

Communicating the Effectiveness of Health Promotion to State-Level Decision-makers and Legislators

*A Directors of Health Promotion and Education (DHPE)
White Paper*

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Introduction and Background

This paper was developed based on the following general assumptions posed by members of the Executive Committee of the Directors of Health Promotion and Education (DHPE):

- Based on their experience, neither the science base nor the benefits of health promotion programs are well understood by public health decision-makers or state legislators.
- Armed with evidence of the science base and benefits of health promotion programs, health promotion leaders would be better positioned to heighten the awareness of and support for health promotion among state legislators.

Internationally, health promotion scholars believe that these concerns merit priority attention:

Improving the evidence base of health promotion is high on the agenda of the international health promotion community and it is becoming increasingly apparent that evidence is needed by practitioners for effective health promotion interventions. It is generally accepted that with quality findings from intervention studies, practitioners can make better decisions to achieve effectiveness in their interventions. Moreover, without evidence of effective health promotion, it may be difficult to obtain policy support. Tang, Ehsani and McQueen¹ (p. 841)

Based on the DHPE assumptions, the questions guiding the development of this paper were two:

1. What is the evidence indicating that health promotion programs are effective?
2. Assuming that health promotion programs yield benefits, what is the most effective way to communicate that to public health decision-makers and legislators at the state level?

Methods

Globally, the question of what constitutes “evidence” of health promotion program effectiveness has given rise to a complex and ongoing debate. At the core of the debate is a lack of agreement on what constitutes appropriate and feasible standards to ascertain program effectiveness. We concur with Rychetnik and colleagues, who suggest that the resolution of the debate will require coming to consensus on some type of hierarchy of evidence that takes into account a range of critical factors including program design, implementation, context, longevity, and documentation of outcomes.²

Accordingly, to address the question of the health promotion program effectiveness in this paper, we sought examples from three “levels” of evidence: (a) programs cited in the *Guide to Community Preventive Services*, which uses a systematic review process based on specific inclusion criteria; (b) programs cited in published journal articles; and (c) programs reported by DHPE directors in their response to a survey requesting examples of health promotion carried out in their respective states that they deemed “successful.” We hasten to point out that we did not undertake a formal meta-analysis; our goal was simply to determine the extent to which evidence of health promotion program effectiveness could be ascertained at the three levels examined.

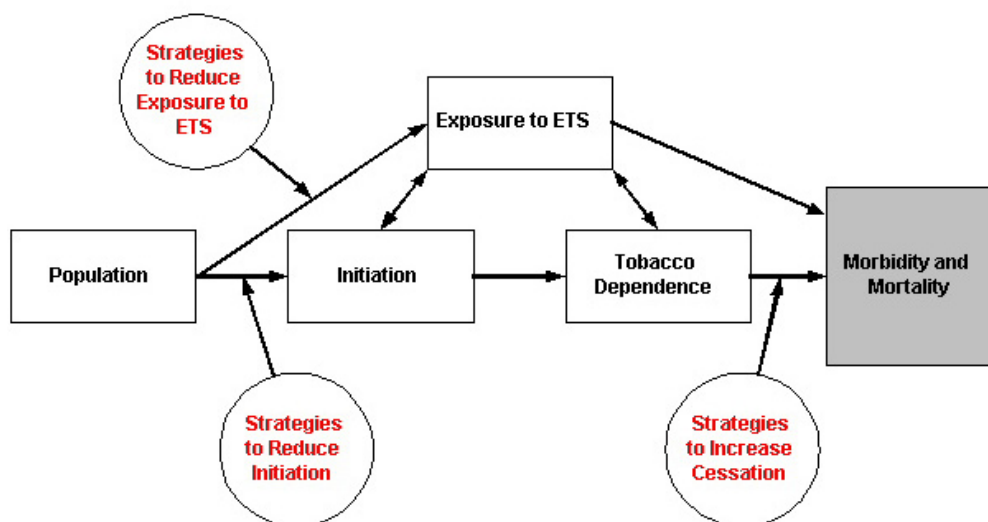
To address the question of how best to communicate the message of health promotion effectiveness to state legislators, we examined both journal articles and guideline documents published by professional organizations that highlighted those factors deemed most relevant in effectively communicating health concepts and issues to state legislators. To add insight to this question, we also sought input through interviews with a small sample of state legislators, former legislative staffers, and health officials with experience interacting with state legislators.

Health Promotion Effectiveness: The *Community Guide*

The *Guide to Community Preventive Services* represents an ongoing national effort to promote evidence-based disease prevention and health promotion programs for defined populations.³ The process was developed by a 15-member, non-federal, independent panel of experts with support from selected subject matter experts, methodologists, and scientific staff. Recommendations were made based on the careful review and assessment of a wide range of evidenced-based intervention programs focusing on the following categorical risk factors and health problems: tobacco, physical activity, the social environment, cancer, diabetes, vaccine preventable diseases, oral health, motor vehicle occupant injury, and violence. All of these areas are among the critical health objectives delineated in Healthy People 2010.⁴

Each problem area addressed by the *Guide* uses a logic model to illustrate the context and the key points within that context upon which interventions can be directed. **Figure 1** shows the logic model that was used for the tobacco area. The three circles denote the kinds of intervention strategies that are intended to have a preventive effect on a specific tobacco problem inferred in several links in the logic model. For example, the arrow linking the boxes labeled “population” and “exposure to environmental tobacco smoke (ETS)” reflects evidence of the public health harm caused by ETS. The circle labeled “strategies to reduce exposure to environmental tobacco smoke” highlights the importance of having effective interventions to counter the problem of ETS.

Figure 1
The Guide to Community Preventive Services - Logic Model for Tobacco



Logic framework illustrating the conceptual approach used in systematic reviews of tobacco use. (ETS = Environmental Tobacco Smoke.) Reprinted from *Am J Prev Med*, Vol. 20, No. 2S, Hopkins DP et al., Reviews of evidence regarding interventions to reduce tobacco use and exposure to environmental tobacco smoke, p. 18.

Based on specific recommendations featured in the 2005 text version of the *Guide*, we highlight findings from two areas: tobacco and social environment.

Tobacco

In tobacco prevention, several basic health promotion strategies were deemed to have “strong evidence” of effectiveness:

- Health promotion policy strategies designed to increase tobacco taxes reduces tobacco consumption among adults. Studies show that a 10% price increase results in a 4% decrease in the amount smoked by adults. This same price increase yields a 2% decrease in smoking by adolescents and young adults.
- Community mobilization strategies, when combined with other interventions, are effective in reducing tobacco consumption among young people by 5.8 percentage points.
- Mass media campaigns, also when combined with other interventions, can reduce tobacco consumption among young people by 2.4 percentage points.

It is interesting to note that although we found studies by Feighery,⁵ Forster,⁶ Jason,⁷ and Rigotti⁸ showing that enforcing existing laws against cigarette sales to youth through regular retailer compliance checks and issuing civil penalties to retailers can significantly reduce youth smoking, the *Guide* concluded that there was insufficient evidence to determine the effectiveness of laws directed at minors’ purchase, possession, or use of tobacco products when implemented alone in efforts to reduce minors’ access to and use of tobacco products.

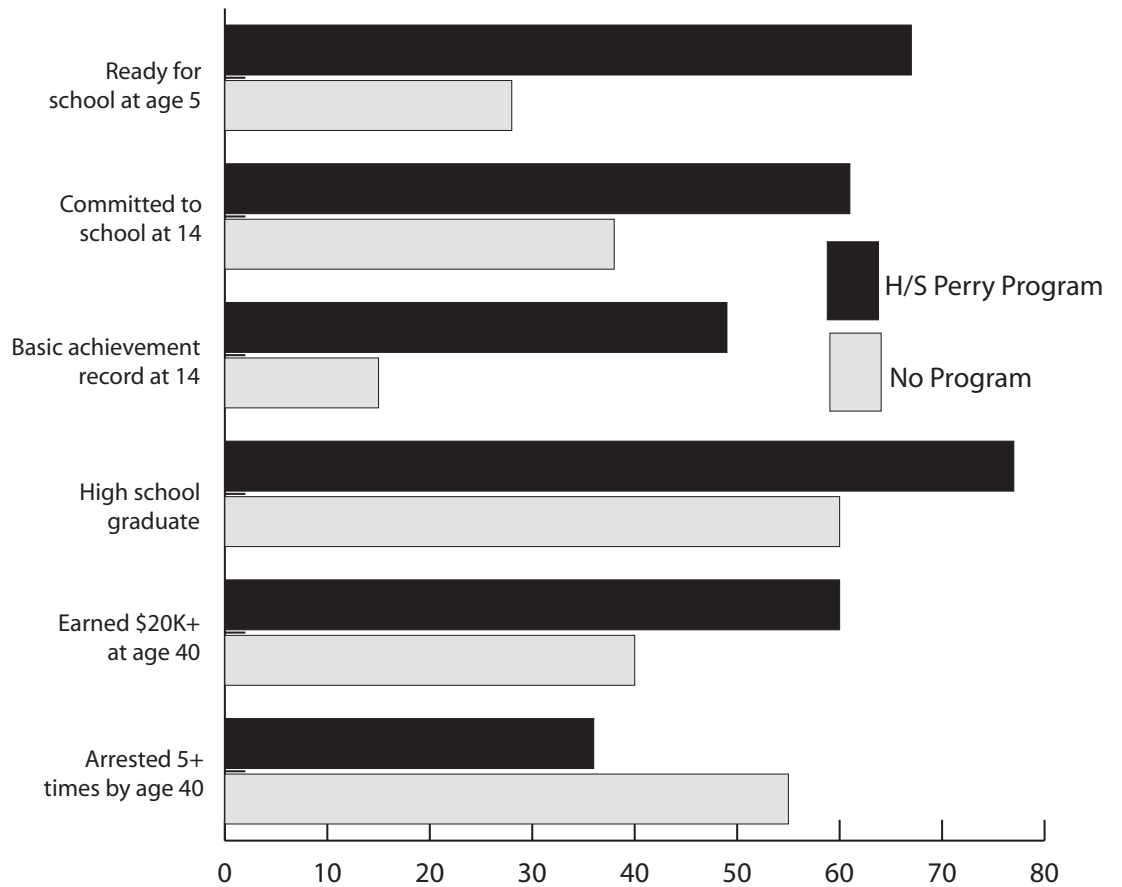
This provides a clear illustration of one of the critical issues embedded in the aforementioned international debate over what indeed constitutes “evidence” of program effectiveness. As advocates point to the beneficial effects of health promotion programs, they should acknowledge that the selection protocols used by review processes such as the *Guide to Community Preventive Services* and the Cochran Collaboration employ research design selection criteria that are intended to enhance the “certainty” and strength of their recommendations. At the same time, however, the use of such criteria can lead to the exclusion of programs that may in fact yield very positive health benefits.

Social Environment

In the category of the Social Environment there was “strong” evidence that comprehensive, center-based, early childhood development programs for low-income children low-income were effective in improving the cognitive, social and emotional functioning of preschool children as well as their readiness to learn.

A 40-year longitudinal study provides a dramatic example. Comparing the effects of the High/Scope Perry Preschool program on low-income African-American children with those who were not in the program, Schweinhart and his colleagues⁹ found that children in the preschool program not only realized significant benefits in subsequent cognitive indicators and school performance, but also on longer-range factors like income and involvement in crime (**Figure 2**).

Figure 2
Evidence of the 40-year Effects of the High/Scope Perry Preschool Program



Calculating differences between the two groups on costs related to welfare, education, earnings, taxes paid and involvement in crime, the authors calculated a return on investment (ROI) of \$17.07 dollars per dollar invested. Interestingly, the largest portion of that ROI was reflected by savings in the category of lower rates of crime.

Health Promotion Effectiveness: Examples from Journals

Our review of sources for this level of analysis came from a search conducted on Health Star on journal articles published between January 1999 and March 2004. The *American Journal of Public Health*, *Health Promotion Practice*, and *American Journal of Health Promotion* were manually searched for articles after March 2004. The search was based on the key words: “health promotion,” “community,” and “programs,” as well as names of specific health categorical areas defined in Healthy People 2010.¹⁰ Issues of research design were not considered. Of the articles reviewed, those included in this summary were domestic programs that: (1) reported measurable results using either quantitative or qualitative methods and (2) were deemed consistent with the kinds of health programs with which state health agencies would be involved. Following are seven examples of programs (addressing a variety problems and contexts) that were reported to be effective.

Environmental Health

A simple but effective example of an environmental health promotion was carried in the “Safe Routes to School” program designed to promote walking and biking to schools in a Marin County, California community.¹¹ Program planners created and identified safe routes to school and activated the participation of teachers, parents, and community volunteers in collaboration with health educators and traffic engineers. By its second year, the program was serving 4,665 students in 15 schools. Participating public schools reported an increase in school trips made by walking (64%), biking (114%), and carpooling (91%) and a decrease in trips by private vehicles carrying only one student (39%).

Breast Cancer Prevention

Anderson and her colleagues compared the effects of two methods of enhancing regular mammography use among 6,592 women over 50 in 40 rural communities.¹²

The two methods were: (1) individual counseling and (2) a coordinated community activities approach. Individual counseling included physician education and recommendations and/or physician reminder systems. Community activities (CA) consisted of the use of trained volunteer women promoting screening and a range of coordinated communication activities, including telephone counseling, to promote mammography. The CA approach was deemed the most effective in reducing relapse and promoting an increase in screening and costs among *regular mammography users* (those women over 50 who had reported having more than one mammogram or at least one in the last 2 years). It was also the most cost-effective, at approximately \$2,000 for each additional mammogram user in the community. For the CA approach, the authors calculated a cost per year of life saved of \$56,000.

An important finding in this study was what the CA strategy *did not* do. While effective for regular users, neither the CA nor the individual counseling approach was effective for non-users. (Non-users were those women over 50 who reported never having had a mammogram). This finding confirms a basic tenet of sound health promotion planning and theory: that the effectiveness of health promotion programs (especially those aimed at modifying specific health practices) will be dependent upon a thorough understanding of the characteristics of the proposed program participants and their social, cultural and economic environment – in short, one size does not fit all and accountable practitioners must plan accordingly.

Faith-based Health Promotion

Researchers from Emory University and the University of North Carolina undertook a collaborative effort with the American Cancer Society to combine previously successful intervention strategies in an effort to determine the effectiveness of churches as a vehicle for modifying fruit and vegetable intake among members of African-American churches in selected southeastern states.¹³ Using a cluster randomized-effectiveness design to allow for comparisons, investigators employed an ecological model that incorporated the following strategies: environmental changes, lay health advisors, church committees, community coalitions, educational sessions, pastor involvement, and tailored newsletters.

At 6-month follow-up, members of the intervention group showed significantly greater fruit and vegetable intake than controls. Also, those in the intervention cohort also showed small but significant positive changes in the percentage of calories from fat, their perceived self efficacy to eat fruits and vegetables, and social support.

Impact of *Promotoras* and Chronic Disease Prevention

In many communities there are those who, for whatever reason, lack access to health care and services. Community health workers (CHWs) are members of a community who are trained to help make connections between providers of preventive and health care service and groups who have traditionally lacked those connections. Globally, CHW programs have been used to address a variety of categorical health problems. Among Hispanic populations, CHWs are referred to as *promotoras*.

In this study, investigators carried out a randomized controlled intervention to test the effectiveness of a CHW (*promotora*) program in increasing compliance with annual preventive exams among uninsured Hispanic women living in a rural U.S.-Mexico border area.¹⁴ During 1999-2000,

household surveys were administered to women aged 40 and older. Uninsured women not receiving routine comprehensive preventive care were invited to participate in a free comprehensive clinical exam. Participants in the initial exam were eligible to participate in the CHW (promotora) intervention. Women were randomized to one of two intervention arms.

One arm received a post-card reminder for an annual preventive exam, the other a postcard reminder and follow-up visit by a *promotora*.

Findings revealed that among those who experienced the *promotora* intervention there was a 35% increase in re-screening over those who had the postcard-only reminder. Researchers concluded that their finding of the efficacy of *promotoras* in increasing compliance with routine chronic disease screening exams supports findings by other investigators who have reported similar results for categorical health problems.

School-based Obesity Reduction

Gortmaker and his colleagues assessed the effectiveness of a 2-year school-based strategy to reduce obesity among sixth- to eighth-grade students.¹⁵ The program, Planet Health, consisted of planned activities that were integrated into existing curricula using classroom teachers in four scholastic topic areas and physical education. Findings compared students in five schools that employed the Planet Health curriculum with students from five schools that did not. Objectives included decreasing television viewing, decreasing consumption of high-fat foods, increasing fruit and vegetable intake, and increasing moderate and vigorous physical activity.

Results indicated that exposure to Planet Health yielded significant reductions in obesity among girls, from 23.6 percent to 20.3 percent, while the prevalence of obesity increased 2.2 percent in the control schools not receiving the Planet Health intervention. The study also found that girls who were already obese at the beginning of the study more than doubled

their chances of becoming non-obese by the end of the study. Findings provided evidence of a lower incidence of disordered eating behaviors among girls in intervention schools; among non-dieting girls, onset of these behaviors was 11 times more likely in control versus intervention schools.

Investigators indicated that data from this study clearly showed the link between time spent watching television and obesity. “We found that changes in television-viewing time were directly related to changes in obesity . . . for each hour of reduction in television-viewing time per day we found about a 15 percent reduction in risk of obesity.”¹⁶

While there were dramatic changes among the girls who participated in Planet Health, similar changes among boys were not detected. No explanation for the differences was given although in an interview later, Gortmaker made this speculation: “Among youth these ages, there are developmental differences between girls and boys that may account for the results. It may also be that boys at these ages are less attuned to issues of diet and activity compared to girls.” (See note 14.)

Adult Smoking

McAllister and his colleagues examined the effects of a comprehensive tobacco-use prevention and cessation program in Texas on adult tobacco cessation.¹⁷ Differences in cessation rates across treatment conditions were measured by following a panel of 622 daily smokers who were followed from baseline to a 7-month follow-up. The adult media campaign combined television, radio, newspaper and billboard advertisements featuring messages and outreach programs to help adults avoid or quit using tobacco products. The ads also promoted quitting assistance programs from the American Cancer Society Smokers’ Quitline, a telephone counseling service. A core feature of the intervention was focused on increasing the availability of and access to cessation counseling services and pharmacological therapy to reduce nicotine dependence.

Researchers found that in the treatment areas that combined cessation activities with high-level media campaigns, the rate of smoking reduction nearly tripled the rates reported in areas that received no services and almost doubled rates in areas with media campaigns alone. Results also show that exposure to media messages was related to processes of change in smoking cessation and that those processes were related to the quitting that was observed in the group receiving the most intensive campaign.

DHPE directors will be especially interested in an important spin-off from this demonstration; specifically, the impact it had on the allocation of resources to support tobacco prevention and control in Texas:

Findings from this study and related studies . . . were reported to the Texas Legislature during the winter of 2001 . . . the conclusion (of the study) was accepted by key decision-makers and, during the Spring of 2001, the legislature appropriated an additional \$5 million per year for the Texas Department of Health to conduct intensive media campaigns in the areas that had no campaigns or limited campaigns in this pilot study.

Safety, Injury Prevention

In a prospective, non-randomized controlled trial, Ebel and her colleagues evaluated the effectiveness of a multi-component booster seat campaign in four communities in the Seattle, Washington area; eight communities in Spokane, Washington and Portland, Oregon served as control sites.¹⁸ The intervention was anchored by community coalitions and citizen advisory committees to ensure community participation. Intervention strategies included: (1) coordinated newspaper, radio and television outreach, telephone information lines and resource kits, and (3) a booster seat Web site.

Observed booster seat use 15 months after the start of the campaign revealed that eligible children in the intervention sites increased seat use from 13.3% to 26.1%. Gains in booster seat use for children in the control sites over the same 15-month period were modest, from 17.3% to 20.2%. These data suggest that a multifaceted community education campaign can significantly increase the use of child booster seats, which have been shown to significantly reduce the risk of injury compared with seat belt use alone for children aged 4 – 8 years.

Health Promotion Effectiveness: Programs Reported by DHPE Directors

We surveyed all of the DHPE Directors requesting examples of programs within their respective states that included the following information:

- Health problem or issue addressed
- Collaborating agencies or groups
- Source of funding Program duration
- Primary program objectives
- Health promotion methods used
- Program outcomes (*Citing specific indicators used to reflect outcomes*)

Forty program descriptions were received from 19 states; summaries of those programs are described in **Table 1**. We found two points to be especially relevant: (1) both intervention strategies and program effects cited in these state-level examples were consistent with many of the methods and outcomes cited in the *Guide to Community Preventive Services* and in the published literature and (2) the process we used to extract this information was simple and time-limited. (DHPE voting members were given a 3-week window to respond.) There can be little question that if a routine system for periodic, biennial updates were in place (so that DHPE respondents could anticipate and prepare their reports), 100% of states and territories would likely respond and the total number of examples would likely exceed 200 or higher.

Table 1
Examples of Programs Reported by DHPE Directors (2005)

| State | Health Issue | Partners | \$ Source | Objectives | Methods | Time | Outcomes |
|--------------|--|--|-----------------------------------|--|---|--------------|--|
| Alabama | Suicide prevention | Multi-sector task force | CDC | Increase awareness of suicide | State suicide plan; mass media & Web site | 1 mo. | A 9-fold increase in Web site hits during intervention month |
| Alabama | Fire prevention | Fire Departments, police, social workers, and LHDs | CDC | Reduce fire fatality rate | Home fire safety education and install alarms | 5 yrs. | 2,836 alarms newly installed – 53% of families practice fire escape |
| Alabama | Breast cancer screening incarcerated women | Avon Breast Care, Ala. Sheriffs Assn. | CDC Prev. Blk. Grant | Increase screening and follow-up | Face-to-face education and AV | 1 yr. | Evaluation in process |
| Arizona | Well Woman Health Check (Breast and Cervical Cancer) | ACS, Arizona Cost Containment System, AZ Medicaid | CDC with 3:1 state matching funds | Increase access to screening, diagnostic and Rx services | Use of promotores, multiple, bilingual communication and incentives | 1 yr. | 103% increase in services to women in target population |
| Arizona | Promoting Lifetime Activity for Youth | ASDH, County HDs, elementary and middle schools | CDC Prev. Blk. Grant | Increase youth participation in PA, develop selected skills, promote parental support, enhance capacity of local HDs to promote PA | Health education, and behavior change strategies | 1 yr. | Increase in students' knowledge and attitudes about PA – decrease in the # of youth reporting that they were not active. |
| Arizona | Arizona Nutrition Network | AZ Cooperative Ext., Co. HD, CHCs, School Districts, Selected Tribes | Food stamp funds, private funds | Increase access to screening, diagnostic and Rx services | Social marketing and community education | 1998 ongoing | In 2003 Network partners made 582,608 nutrition education contacts -- survey results indicated a wide range of positive effects on selected communication variables among target population. |

Table 1, Continued

| State | Health Issue | Partners | \$ Source | Objectives | Methods | Time | Outcomes |
|------------|--|---|--|---|--|--------------|--|
| Arkansas | Physical Activity: youth ages 9-13 (twens) | Media and marketing groups | CDC Prev. Blk. Grant | Increase physical activity in non-school hours | VERB radio campaign (evaluation study) | 4 mo. | Of those surveyed, 56% heard the messages, 76% "were more likely to get active" |
| Arkansas | Diabetes (Medicaid) | Eli Lilly, Ark. Diabetes Assn. | Eli Lilly; ADH | Increase access to diabetes specific care | Diabetes self-management program | Ongoing | Reductions in HBP; increase in frequency of self foot exams; decrease in ER visits |
| California | Healthy Cities and Communities (Inequities in pop. Health) | League of CA Cities, Assn of Health Districts, Parks and Rec., Kaiser, Assn. Health Improvement | CDC Prev. Blk. Grant; Several CA foundations | Enhance capacity of indigenous leaders to address upstream causes of health disparities | Multi-tiered effort with common health goals | 1988-ongoing | HC/C implemented in 70 sites; documented; (1) services, (2) infrastructure, (3) policy changes. HC/C have leveraged \$21 million = an 8.4 fold ROI |
| California | CA Center for Physical Activity (Physical Activity) | Local orgs including health and school districts; multiple grass roots organizations | CDC Prev. Blk. Grant; USDA; multiple foundations | Increase physical fitness of all Californians | PA promotion, advocacy education, and training | 1996-ongoing | Leverage prev. block grant \$, gaining nearly \$4 million leading to significant increases in local bicycle and pedestrian advocacy coalitions and senior fitness programs |
| California | Project LEAN (Obesity and its co-morbidities) | School Brd Assoc., and health coalitions and associations | CDC Prev. Blk Grant; USDA; Foundation support | Implement policy changes that support healthful eating and physical activity | Youth empowerment, policy strategies, community advocacy | 1993-ongoing | Positive changes in eating and physical activity; documented policy and environmental changes. (See CA Lean Web site) |

Table 1, Continued

| State | Health Issue | Partners | \$ Source | Objectives | Methods | Time | Outcomes |
|------------|---|---|------------------------------|--|--|-------------------------|---|
| California | Korean Grocer Outreach Campaign (Breast cancer screening) | Los Angeles Korean Grocers Assn. (KARGO) | CSDH, CDC | Encourage monolingual Korean women to call to seek ca. screening information | KARGO stores provided culturally appropriate messages and promotions and donations | June 2003; June 2004 | 3-fold increase in calls during intervention period – Based on findings, the Chinese Grocers Assn. is planning to replicate the campaign. |
| Colorado | Prenatal Plus (low birth weight) | Colorado Dept. of Health Care Policy and Finance | MCH Block Grant and local \$ | Reduce prevalence of low birth weight for high risk Medicaid eligible women | Client counseling and education (psychosocial awareness, lifestyle education eg, smoking cessation, PA, nutrition) | Ongoing | In 2003, 3,516 received PP services; at the end of 2003, the prevalence of low birth weight was 9.6%, significantly lower than the projected 13.3%. For every \$1 spent for PP, \$2.48 was saved in Medicaid costs. |
| Florida | Arthritis Prevention Program | Local health departments | CDC | Increase the availability of evidenced based Arthritis self-mgt self-help course | Six-week (21/2 hours per wk) Arthritis self-management course base on SLT for 12-15 participants | 2003-2004 | 163 participants in three counties, great majority over 65 and female. Decreases in pain and increases in PA reported in 2 counties other outcomes were variable. |
| Florida | Chronic disease risk factors | Local health departments | CDC Prev. Blk Grant | Help communities achieve and maintain healthy lifestyles | Comm. Health assessments, PATCH, MAPP, other community efforts | 2000-ongoing | Increases in programs within schools, worksites, and communities; positive changes in vending machines; increased knowledge of risk factors and chronic disease. |
| Georgia | Healthy Solutions: the Business of Good Health (worksite risk reduction) | Worksites, hospitals, insurance payers and brokers, local health agencies | CDC-CVD | Provide worksites with TA and resources; improve employee health; show cost benefits | In-depth health, theoretically sound, evidenced-based work site health promotion training | 2000-ongoing | Of the participating businesses, 34 provide health screening, 30 smkg cessation; 28 PA programs 26 nutrition classes; 26 improved vending options. |

Table 1, Continued

| State | Health Issue | Partners | \$ Source | Objectives | Methods | Time | Outcomes |
|----------|---|--|--------------------------------------|---|---|------------------------|--|
| Georgia | Take 10! (Increase physical activity among elementary school children grade 3) | Hollis Hand Elementary School – La Grange, GA | CDC-CVD | Insure the provision of 10 minutes of physical activity per academic day of physical activity | Ten minutes of planned physical activity by teacher – minimal description | Fall 2003 –Spring 2004 | Increases in level of PA among children in intervention group in both nutrition knowledge and PA |
| Kentucky | Physical Activity: 3000 youth ages 9-13 (twens) | Lexington-Fayette Co. Health Dept; YMCA; Churches, 14 businesses | CDC Prev. Blk. Grant | Increase physical activity and healthful eating | VERB summer scorecards; wide range of activities, | 2004 | PA initiated in new business and church venues; 3 other counties planning to implement VERB |
| Kentucky | Take 10! (Increase physical activity among 2 nd and 3 rd graders | No. Kentucky Dept. of Health and elementary school personnel | CDC Prev. Blk. Grant | Increase participation in PA in schools | Cline Elem. staff trained to increase PA in classroom and change school environment. | 2003-04 School Year | Student participation in PA increased 75-100 min per wk. Program being expanded to other schools. |
| Kentucky | Kentucky Vending Machine Prog. (Prevalence of overweight children) | Fayette County H.D. and nutritionists; and Pepsi Cola Co. | CDC Prev. Blk. Grant; Pepsi Cola Co. | Increase availability of health foods and snacks in vending machines | Nutritionists from HD worked with school staff to negotiate and monitor school vending machines | 2003-04 School Year | Healthy beverage consumption increased from 21% to 72%; Pepsi sponsored fitness day and donated 5 Mt. bikes – Vending machine sales increased by \$40,000. |
| Maine | Maine School Oral Health Program (SOHP) | School districts and community agencies | MCH Block Grant; Medicaid | Improve oral health; reduce dental caries | Education; weekly fluoride rinse program; health screening; provision of sealants | Annual Program | Evidence that youth exposed to SOHP and the sealants prevented decay |

Table 1, Continued

| State | Health Issue | Partners | \$ Source | Objectives | Methods | Time | Outcomes |
|----------------|---|---|-----------------------------------|--|--|------------------------|---|
| Maine | Maine Breast and Cervical Health Program | ACS, Maine Assn. of Broadcasters; Burgess Advertising Co. | CDC and MSDH | Provide information women can trust, reduce barriers to screening | Media tailored to needs; multiple support options; volunteer support; toll-free call center. | June 2002 June 2003 | 59% increase in women who were never or rarely received a Pap screening test |
| Mississippi | Cardiovascular Health | Faith based orgs.; workites; community organizations | CDC | Stimulate community implementation of policy and environ. changes; promote collaboration | Training in: (1) HP, (2) policy and environ. chngs, (3) worksite health promotion, (4) behave. Change. | June 2003 June 2004 | Programs started and sustained in workites and churches; improved access to fitness, increase public awareness. |
| Mississippi | LEAP - Lower Extremity Amputation Prevention (Diabetes) | Center for Diabetes Foot Care; Medical Center, Regional Health Center | CDC | Train foot specialists; increase awareness among diabetics; reduce amp | Conduct LEAP training among providers | Mar. 2003 Mar. 2005 | 199 provider strained; As a result: (1) 2,142 visual foot screens, (2) 2,119 physical foot screens, |
| North Carolina | Healthy Carolinians (community capacity) | 72 NC Counties | NCDPH, CDC and RWJ Turning Points | Community determined objectives aimed at reducing health disparities | Training in and application of standardized community assessment process and community capacity building | 1991 Ongoing | Multiple success stories available on line: www.healthcarolinians.org |

Table 1, Continued

| State | Health Issue | Partners | \$ Source | Objectives | Methods | Time | Outcomes |
|----------------|---|--|---|---|---|----------------------------|---|
| North Carolina | Healthy Carolinians Community Micro Grant Project (stimulate community investment) | 199 local NC communities (CBOs) | ODPHP DHHS | Leverage small resources to stimulate community actions to promote health and safety | Provision of \$2,010 mini-grants to 199 communities | Mar. 2001 Mar. 2002 | 98.7% of COB reported the initiative as effective; 97.4 met their stated goals; 93% said projects will continue beyond 2010 |
| Nebraska | "Well Workplace" (multiple risk and lifestyle factors among employees) | Workwell Council; WELCOA and 33 businesses Lancaster Co, NE | CDC Prev. Blk Grant | Locally determined objectives aimed at improving health; reducing cost of health care | Ongoing, updated worksite health promotion training and TA | 1984 Ongoing | 38,000 employees reached; In one company, documentation decrease in compensation claims over a 5-year period; a cost-benefit ratio of 6-1 |
| Ohio | Cardiovascular health | Trumble Co. HD; Ohio Parks/Rec Assn; Friends of Western Reserve Greenway, Neighborhood Assn | CDC Prev. Blk Grant | Modify environment to enhance and promote physical activity | Social marketing and community advocacy and participation | 2000 Ongoing | New walking trails developed; final section of cross-county trail completed after 20 yrs.; neighborhood park revitalized after being closed for 10 yrs. |
| Ohio | "Healthy Ohioans" (Cardio health) | ACS, AHA, State of Ohio Exec. Branch, Ohio Parks/Rec Assn | CDC Prev. Blk Grant; and state funds | Increase PA and nutrition; decrease smoking activity | Social marketing; surveys; modeling, TA; incentives and competition | 2001 Ongoing | Development of: (1) "Buckeye Best" program for schools – 1,000 schools participating; (2) Ohio Business Council – 17 successful business that model employee health; program logo & philosophy incorporated in to chronic disease programs. |

Table 1, Continued

| State | Health Issue | Partners | \$ Source | Objectives | Methods | Time | Outcomes |
|----------------|---|---|---|---|--|------------------------|---|
| South Carolina | Community Collaboration for Improved School Nutrition Environment (Nutrition) | Saluda Co. HD and School District, (elem and HS), local businesses, community coalition | SCDH and CDC | Increase availability and consumption of fruits and vegetables among school youth environmental and policy change | Use of SHI; school garden program; implement "Punch Out Junk Food" program | 2002 Ongoing | Garden program sustained by students; organic foods are regularly donated to school lunch program; in 2003 health snacks sales exceeded unhealthy snack sales. |
| Texas | Tobacco Prevention Initiative (tobacco prevention and control) | TDH and multiple state/local agencies, universities, & volunteers | Interest from the \$200 million tobacco trust | Reduce youth tob. Initiation; increase cessation; decrease illegal access. | Mass media, school and community education, enforcement, and cessation. | 1999 Ongoing | A 40% decline in usage among 6 th and 7 th graders. 14% reduction in tobacco use among adults. |
| Utah | Gold Medal Schools (childhood obesity and physical activity) | Action of Healthy Kids; PTA; State Dept. of Educ.; Utah's A Healthier You | Tobacco Control Program, State Dept Health and Educ. Corporate sponsors | Make health a tradition in Utah; create opportunities for students to be active, tobacco free, and eat healthy | Create healthful school policies; newsletters and media support | August 2001 Ongoing | 1,086 total individual school policies linked to promoting healthy choices; 140 schools are implementing state PE Curriculum; in compliance with tobacco free policy; have Gold Medal Mile walking program, have safe routes to school. |
| Virgin Islands | "Doctor Dad" (Infant mortality) | VIDOH & DHHS & the Virgin Islands Perinatal Partnership (VIPP) | Healthy start (VIPP) | Enhance the awareness and parenting skills of fathers | Social marketing and radio campaign. Formal health education and community outreach. | 2004 | Evaluation forthcoming |

Table 1, Continued

| State | Health Issue | Partners | \$ Source | Objectives | Methods | Time | Outcomes |
|---------------|--|--|---|---|--|----------------------------------|---|
| West Virginia | Diabetes Support Group | Cross Lanes, West Virginia Lions Club and United Methodist Church | All donated and volunteer support | Provide public with diabetes information | Telephone communication; small group meeting and an annual health fair | 2000 Ongoing | Monthly participation in support group is 40-60 |
| West Virginia | CARDIAC Project Screening program to identify children at high risk for CVD | Rural HE Partners; WVU | \$250,000 annual from state legislature | Early detection of "at risk children" | Screening, nutrition education and extended family education | 1999 Ongoing | Completed screens on 10,000 5 th graders and many of their parents from 55 counties – was leveraged to secure CDC grant which rejuvenated their genomics program |
| West Virginia | WV Osteoporosis Program (osteoporosis detection, prevention and education) | 15 agencies from various government agencies, and non-profit, and voluntary orgs. | \$250,000 annual from state legislature | Raise public awareness about osteoporosis | Assessments, screening, counseling, milk vending machines, health fairs, sharing of relevant literature | 1996 Ongoing | State-wide reduction of hip-fractures |
| Wisconsin | "Diabetes at Work!" Corporate Breakfast meetings (diabetes) | WDPH CDC, NIH and 21 orgs from 4 WI sites: Eau Claire, Milwaukee, Wasau, and Appleton. | WDPH, CDC, ADA, Nordisk Pharm. and Pfizer | Increase corporate awareness about diabetes and stimulate corporate participation | Participants were exposed to expert speakers who covered: diabetes as a health issue, corporate wellness and profitability | 1996 Ongoing (Nation-wide) | 86 Companies representing 277,178 employees have participated in the breakfast meetings – other findings pending |

Table 1, Continued

| State | Health Issue | Partners | \$ Source | Objectives | Methods | Time | Outcomes |
|-----------|--|---|---|--|--|----------------------------|--|
| Wisconsin | "WIC Bilingual Program" (nutrition services) | WIC program. Bilingual staff from multiple departments | Special funding from USDA and Wausau Health Found. | Improve quality and effectiveness of nutrition services to non-English speaking Hmong and Hispanic participants | In-depth training (4-6 months) in the language and culture of participants | 2001 Ongoing | Trained 29 certifiers, 17 educators, and 24 interpreters. After exposure to trained staff, participants reported understanding the program better, were more willing to share health information and were more honest and open |
| Wisconsin | "Medicaid Family Planning Waiver" (unintended pregnancy) | Multiple orgs: WDPH, WMCHP, Wisc. Fam. Planning & Repro Health Assn. (WFPFHA) | MCH Block Grant; Title X; and donations from WFPFHA | Increase awareness among, and make services available and accessible to income-eligible women at risk of unintended pregnancy. | Health education, outreach and services | Jan 2003 Ongoing | After 1 st year enrolled over 55,000 eligible women reaching over 24% of estimated # in need of services. Lower rates of unintended pregnancies among women enrolled. |
| Wyoming | Immunization Program Adult influenza | Multiple orgs: Div. Aging; Diabetes, PH Nursing Mt. Pacific Quality Care | CDC Immuniz. Grant | Increase immunization coverage in WY, especially for citizens 65+ | Mass media combined with state-base and community outreach | April - March (Flu season) | In 2002, the WY immunization coverage for adults 65+ was 18 th in U.S. After the 2003 season, WY had the highest immunization rate in the U.S. |

Each of the three levels of review summarized in this paper provide considerable evidence to support the conclusion that well-planned health promotion programs do lead to outcomes across a wide range of health issues. These outcomes include documented changes in sought-after knowledge, attitudes, behaviors and health screening practices, environmental conditions, relevant policy and regulatory actions, and improvements in health status. In some instances, health promotion programs yield cost savings as well as improvements in health status and/or risk factors or risk conditions.

As this paper is being prepared, the Institute of Medicine (IOM) is following up on its 2005 report: *Preventing Childhood Obesity: Health in the Balance* through a special IOM committee whose mission, in part, is to assess progress being made on the recommendations of the report and hold regional meetings that highlight the need for a sustained national effort and identify examples of progress being made by local stakeholders. In light of this national priority health issue, note the findings reported from the South Carolina and Kentucky examples in Table 1. Both provide concrete examples of initiatives that not only directly address key recommendations in the IOM report, but also provided measurable evidence that the programs yielded positive outcomes.

Furthermore, the methods reported in achieving these positive outcomes are consistent with the well accepted essential skills of health promotion practice described in **Table 2**.

Table 2
The Essential Skills of Community Health Promotion Practice^a

| SKILL | | GENERAL INDICATOR OF COMPETENCE |
|--------------|--|--|
| 1. | Understanding the health problem (or problems) that constitute the focus of the health program | 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. |
| 2. | Conducting an appropriate health and social assessment | 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 |
| 3. | Planning theoretically sound health promotion programs | 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 |
| 4. | Applying appropriate health promotion strategies | 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. |
| 5. | Providing effective leadership and management to deliver programs and relevant services | 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. |
| 6. | Collaborating across sectors | 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. |
| 7. | Monitoring and evaluating processes and outcomes in health promotion | 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. |

^a Adapted for this report in part from: (1) “A Framework for collaborative public health action by communities” Fawcett SB, Francisco VT, Hyra D, Paine-Andrews A, Shultz, JA, Roussos S, Fisher JL, Evenses P. 2000, Building Healthy Communities, in Tarlov AR, St. Peter RF, (eds), The Society and Population Health Reader: A State – Community Perspective, the New Press (New York), and (2) Indicators to Help with Capacity Building In Health Promotion, NSWHealth (New South Wales, Australia), 2001, Web site: <http://www.health.nsw.gov.au/public-health/health-promotion/hpss/capacitybuilding/indicators/indicators.htm>

Communicating with State Legislatures

The evidence provided in the previous section justifies the following message: “Health promotion programs work. Not only do they contribute to the prevention of illness and injury, but they also equip children with skills that yield lifelong benefits. They enhance quality of life and constitute a good investment.”

How can DHPE leaders best communicate that message such that legislators come to perceive public health and health promotion as worthy of their support?

Understanding Differences

Communication requires contact; meaningful, sustained communication requires a relationship. Establishing contact leading to a relationship with legislators begins with an understanding of a fundamental reality: no two state legislatures are the same.

Results from a 2004 report by National Conference of State Legislatures (NCSL) indicates that across the states, issues about balance of power, organizational structure, and even time dedicated to governing are more dissimilar than similar. Thus, just as health promotion practitioners must tailor programs to the characteristics and circumstances of a given place and population, so too must they select communication strategies with legislators based on unique circumstances that exist in their respective state legislative bodies. Based on variability across several basic factors, the NCSL report grouped the 50 state legislatures into three major categories: Red, White, and Blue.

“Red legislatures require the most time of legislators, usually 80 percent or more of a full-time job. They have large staffs. In most Red states, legislators are paid enough to make a living without requiring outside income. These legislatures are most like Congress. Most of the nation’s largest population states fall in this category.

Legislatures in the White category are hybrids. Legislatures in these states typically say that they spend more than two-thirds of a full time job being legislators. Although their income from legislative work is greater than that in the Blue states, it's usually not enough to allow them to make a living without having other sources of income.

In the Blue states, average lawmaker spends the equivalent of half of a full-time job doing legislative work. The compensation they receive for this work is quite low and requires them to have other sources of income in order to make a living. The blue states have relatively small staffs. They are often called traditional or citizen legislatures and they are most often found in the smallest population, more rural states.”¹⁹

Table 3^b shows the breakdown of states by their Red, White, and Blue categories and the averages for each on three factors: time on the job, compensation, and staff support.

^b While the Red, White and Blue categories help illustrate basic differences generally by population, and selected indicators for legislators (time spent, income, and staff support) NCSL recognizes additional state differences and their formal report addresses those by adding another dimension to each of the three categories.

Table 3
NCSL Breakdown of States by Category

| Red States | | White States | | Blue States | |
|-------------------|----------|---------------------|----------|--------------------|----------|
| Time: | 80% | Time: | 70% | Time: | 54% |
| Compensation: | \$68,599 | Compensation: | \$35,326 | Compensation: | \$15,984 |
| Staff: | 8.9 | Staff: | 3.1 | Staff: | 1.2 |
| Alaska | | Alabama | | Georgia | |
| California | | Arizona | | Idaho | |
| Florida | | Arkansas | | Indiana | |
| Illinois | | Colorado | | Kansas | |
| Massachusetts | | Connecticut | | Maine | |
| Michigan | | Delaware | | Mississippi | |
| New Jersey | | Hawaii | | Montana | |
| New York | | Iowa | | Nevada | |
| Ohio | | Kentucky | | New Hampshire | |
| Pennsylvania | | Louisiana | | New Mexico | |
| Wisconsin | | Maryland | | North Dakota | |
| | | Minnesota | | Rhode Island | |
| | | Missouri | | South Dakota | |
| | | Nebraska | | Utah | |
| | | North Carolina | | Vermont | |
| | | Oklahoma | | West Virginia | |
| | | Oregon | | Wyoming | |
| | | South Carolina | | | |
| | | Tennessee | | | |
| | | Texas | | | |
| | | Virginia | | | |
| | | Washington | | | |

Table 3 Notes:

1. Estimated proportion of a full-time job spent on legislative work including time in session, constituent service, interim committee work, and election campaigns.
2. Estimated annual compensation of an average legislator including salary, per diem, and any other unvouchered expense payments.
3. Ratio of total legislative staff to number of legislators.

One of the key take-home messages of the NCSL report is that it underlines the fact that being a legislator *goes beyond the work they do in the Statehouse* attending legislative sessions, reviewing and acting on the Governor's proposed budget, and voting on proposed laws. It also includes spending substantial time assisting constituents, studying state issues during the interim, and campaigning for election. Decisions about how and when to interact with a legislator should take into account the reality that elements of legislative life go on throughout the year, whether legislators are in the Statehouse or in their home districts.

How Legislators and State Leaders Get and Use Health Information

To better understand how state legislators receive, use, and perceive the usefulness of health information, Soriano and Baugh conducted a national telephone survey of nearly 292 policymakers from across the country; the sample included legislators from health-related committees (N=97), legislative staff who focused on health (N=97), and managers of state health agencies (N=98).²⁰ Respondents' characteristics were representative of state governments as a whole.

The average age of respondents was 50 years. More than half were male. The average tenure in their current position was 6.5 years and health-related experience was around 14 years. Legislators were the oldest and most experienced group. Staff were the youngest and least experienced group, although they still had more than 10 years of experience. Agency heads were more likely to have been in their positions for many years.

Overall, respondents said they never get to more than a third (35%) of all information. They said they were likely to skim about 53% of what they receive and actually read only 27% of information in detail. Critical factors in making the cut in terms of decisions to read were "relevancy to current state debates" and "easy to read." Popular formats included bulleted points and simple graphs.

Respondents were least likely to read material that was long, not relevant to current debates, full of jargon, too detailed, or seen as biased. In this study, two-thirds of respondents said they were more likely to read hard copies than use internet sites. Younger respondents and legislative staff were more likely to use the Internet than other respondents.

Sorian and Baugh found three points especially salient:

1. Public health and policy information must be framed such that it is relevant to current debates at the state level.
2. While researchers and health professionals may be focused on long-term solutions to systemic problems, what legislators want is information about the news “in the paper today.”
3. It is critical to layer information so that the most easily read information will be used immediately. Policymakers and staff can read additional information in greater detail once they get the overview.

The extent to which legislators trusted the sources of information was an important factor in their decisions to use the health data and information they received. Most said they trusted some sources more than others. Professional associations like the Association of State and Territorial Health Officers (ASTHO) and the National Conference of State Legislators (NCSL) ranked high on the trust scale.

Results also revealed that when asked what makes information relevant, 67% said relevance to current debates and 25% said impact on real people. Journals were least likely to be used by legislators and more likely to be used by state agency heads.

Few respondents were likely to attend meetings and conferences to get information to make policy decisions. In general, policymakers are overwhelmed with information. More than one-fourth (27%) said they already have too much information or don't want any more.

Insights from the RWJ Research!America Study

In 2000, the Robert Wood Johnson Foundation funded Research!America to conduct a feasibility study involving opinion polling of 1,969 Congressional representatives and staff, public health professionals, the media, and the public to understand public attitudes toward and support for prevention and behavioral research.²¹ Although the goal of the study was to ascertain attitudes about the importance of funding prevention research, some of the findings (presented below) provide insights on issues relevant to the goals of this paper. In the selected findings excerpted below, note the positive context in which prevention, health, and health promotion are held.

“Nearly all of the Congressional representatives and staff and public health professionals polled believed that ‘preventable diseases and injuries are a major health problem in the United States.’ Smaller majorities of the public and media surveyed held this belief.

The majority of each respondent group — Congressional representatives or staff, public health professionals, the general public, and survivors or families of survivors — believed that ‘health promotion and disease prevention research and programs have an impact on the health and wealth of the country.’ And, Congressional staff and representatives, public health professionals and media respondents believed that it has a ‘far greater impact on the nation’s, or their state’s, health than it does on the economy.’

Overall, the majority of each group polled believed that ‘the amount of total federal funding for health promotion and disease prevention research and programs is inadequate.’ Public health professionals were more likely than others surveyed to believe federal funding is insufficient.

Public health professionals and Congressional representatives or staff agreed that ‘a lack of political will or effective interest group representation is the biggest barrier to greater support for health promotion and disease prevention.’ However, professionals were much more likely than Congressional respondents to believe it was a major barrier. Media respondents found the ‘lack of public understanding’ to be the biggest barrier, while the public cited a ‘lack of clarity regarding who should pay for preventive care.’

Although the public health professionals surveyed believed there are many strong arguments for supporting health promotion and disease prevention research, they cited public health’s positive impact on quality of life as the strongest argument.

The other groups surveyed considered all five arguments for increasing support to be persuasive. They are ‘improves quality of life,’ ‘lowers health care costs,’ ‘increases life expectancy,’ ‘keeps people safe at home and in the workplace,’ and ‘improves access to health care services.’ The public considered ‘improves quality of life’ most persuasive, whereas Congressional respondents and survivors or their family members found ‘lowers health care costs’ to be most persuasive.”

Perceptions

Gottlieb and her colleagues²² carried out a three-state research study to ascertain state legislators’ intentions to support or oppose tobacco-control legislation and determine how such intentions are influenced by legislators’ demographic characteristics, their knowledge of and attitudes toward tobacco control, and their perception of and contact with lobbyists on tobacco-related issues. Interviews were completed with 84% (444 of 529) of all state legislators who were serving in North Carolina, Texas,

and Vermont at the time of the interviews in May and October 1994. These states were chosen to represent a spectrum of tobacco-control laws, dependence on tobacco income, demographic composition, and health status measures. A data set was established that included information on legislators' intentions related to tobacco prevention and control initiatives. In addition, the data set contained information on constituent demographics, campaign contributions, and voting record on tobacco-related legislation.

- Most legislators believe tobacco is addictive, although there were differences among the states: 82% from Vermont, 70% from Texas, and 56% from North Carolina believe that people who smoke cigarettes do so mainly because they are addicted to nicotine.
- 79% from Vermont, 65% from Texas, and 42% from North Carolina agreed with the statement that environmental tobacco smoke can cause lung cancer in nonsmokers.
- More than 75% of legislators stated that they would support measures to enforce laws preventing tobacco sales to youth. The enforcement mechanisms described included unannounced annual inspections of all merchants, merchant education programs, and a fine of \$100 for failure to comply with the law.
- 75% of the legislators did not believe that smoking in indoor public places was a personal right.
- Overall, three to four times more legislators said they could be persuaded on tobacco issues by medical society and nonprofit health lobbyists than said they could be persuaded by tobacco lobbyists.

Legislators reported less contact with medical society lobbyists than tobacco lobbyists about tobacco issues. Overall, 58% of legislators reported any face-to-face contact with medical society lobbyists, 72% with nonprofit health

lobbyists, and 72% with tobacco lobbyists during the 1993–94 legislative session. When asked to evaluate the amount of contact with lobbyists on tobacco-related issues, 26% stated that they had too little contact.

The Importance of Voter Preference in a Given District

Gerber and Lewis²³ studied the linkages between voter preferences, district heterogeneity, and legislator behavior in Los Angeles County, California. Essentially, district homogeneity implies that collectively the majority of voters in a given district hold common views on political issues; in heterogeneous districts, the situation is just the opposite. The study concluded that in homogeneous districts, the median voting preferences of district residents is a good predictor of the legislator behavior (voting). Conversely, in heterogeneous districts (where the political views of voters are less consistent) the voting behaviors of legislators are more likely to reflect their personal political biases, even though the median voting preference of those in the district favor a position opposite of the legislator's.

This finding has implications for undertaking strategic efforts within legislative voting districts. Specifically, such efforts might use local evidence of health promotion effectiveness and frame that evidence in the context of how those programs yield direct local benefits in terms of quality of life and, in some instances, cost savings. Findings from district-level surveys showing that a large portion of residents see public health and health promotion as a high priority offer evidence that legislators will have difficulty ignoring these views.

In the book *Republic On Trial: The Case for Representative Democracy*,²⁴ Alan Rosenthal and his co-authors reinforce the importance of the views held by constituents. They point out that the legislative process, consistent with the reality of democracy in action, is necessarily complex and is manifested by uncertainty, competing interests, confusion, bargaining, compromise, and conflict. However, constituents hold an important key for legislators as they

grapple with those complexities:

“Legislators pay close attention to their constituents’ views because they are products of their communities and think in similar ways. They want to do good for their districts and most want to be reelected to office.” (p. 85)

The examples of successful programs within their states (and specifically within legislative districts in their respective states) give state and local health educators an ideal and relevant entrée for enhancing communication with legislators and engaging them in the development and support of public health programs that will make a difference in their “backyards.”

Interviews with Legislators: Major Themes

The following quotes and narratives were made by legislators from West Virginia, Mississippi, and Georgia during unstructured interviews and discussions carried out in April and May, 2005.

“Keep in mind that most of us pay serious attention to three factors: (1) votes, (2) money, and (3) media. To stay in office, we must have votes and must respect the views, interests and values of those who elected us. We have to run campaigns and we need support for that. Also we don’t easily forget those who provided support for a priority issue we were pushing for — it’s called reciprocity. Media is critical because it equals exposure — it helps bring attention to an important issue or debate, and us as well.”

“Those early session briefings are very helpful.” In West Virginia, at the beginning of each year’s legislative session, leading academic economists from the University of West Virginia provide an assessment of West Virginia’s economy. Legislators are unanimous in their support of a “health of the

state” briefing to give them perspective. We were told by two key legislative leaders that in 2006, they hope to add a similar, unbiased briefing on the State of West Virginia’s Health. This is consistent with the annual health status briefing for Massachusetts conducted by staff from Harvard University’s School of Public Health.

“Constituents matter – if they want it, I listen.”

“Pay attention to the current debates – during any given year there are a few topics or issues that are clearly legislative and budget priorities we must all grapple with – that is what we are referring to when we use the term ‘current debates.’ So if the current debate is over Medicaid, tie your health promotion issue to that!” In a similar vein, one legislator said; “Don’t get sideways with other health constituents.” He explained that public health should present a common, consistent message and implied that if diabetes is seen as competing with immunization or environmental health “it just looks bad.”

“I rely on personal relationships – people and groups I can count on – like the West Virginia Medical Society.” A site visit to the West Virginia Medical Society (WMS) confirmed the view expressed by legislative leaders in West Virginia. WMS members and staff worked very closely with public health staff on a variety of priority health issues in the state and it appears unlikely that the passage of the *Healthy West Virginia Act of 2005* would have been possible without this collaboration.

Specifically, the *Healthy West Virginia Act of 2005* encourages and supports healthy lifestyles in the state and includes the following actions:

- Creation of the Office of Healthy Lifestyles within the Office of the Secretary of the West Virginia Department of Health and Human Resources;

- Establishing a clinical advisory committee;
- Establishing a statewide voluntary private sector partnership and recognition program;
- Encouraging the development of incentives for participation in employee wellness programs;
- Establishing a definition of healthy beverages that can be sold in schools; and
- Enhancing requirements for physical education and health education.

Recommendations for DHPE Consideration

At the national level, DHPE has gained a reputation as a credible resource for health promotion at the national level. DHPE voting members have been called upon in numerous situations to provide testimony and support for health education and health promotion policies to Congress (and to state legislators in some instances) on a wide variety of specific health issues including cardiovascular disease, diabetes, physical activity, and tobacco. Given its collective national reach, we believe that it would be prudent for DHPE to build on the assets highlighted in this paper and consider undertaking planned actions aimed at creating a national, evidenced-based health promotion advocacy “system” consisting of coordinated strategies at the state and local level.

With that general goal in mind, several recommendations are offered:

1. General Evidence of the Effectiveness of Health Promotion

Add a feature to the DHPE Web site that provides a sampling of evidence documenting the effectiveness of health promotion (as illustrated in this report). The Web site should be created in an easy-to-access and understandable format that is reviewed and updated biennially. With easy access to that information, all DHPE voting members and their co-workers should be prepared to use it in responding to requests for evidence in a concise and timely manner.

2. Local (State-by-State) Evidence of the Effectiveness of Health Promotion

DHPE, in concert with the CDC, needs to take steps to strategically give greater emphasis to existing state-level evidence of the benefits of health promotion. In this paper we have demonstrated how, with relative ease, evidence of effective health promotion programs *within each state* is

readily available. Our examination of the literature on legislative behavior, supported by face-to-face discussions with a sampling of legislators, leaves little doubt that “evidence” takes on special relevance when it is a local example and when the effects of that example are framed in terms of its direct impact on one’s local community, family, or constituents. In effect, such examples send the message that “health promotion works and it is working in our own backyard! Furthermore, our residents support and value [this program] and here are the tangible benefits it generated.”

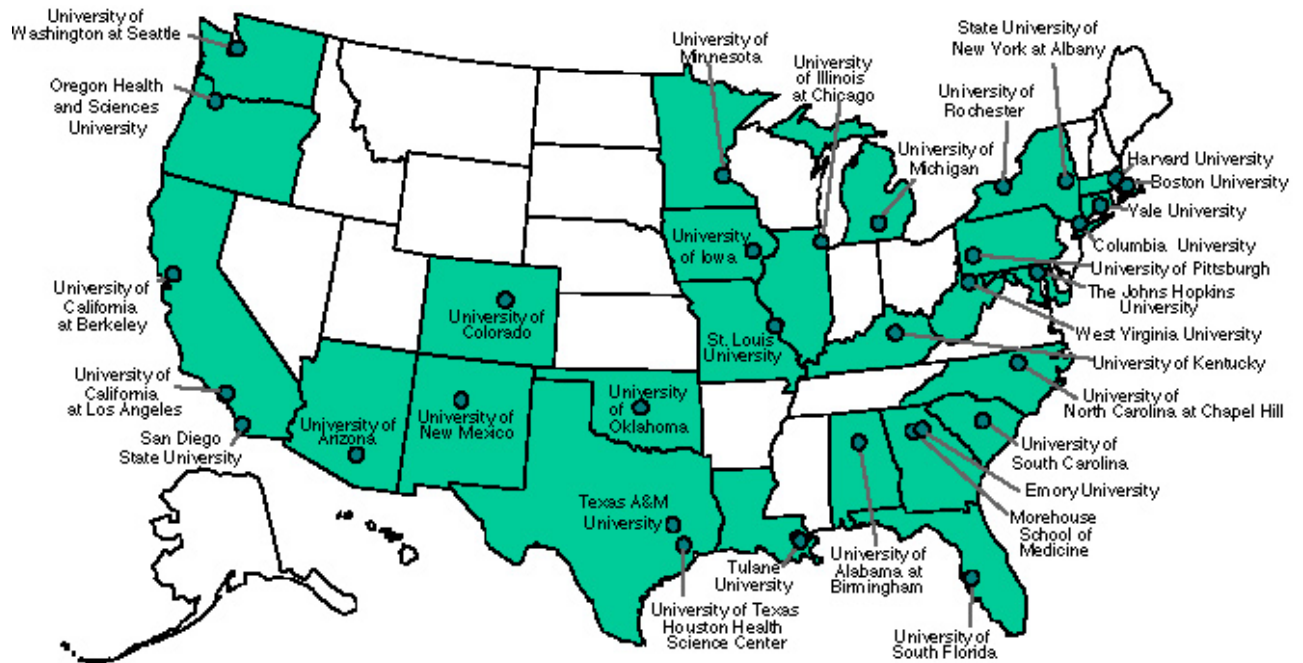
Furthermore, the “evidence” from state programs suggests the following: both the methods used and many of the outcomes reported are very much in alignment with programs reported in research studies. In effect, state programs are applying “best” and “promising” practices and they are reporting that desired and hoped for results are being attained.

3. Establish an Ongoing Academic Partnership

Although local success stories have universal appeal, they are especially relevant in the White and Blue States (78% of all states) where a greater effort is needed to establish relationships with legislators who spend most of their time “at home.” While positive stories are available in virtually all states, local success stories appear to be an underutilized resource.

To maximize and strengthen this resource, we encourage the leadership of DHPE to explore the possibility of a collaborative effort involving the respective state health agencies and selected Prevention Research Centers (PRCs). (**Figure 3** shows the state location of the 33 PRCs.) Using the Special Interest Project (SIP) funding mechanism, the general goal of such a collaborative effort would be that participating PRCs would use their academic research and evaluation experience and capacity to aid state health agencies (located in their states or regions) in developing evidenced-based reports of state health promotion programs.

Figure 3
CDC Prevention Research Centers, 2005



The need to establish credible and feasible levels of criteria to determine program effectiveness is frequently cited in the literature. Through this partnership with DHPE, participating PRCs could come to consensus on: (1) the criteria for determining those levels of evidence; (2) the protocols for working with state health agencies; (3) the format of the program description; and (4) innovative applications and use of success stories.

Not only would such a collaborative effort contribute to strengthening the science base of health promotion practice, it would also provide a sound foundation upon which to explore efforts for more states to follow the lead of Massachusetts (and perhaps West Virginia) in creating a legislative “state of the state’s health” briefing for all states.

Figure 3 calls attention to an inherent caveat in a proposed DHPE/PRC collaboration: that is, 17 states and the U.S. territories are not covered by the 33 PRCs. However, the gaps in coverage need not be a major barrier. PRCs currently have several projects in which multiple PRCs join together to form networks addressing a common public health issue. This model can be expanded to enable selected PRCs to collaborate with state health agencies which, although not in their particular state, are within their geographic region. A good model exists in the long-standing and productive collaboration that the Harvard PRC (Massachusetts) has with the Maine Departments of Health and Education.

4. An Innovation Worth Considering

*Health Policy Coach*²⁵ is an innovative Web site created and managed by the California Health Institute (CHI). The Health Policy Guide provides evidence-based policy guidance and resources addressing over 150 health topics all of which are presented in a standard format. For example, the topic “Addressing Childhood Obesity: Nutrition Education and Policies in Schools” consists of three sections: (1) *Background* - a documented synopsis of childhood obesity as a priority health issue; (2) *Policies* - a description

of existing or potential policies designed to positively influence reducing childhood obesity; and (3) *Effectiveness Data* - examples of activities and/or programs that have yielded documented positive effects on factors associated with childhood obesity. In **Table 4**, we can see how the issue of the “effectiveness” of school-based educational and policy strategies is based not only on examples from the CDC’s Preventive Services Task Force and the professional nutrition literature, but also on a documented (local) success within the Malibu, California school district. We highlight Health Policy Coach for several reasons:

- First, it provides a very practical example of how to communicate the evidenced-based message: “Not only does health promotion work, it works in our backyard.”
- Second, Web sites are popular channels that are accessed by multiple audiences at minimal costs and at a modest burden of time to the recipient. All state health agencies and almost all local health departments have Web sites that are constantly being updated and being made more user-friendly. This medium can effectively reach the general public, the media, and decision-makers with the evidenced-based message that “investments in health promotion are working and they are yielding tangible benefits to our residents.”
- Third, it is consistent with the recommendation of Sorian and Baugh, in that it frames the message in layers so that policy makers get the main point immediately with added details and depth as needed.
- Finally, the credibility of an innovation like this will be strengthened if a working partnership is established with a respected system made up of the universities that constitute the network of PRCs.

Table 4

Policy Coach Example: Effective School Education and Nutrition Policies to Prevent Childhood Obesity

A society that is “health literate” can act positively to promote its good health. Nutrition education in schools has shown promising results. Several programs using a behavioral approach have achieved significant positive changes in students’ eating behaviors. Compared with students in control schools, students in some behaviorally based health and nutrition education programs had significant favorable changes in serum cholesterol levels, blood pressure levels, and body mass index (1). For example, the Know Your Body program was a sequential nutrition curriculum from kindergarten through grade 7 designed to reduce disease risk. In one study of the effectiveness of the program, in New York City, teachers taught the curriculum for 30 minutes each week throughout the school year, and the school meal program provided healthier lunches. A longitudinal study of the program over 5 years showed significant improvements in nutrition knowledge, in intake of total fat and complex carbohydrates, and in total cholesterol (2). In 1989, after extensive evaluation, the Know Your Body program became only the second school health curriculum to receive approval from the U.S. Department of Education’s Program Effectiveness Panel (3).

The Santa Monica - Malibu School District has chosen to take a comprehensive, total environment approach to nutrition and education. In 1997, the district launched the Farmers’ Market Fresh Fruit and Salad Bar at McKinley Elementary School in Santa Monica. The school district purchases produce for the salad bar directly from local farmers to give students the freshest produce possible. In addition, the program also provides farm tours, farmers’ market tours, a “chef in the classroom” component, cooking cart demonstrations connected to the curriculum, nutrition education materials, and gardening and composting lessons. The school children, through this process, become enmeshed in the whole food system, from farm to cafeteria, which allows students to learn where food comes from, how it is grown, the importance of agriculture, and to understand that selecting health food choices can improve their quality of life. The school district also encourages parents to become involved in the nutrition education of their children, as parents can act as volunteers to set up the salad bar and to coordinate the program. After the implementation of this program, use of the school salad bar increased by up to seven times. The district has expanded the pilot program to fourteen other school sites, where participation in the salad bar program has increased by up to 1700% in some schools (40).

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5. Finger on the Pulse

Directors of Health Promotion and Education must become more astute at keeping their “finger on the pulse” of relevant health issues in their respective states. Evidence we reviewed repeatedly pointed to relevance to current debates as a critical factor in health policy. Understanding this will serve the health educator in at least two ways. First, it broadens health educators’ understanding of important health issues facing policymakers. These may be issues traditionally outside the purview of public health education units. By understanding these pressing issues, health educators can better frame their issues. Secondly, opportunities to expand current discussion so that they include the benefits of health promotion and education may be identified. By “tagging on” to current debates, educators make health promotion issues more relevant.

To ensure that DHPE voting members remain mindful and capable of keeping their finger on the pulse of relevant health issues in their respective states, we encourage DHPE to provide leadership in creating regional training opportunities in the use of strategic communication with legislators for staff in state health agencies. One manifestation of that leadership would be to expand upon current ties with two key organizations: the National Conference of State Legislatures (NCSL) and the Council of State Governments (CSG).

NCSL is a bipartisan organization that serves the legislators and staffs of the nation’s 50 states, its commonwealths and territories. It provides research, technical support for policymakers to exchange ideas on the priority issues across the states. NCSL is also a well-respected advocate for the interests of state governments before Congress and federal agencies.

The CSG plays an active role in forecasting policy trends for the community of states, commonwealths and territories on a national and regional basis. CSG also appraises state elected and appointed officials to emerging social, economic and political trends and offers innovative state policy responses to rapidly changing conditions.

6. Sustained Leadership as Part of a Team

Whatever strategy is undertaken by DHPE voting members to enhance the credibility and effectiveness of health promotion with legislative leaders, care should be taken in the way that effort is framed. That is, it should be seen as a planned activity that clearly *complements* the ongoing efforts of your state health department and other health advocacy groups.

Furthermore, while undertaking such an effort, state and local health promotion advocates must remain mindful that communicating with state and local policymakers is an ongoing effort. Agency heads and elected officials change frequently, the relevance of health issues is fluid, and partners whose mission involves state and local advocacy are not static. DHPE voting members should be committed to the principle that an integral part of their job is to seek to maintain ongoing communication with individuals and groups that influence health at the state level.

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