation, time and cost, and complexity.

**Evaluation anxiety** - The idea of evaluation seems to generate a degree of anxiety for some practitioners. In some instances, the anxiety is triggered by the
perceived complexity of the task, especially when the language of evaluation is expressed in research terms: e.g., control groups, validity of measures, generalizable outcomes, etc. For some people, especially those in the community setting, anxiety is often triggered when evaluation is translated into “judgment.” That can occur when an evaluation report connotes failure and raises the possibility that funding will be diminished or discontinued.

**Confusion about purpose** - Is the purpose of evaluation to detect outcomes – that is, to show whether the program caused a specific health effect? Or is evaluation a means of quality assurance where the purpose is to monitor the processes of the program in order to provide on-going feedback for the purpose of making corrections and adjustments to the program? Or is it a combination of both?

**Complexity** - Health promotion programs tackle complex problems that exist in, and are influenced by, complex ecological factors. DHPE respondents were clear that their state and local colleagues are well-aware of those complexities, especially those that are encountered when the task of evaluation is to demonstrate program outcomes (e.g., point raised in previous item). They agree with the academic experts who point out that traditional, linear problem-solving methods do not meet the evaluation challenges local practitioners face. They also concur that a new paradigm is needed but have yet to see one practical enough for them to apply, given their day-to-day realities. However, as one DHPE respondent said: “I agree that we need a new paradigm, but it has to be one that allows us to undertake evaluation that is practical and relevant to our situation!”

**Time and cost** - Two dimensions of time were raised. One had to do with time in relation to outcome (especially if the purpose of the evaluation is to show a cause effect between the program and outcome). It can take considerable time to detect health improvement associated with a program intervention. In light of that reality programs are, for the most part, funded for 2 or 3 years. This becomes a practical issue because rarely can health outcomes be ascertained over a 2 to 3 year time period.

The second dimension of time is related to the investment of time and resources to carry out the evaluation process. Because gathering baseline data and collecting quantitative information is complex and expensive, it is frequently subcontracted out. One CDC respondent recalled situations where evaluation was handled as a separate item in a program budget. In those situations, evaluation is sometimes not integrated into the planning process early on, but tacked on at the end. When such programs face shortfalls, the “evaluation budget” can be cut, sometimes severely.

The need to strengthen the program evaluation in public health has long been recognized as a priority. In addition to those efforts cited earlier (MAPP, the course in “Evidenced-based Chronic Disease Prevention, and Utah’s newly
emerging IBIS data system, respondents mentioned other efforts that have been especially helpful in strengthening the evaluation skills of practitioners. One was CDC’s Framework for Program Evaluation, presenting the key principles and steps for carrying out effective program evaluation. Published as MMWR Report in 1999, the forward contained this statement by CDC Director Jeffrey Koplan:

“By integrating the principles of this framework into all CDC program operations, we will stimulate innovation toward outcome improvement and be better positioned to detect program effects. More efficient and timely detection of these effects will enhance our ability to translate findings into practice. Guided by the steps and standards in the framework, our basic approach to program planning will also evolve. Findings from prevention research will lead to program plans that are clearer and more logical; stronger partnerships will allow collaborators to focus on achieving common goals; integrated information systems will support more systematic measurement; and lessons learned from evaluations will be used more effectively to guide changes in public health strategies. MMWR, September 17, 1999 / 48(RR11);1-40”

Another example was one that appeared to follow up the above call to integrate the principles of the framework into the agency’s various programs. Based on the principles of the Program Evaluation Framework, the Office on Smoking and Health (OSH) created a training program for state tobacco prevention and control programs called Program Evaluation for Comprehensive Tobacco Control. It includes a published evaluation manual and detailed curriculum with practical exercises. Even though the OSH program appears to be relevant and technically sound, to this point, its “reach” is limited. In the past three years, only a total of 150 state participants have taken the OSH evaluation course.

Important Perceptions from the State

Overall, the DHPE respondents were unanimous in their perception that state-level health promotion programs benefit greatly from the economic and technical support and training opportunities afforded them by their counterparts in programs throughout CDC. They are also cognizant of the scientific and political rationale behind categorical program funding and most have found ways to integrate health promotion/disease prevention and control program activities in their states without compromising the intent and integrity of a given categorical approach.

However, state level practitioners rather consistently expressed the a degree of frustration over inconsistencies that range from subtle differences in terminology for similar evaluation activities to the problem that coordinators of CDC health promotion programs appear to operate with little awareness of what their counterparts in other CIOs (and sometimes within their own CIO) are doing.
These perceived inconsistencies are attributed to several factors: (1) the exponential growth of programs and activities related to health promotion within the various CIOs at CDC, (2) limited staff time, (3) no recognized focal point or coordinating center for health promotion, (4) territorial prerogatives that keep categorical programs in their “silos,” and (5) the apparent lack of vision that such coordination is necessary.

DHPE respondents indicated that this internal lack of coordination can have subtle but important implications for health promotion practitioners at the state level. One DHPE member detailed the following example. She and a staff colleague had participated in the social marketing and health course supported by CDC at the University of South Florida. As a part of their training, they were asked to apply a social marketing strategy to a specific categorical health problem they were addressing in their state. During the course, they developed a market analysis strategy to get information that would enable them to tailor a community-based [specific health category] program to meet the needs of a specific population in their state. This approach would also give them critical indicators to use in their evaluation. They incorporated their market analysis strategy into their next CDC cooperative agreement application. After submitting their proposal, their CDC program officer informed them that their application was going to be held up because of the formative research aspect of the social marketing component. Staff from CDC’s Procurement and Grants Office (PGO) said the proposal required an IRB review. Eight months and numerous revisions later, they received their program grant.

The ASTDHPPE respondent translated that story as follows:

“At the recommendation of CDC, we received training (sponsored by CDC) to strengthen our intervention and evaluation capacities. We applied what we learned to a cooperative agreement application the state. We were told it was a sound application. Our application process was delayed for a year. Clearly the buck stops with us – in retrospect, we should have known that PGO would interpret our assessment as “formative” research and in need of an IRB review. It sure would have been helpful if that issue was a part of the training. Do you know if CDC program staff interacts at all with PGO to anticipate these kinds of problems?”
General Note: Peer Assistance and Training

Several members of the DHPE and CDC panels cited two separate, but similar examples of “consultation site visits to states” as effective models for overall training and, consequently, leadership development. Both received considerable praise. In one, a given state requests consultation on specific issues and ASTDHPPE (the sponsoring organization) contacts leaders from other states who have experience in the area of interest. Those leaders (consultants) constitute a consultant team and work with the state requesting assistance during a prearranged site visit. Although a comparatively new, this initiative received very positive feedback from those who had experienced it first hand.

The other model is called the State Technical Assessment Team (STAT) Program and is designed to assist state health departments in developing capacity and enhancing injury prevention programs. The STAT Program brings a team of injury prevention experts into a state for a week-long site visit. During the visit, the team interviews the staff and partners of the state’s injury prevention program, assesses the primary prevention capacity of the program at that point in time, and produces a report describing the status of the program and recommendations for its advancement. STAT is co-sponsored by CDC and the Health Resource Services Administration, Maternal and Child Health Bureau (HRSA/MCHB). Within this report, these models will be referred to as Peer Assistance and Training (PAT).

Summary of Salient Points: Health Promotion Skills

- While there is considerable variability among and within states, those responsible for health promotion programs in states appear be generally competent in applying the skills required to plan and implement those programs.

- In some skill areas (e.g., local-level health assessment and monitoring, leadership and collaboration), the level of competency in several states was deemed extraordinary.

- Although most state-level health promotion practitioners have a good working “knowledge” of how to plan programs, there is a perception that they do not do enough of it.

- The perception that more attention needs to be given to planning at the state level may be in part the result of competing administrative duties, frequent changes in the organizational configuration of the health department, restrictive and unrealistic timelines, and limited economic and personnel resources. It may also be a function of the reality that most planning in states is done at the local level, and the primary
planning task for state-level personnel is one of training and/or technical support with local-level counterparts.

- Participants deemed the need to strengthen evaluation skills to be a universal priority.

- Training programs designed to improve the evaluation of health promotion programs should address several barriers including: evaluation anxiety, complexity, clarifying the purpose of evaluation, problems of time and cost, and access to training.

- CDC, often in collaboration with professional health organizations including DHPE and SOPHE, has developed a wide range of training and technical support initiatives which state-level practitioners have found very helpful in enhancing their health promotion skills and competencies.

- Among the training examples, the “Peer Assistance Training” received strong support. However, because these technical support efforts are not well-coordinated within CDC (and consequently across state health agencies), their contribution to improving health promotion within the CDC/state health agency “system” has been limited.
3. Priority Health Issues

DHPE panelists were asked to identify the priority health problems (e.g. diseases, risk factors, social/economic/environmental determinants) that were being addressed by health promotion programs in their respective states. They were also asked to describe how those priorities were determined. Generally, priority health issues were predicted by the organizational location of the respondent and the extent to which those programs were funded either through state budget appropriation, federal grants and cooperative agreements, or, in the case of tobacco, tobacco settlement monies. Thus, those working in chronic disease units or programs identified cardiovascular disease, diabetes, breast and cervical cancer and their attending risk factors as priorities. Members of the DHPE panel did not interpret CDC’s funding national priorities as a “top down” federal mandate. As one state respondent said:

“National health priorities are based on data gathered in states and communities. Chronic diseases, injuries, HIV, environmental health – all of these issues are priorities for us.”

Priorities appear to be shaped by a myriad of factors including:

- State health plans or policies (a model consistent with Healthy People 2010);
- BRFFS data indicating that specific risk factors are disproportionately high in their state (e.g., rates of smoking, obesity, physical inactivity, screening, etc.);
- Results from the analysis of local area data indicating priority problems unique either to specific localities or populations (e.g., native Americans);
- Budget allocations from the tobacco settlement, specific legislative mandates.

Health promotion per se could be seen as a “priority” to the extent that: (1) leaders in the states insured that it was a component of public health strategies aimed at redressing priority health problems, and (2) CDC program grants called for the inclusion of strategies consistent with effective health promotion practice.

Several DHPE respondents commented that they have observed a gradual decline in “stand alone” health promotion units. They felt that such units were important because they served as a focal point to provide continuity and expertise for training across the health department, especially in the areas of community assessment, coalition development, and in community intervention and policy strategies. They said that states have a strong tendency to follow actions taken by CDC:
States tend to follow CDC’s lead; if they develop chronic disease units, so will we; if they have a health promotion focal point, we will too.

One ASTDHPPE respondent expressed the concern that this decline might diminish the importance of having a non-categorical focal point to promote key aspects of effective public health promotion practice.

“We have been working with the Robert Wood Johnson “Turning Points Initiative” and it has proven to be very effective not only in helping communities identify and “own” health issues of concern to them, but also in finding resources to act on those issues of local concern. We provide training to staff in other areas like CVD, diabetes and injury. Like most of the core aspects of health promotion, “Turning Points” is not health problem specific. Without a unit like ours (health promotion), I don't think the categorical units in the rest of the agency would have the capacity to do this kind of community assessment and development work.”

Summary of Salient Points: Priority Health Issues

- Priority health issues in states are not inconsistent with national priorities reflected by documents and process like Healthy People 2010.
- Health promotion is a key component in programs addressing virtually all public health priorities.
- Health promotion per se is a priority to the extent that it is seen as a priority component in effective health promotion programs.
Conclusions and Options for Action

“W hat can we do to improve?” That was the basic question posed in this report. Often, when we raise that question our natural tendency is to ask another question: “what’s wrong?” “What’s wrong with health promotion at CDC?” “What’s wrong with the practice of health promotion in states?”

During the interview process used to gather information for this report, rarely did a panelist address a problem or concern without calling attention to a positive dimension related to that problem or concern. Their comments were not framed in the context that something was “wrong” or that health promotion was in disarray. On the contrary, the spirit in which comments were offered was that health promotion has a strong foundation and is well positioned to take those actions deemed strengthen health promotion as an essential component of public health.

Accordingly, this report offers the following four recommendations. Each recommendation includes: (1) a specific goal, (2) the delineation of actions proposed to achieve that goal, (3) a brief justification based on findings from the assessment process.

Recommendation 1 - Re-establish a Health Promotion Focal Point at CDC

**Goal:** Establish an official CDC focal point for health promotion with the responsibility of assuring that health promotion components of CDC health programs employ common guidelines, standards and terminology in their program grants and training programs.

**Action:** DHPE should identify a health promotion professional whose task would be carry out a strategic assessment to determine how, taking into account organizational, communications, and feasibility perspectives, such a focal point would be best situated within the agency. It is recommended that the person responsible for carrying out the strategic assessment be situated at the CDC and deliver a final report within one year of initiating the assessment process. Funding for this assignment should be made available through the National Center for Chronic Disease Prevention and Health Promotion. It is further recommended that the findings from this report be used as an initial point of departure for developing the assessment process.
**Justification:** Clearly, the exponential growth in resources to states from CDC to support health promotion has contributed greatly to state-level health promotion capacity. This is in part manifested by CDC’s development of technical support and training innovations (e.g., CDCynergy, MAPP, the CDC Framework for Program Evaluation, Integrated School Health Programs). However, that growth has been accompanied by a concurrent increase in the fragmentation (discontinuity) in communications, and technical support from CDC CIOs to states. There is evidence that both state and CDC health promotion staff believe that, left unaddressed, such discontinuity will inevitably impair efforts to achieve the health improvement goals of programs.

**Recommendation 2 - Create an Inventory of Health Promotion Programs That Work**

**Goal:** Establish a single, easy-to-access source that describes the health benefits and (as appropriate) the cost effectiveness of public health promotion programs.

**Action:** Working with their respective counterparts in state health agencies, CDC CIOs should create an on-line inventory of those public health promotion strategies and programs for there is evidence for their effectiveness. An inventory of “health promotion practices that work” should follow an evidenced based process that highlights those health promotion strategies which have been shown to yield tangible health benefits. At minimum, the inventory should include (1) the health benefits gained, (2) descriptions of key mechanism(s) accounting for those benefits, (3) the costs and time required to attain the desired outcome.

**Justification:** Results of this assessment confirm the findings from previous studies: traditionally, neither politicians nor the general public have more than a modest understanding of benefits yielded by public health and, therefore health promotion. This appears to remain the case nationwide for most state legislators. The majority tend to frame health in the context “health care,” especially the funding of health care services. This incomplete view of public health, coupled with severe budget limitations in states, exacerbates to the difficulties faced by state health agencies as they seek appropriations to support their programs.

Within the system of public health practice in the United States (public health agencies at the federal, state and local level of government) there is currently no single, easy-to-access source that describes the effectiveness of public health promotion programs. Access to such information is essential if public health professionals are to make a credible case for the benefits of investments in health promotion programs.
Recommendation 3 - Develop and Implement a Strategic Plan to Strengthen the Evaluation Capacities of State Practitioners

Goal: Improve the evaluation capacities of state health promotion practitioners.

Action: As part of its annual national meeting, DHPE, in close collaboration with all CDC CIOs and the Academic Prevention Research Centers Program, should hold a jointly sponsored “Evaluation Summit.” With input from relevant health promotion program evaluation stakeholders representing national, state, and local perspectives, the goal of the summit should be to produce a scientifically credible and practical document that delineates the common principles, guidelines, and terminology for health promotion program evaluation.

NOTE: This recommendation includes two important extensions: (1) As a part of CDC’s commitment to public health workforce development, implement a training program within the agency for all program and grants managers instructing them on how to frame evaluation tasks in crafting proposal guidelines (RFAs/RFPs) such that carrying out those tasks in the scope of work will be consistent with the common program evaluation guidelines. As such, it is recommended that evaluation should be incorporated as an integral part of the entire planning and program implementation process and should not just an “added component,” and (2) as a part of workforce development, insure that all public health program training institutes, programs, and workshops that are endorsed or supported by CDC incorporate (where appropriate) common evaluation terminology and standards into the training.

Justification: Program evaluation problems appear to be associated with two related factors: (1) variable levels of skills among practitioners across the states, and (2) the absence of consistent and coordinated evaluation expectations and processes among the various CDC categorical program grants. The latter is deemed a first priority for action because without clear and consistent evaluation goals and principles, even skilled practitioners will be confounded when they are asked to address ever-changing evaluation goals and expectations. This is especially problematic for state and local-level practitioners who wear the hats of multiple programs (e.g., cardiovascular disease, diabetes, injury, school health). In most states, this is the norm.
Recommendation 4 – Refine and Expand the DHPE Peer Assistance Training Program

**Goal:** To provide practical, timely, peer-based health promotion technical assistance tailored to address local (state) needs.

**Action:** DHPE, with financial support from CDC, should provide support to refine and accelerate the implementation of the Peer Assistance and Training model (PAT) model. Refinement would include: (1) developing a mechanism for identifying, selecting and training prospective peer leaders, (2) adding, as deemed appropriate, selected CDC staff and faculty from Preventions Research Centers (PRCs) to the peer teams, (3) incorporating an evaluation protocol to the process, and (4) provide options for the integration of programs across categorical health topics.

**Justification:** The continuous development of health promotion technology presents an on-going challenge for practitioners as they try to keep pace with the emerging innovations in planning, and theory development, and intervention strategies and tactics. Effective health promotion workforce development in states faces two central challenges. The first has to do with timing. Innovations are commonly shared at annual state or national meetings. However, these are usually plenary sessions and even if they are presented at workshops, they are too brief to develop the level of competence needed for implementation. Practitioners would benefit greatly from a system that gives them in-depth exposure to “late breaking” innovations and developments.

The second challenge has to do with differences among the states. The “variability” in skills noted in this report is in large part a function of the reality that, other than evaluation, training needs vary across the spectrum of the seven health promotion skills. While assessment skills may surface as a training priority in West Virginia, the priority needs in North Dakota may be the application of innovative strategies to combat obesity. Thus, practitioners would also benefit from a system that provides them with training that is tailored to their unique needs and circumstances.

Input from the two panels in this study suggests that: (1) priority attention should be given to the development of a more efficient strategy for health promotion workforce development; (2) the PAT model has been “field tested” and perceived to be credible, effective and relevant by users, (3) that, as a general philosophy, health promotion technical assistance to states should be viewed as a part of a comprehensive, on-going system of support, not a “one shot” effort.

A caveat to the PAT recommendation is that care has to be taken not to create an unreasonable burden on the peers who are being asked to provide technical support. Furthermore, specific efforts should be undertaken to
insure that health officers are aware and supportive of the service and benefits this program yields.
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**Florida** Department of Health

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**Idaho** Dept of Health & Welfare

Paula F. Marmet
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**Kansas** Department of Health and Environment

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**Louisiana** Office of Public Health

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Grant Baldwin – Site Activities Branch, Division of Health Education and Promotion, ATSDR

Jim Belloni – Office of the Director, NCI PC

Joan Cioffi – Office of the Director, PHPPO

Janet Cleveland – Capacity Building Branch, Division of HIV/AIDS, NCHSTP

Galen Cole – Division of Health Communication, Office of Communication, Office of Director, CDC

Richard Gillig – Site Activities Branch, Division of Health Assessment and Consultation, ATSDR

Corinne Graffunder – Division of Violence Prevention - NCI PC

Meredith Hickson – Office of the Director, NCI D

Pete Hunt – Division of Adolescent and School Health, NCCDPHP

Dennis Jarvis – Prevention Specialist Program, Epidemiology Program Office

Cynthia Jørgenson – Division of Cancer Prevention and Control, NCCDPHP

Sarah Kuester – Division of Nutrition and Physical Activity, NCCDPHP

Brick Lancaster – Office on Smoking and Health, NCCDPHP

Katherine Lyon-Daniel, Behavioral Science and Health Education Division, NCBDDD

Jeannette May – Division of Diabetes Translation, NCCDPHP

Jude McDivitt – Division of Nutrition and Physical Activity, NCDPHP

Mary Neumann – Prevention and Research Branch, Division of STD Prevention, NCHSTP

Sarah Olson – Division of Unintentional Injury Prevention, NCI PC
Appendix C: Discussion Guide for DHPE Directors
In preparation for our interview, please review the assumptions and the 11 self study questions included below.

**Assumptions underlying the questions being asked:**

First, for many, it is difficult to distinguish the differences between *Health Promotion, Health Education, and Health Communication*. Here are three definitions:

**Health Communication.** The study and use of methods to inform and influence community decisions that enhance health.

**Health Education.** Any planned combination of learning experiences designed to promote the voluntary adaptation of behavior conducive to health in individuals, groups, or communities.

**Health Promotion.** Any planned combination of educational, political, regulatory, and organizational supports for actions and conditions of living conducive to health in individuals, groups, or communities.

During our discussion, we will **not** spend time teasing out the independent, unique merits of each discipline. Rather, we will assume that all three share considerable common ground and that health promotion represents a reasonably comprehensive umbrella under which you can frame your comments and recommendations. **If you need to make reference to a specific discipline, please feel free to do so in your response.**

For the purposes of our discussions, “Health Promotion Capacity at the State Level” will be understood to require two complementary components: (1) the presence of health program planning, implementation, and evaluation skills, and (2) the organizational structures, resources and commitment needed to support the implementation of those skills.

The specific skills of health promotion are generally captured in the following list:

- **Understanding** the health problem (or problems) that constitute the focus of the health program. Such understanding includes what is known about the factors and conditions known to influence to presence (or control) of the health problem(s) in question.

- **Conduct an appropriate assessment** to ascertain population needs, cultural and historical idiosyncrasies, and resources.

- **Plan theoretically sound health promotion programs** that incorporate, whenever feasible, the application of strategies and tactics (shown to be effective in previous applications) to address the needs identified through the assessment.
Effectively apply health promotion strategies and tactics including: (1) health education programs in community, school, worksite and clinical settings, (2) specific education of health care providers, (3) targeted health communications, and (4) the use of policies and the enforcement of existing regulations.

Provide effective leadership and management to deliver programs and relevant services. This includes the capacity to: (1) promote a common vision and framework for the program in question, (2) call on skilled staff to carryout the program, (3) motivate staff at all levels (from top levels for funding to school level for implementation), (3) manage human and financial resources, and (4) continually assess and respond to leadership and management needs.

Collaborate across sectors. This includes the capacity to: (1) identify common ground in priorities and unique contributions of different sectors and stakeholders, and (2) coordinate to leverage the resources that each can contribute to the program effort in question.

Monitor and evaluate processes and outcomes in health promotion. This would include the capacity to: (1) routinely monitor relevant health status indicators and determinants of health, (2) assess program progress including the effectiveness of intervention components, and (3) document, disseminate and use monitoring and evaluation results to publicize achievements and improve efforts.

INTERVIEW QUESTIONS

The first 4 questions ask for your perception of the state level support given to health promotion.

1. Support for health promotion by the State Health Department?

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<th>3</th>
<th>2</th>
<th>1</th>
<th>0</th>
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<tbody>
<tr>
<td>Unequivocally</td>
<td>Generally</td>
<td>Sometimes</td>
<td>Generally</td>
<td>Not Supportive</td>
</tr>
<tr>
<td>Supportive</td>
<td>Supportive</td>
<td>Supportive</td>
<td>non-supportive</td>
<td>Sure</td>
</tr>
</tbody>
</table>
If response is 4 or 3, ask what accounts for that support?

If response is 2, 1 or 0, please explain why.

Are health department leaders more or less supportive than 5 years ago?

2. Support for health promotion programs among state political leaders?

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<tbody>
<tr>
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<td>Generally</td>
<td>Sometimes</td>
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<tr>
<td>Supportive</td>
<td>Supportive</td>
<td>Supportive</td>
<td>non-supportive</td>
<td>Sure</td>
<td></td>
</tr>
</tbody>
</table>

If response is 4 or 3, ask what accounts for that support?

If response is 2, 1 or 0, please explain why.

Are political leaders more or less supportive than 5 years ago?

3. How would you assess the economic support for health promotion programs and staff at the state level?

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</thead>
<tbody>
<tr>
<td>Consistently</td>
<td>Adequate only</td>
<td>Marginally</td>
<td>Not at all</td>
<td>Not Adequate for High priority Adequate Adequate Sure</td>
<td></td>
</tr>
<tr>
<td>health problems</td>
<td></td>
<td></td>
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</tbody>
</table>

If response is 4 or 3, ask why? If response is 2, 1 or 0, ask why not?
4. Suppose you had a pie chart in front of you representing the budget for health promotion programs in your state. Divide the pie into three parts to represent the proportion that comes from: (1) federal sources, (2) your state budget, or (3) other sources like foundation grants, etc. What percentage comes from each?

______________  _______________  _______________
Federal         State           Other

5. What are priority health problems (e.g. diseases, risk factors, social/economic/environmental determinants) being addressed by health promotion programs in your state? (On what basis were they deemed priorities?)

6. Based on your experience, how would you characterize the current health promotion capacity at your state health department level in terms of the seven categories below?

Extremely Competent  Competent  Needs Substantial Improvement

Understanding of health problems  EC C NSI
Community assessment/Planning  EC C NSI
Application of strategies/tactics  EC C NSI
Leadership and management  EC C NSI
Collaboration  EC C NSI
Monitoring and evaluation  EC C NSI

7. What would you say are the strengths of health promotion in your state?
8. Are there specific issues or problems that hinder the improvement of health promotion capacity in your state?

9. What have been the main sources for health promotion capacity building in your state? (E.g., in-service training, academic courses/workshops, special training from federal government, distance learning, on-line or e-tools, etc.)

10. Have those actions made a difference in your state? (Were they evaluated?)

11. Given your perspective, what actions would you urge CDC to consider (beyond its current efforts) to strengthen the capacity of state level health promotion practitioners? Please provide the rationale for your suggestion.
Appendix D: Discussion Guide for CDC Participants
Introduction:

Before we get started in our discussion, I would like to clarify two points regarding terminology.

First, for many, it is difficult to distinguish the differences between Health Promotion, Health Education, and Health Communication. Here are three definitions:

*Health Communication:* The study and use of methods to inform and influence community decisions that enhance health. (Friemuth)

*Health Education:* Any planned combination of learning experiences designed to promote the voluntary adaptation of behavior conducive to health in individuals, groups, or communities. (Green and Kreuter)

*Health Promotion:* Any planned combination of educational, political, regulatory, and organizational supports for actions and conditions of living conducive to health in individuals, groups, or communities. (Green and Kreuter)

During our discussions, we will not spend time teasing out the independent, unique merits of each discipline. Rather, we will assume that all three share considerable common ground and that health promotion represents a reasonably comprehensive umbrella under which you can frame your comments and recommendations. *If you need to make reference to a specific discipline, please feel free to do so in your response.*

Second, for the purposes of our discussions, “Health Promotion Capacity at the State Level” will be understood to require two complementary components: (1) the presence of health program planning, implementation, and evaluation skills, and (2) the organizational structures, resources and commitment needed to support the implementation of those skills.

The specific skills of health promotion are generally captured in the following list:

- Understand the health problem (or problems) that constitute the focus of the health program. Such understanding includes what is known about the factors and conditions known to influence to presence (or control) of the health problem(s) in question.

- Conduct an appropriate assessment to ascertain population needs, cultural and historical idiosyncrasies, and resources.

- Plan theoretically sound health promotion programs that incorporate, whenever feasible, the application of strategies and tactics (shown to be effective in previous applications) to address the needs identified through the assessment.
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Provide effective leadership and management to deliver programs and relevant services. This includes the capacity to: (1) promote a common vision and framework for the program in question, (2) call on skilled staff to carryout the program, (3) motivate staff at all levels (from top levels for funding to school level for implementation), (3) manage human and financial resources, and (4) continually assess and respond to leadership and management needs.

Collaborate across sectors. This includes the capacity to: (1) identify common ground in priorities and unique contributions of different sectors and stakeholders, and (2) coordinate to leverage the resources that each can contribute to the program effort in question.

Monitor and evaluate processes and outcomes in health promotion. This would include the capacity to: (1) routinely monitor relevant health status indicators and determinants of health, (2) assess program progress including the effectiveness of intervention components, and (3) document, disseminate and use monitoring and evaluation results to publicize achievements and improve efforts.

INTERVIEW QUESTIONS

Based on your experience, to what extent do you think that CDC administrators understand the role that health promotion plays in public health programs?

<table>
<thead>
<tr>
<th>Fully understand</th>
<th>Understand somewhat</th>
<th>Not at all</th>
<th>Can’t say</th>
</tr>
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<tbody>
<tr>
<td>3</td>
<td>2</td>
<td>1</td>
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</table>

Based on your experience, to what extent do you think that CDC administrators value the role that health promotion plays in public health programs?

<table>
<thead>
<tr>
<th>Strongly value</th>
<th>Value somewhat</th>
<th>Value very little</th>
<th>Can’t Say</th>
</tr>
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<tbody>
<tr>
<td>3</td>
<td>2</td>
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</table>
3. Based on your experience, how would you characterize the current health promotion capacity at the state level in terms of the seven categories cited above? (NOTE: This is a difficult question because of the variability between the states - try to frame your response to reflect your perception of the norm.)

**Extremely Competent  Competent  Needs Substantial Improvement**

- Understanding of health problems: EC C NSI
- Community assessment/Planning: EC C NSI
- Application of strategies/tactics: EC C NSI
- Leadership and management: EC C NSI
- Collaboration: EC C NSI
- Monitoring and evaluation: EC C NSI

4. What HP capacity building actions have been or are currently being undertaken by your Division?

5. Is there any evidence that those actions made a difference?

6. Given your perspective, what actions might CDC take (beyond its current efforts) to strengthen the capacity of state level health promotion practitioners? Please provide the rationale for your suggestion.

7. What barriers stand in the way of making yours suggestion a reality? How can those barriers be overcome?