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Evolution of HERR grants as first targeted funding for health education activities, Prevention Block Grants, Multiplier Effect, School Health programs, establishment of the Division of Adolescent and School Health at the CDC, BRFSS as a sentinel event to collect baseline data and the beginning of behavioral epidemiology and evaluation, YBRFSS and PATCH.

Transcript of video interview produced by the Directors of Health Promotion and Education, 2009.

I began my health education career as a public school teacher, first in California. Then I got an advanced degree at the University of Utah and taught at the University of Utah. I then took a position for a year or two to head up the health education program in the State of Utah and then went back to the University. I was recruited by the CDC to come to Atlanta in 1982. And I had the privilege of playing a leadership role in their division of health education, which was a transition from the Bureau of Health Education prior that and stayed at CDC for about 15-16 years. Then I retired from CDC, set up my own consulting business. Did that for several years. Became a professor at Georgia State's University of Public Health. And last December I decided to retire from there.

Well, I think the HERR grants were important for several reasons: First, they provided the first direct source of income targeted specifically for health education programs in states. They established a relationship between the Centers for Disease Control and Prevention and states to develop programs that targeted primarily on tobacco prevention at that point in time. I think that it had a big effect on creating capacity in states to do thoughtful, planned, targeted health education programs, and it required the states, as it turns out, from their state health education office to work with localities, which could be local health departments, could be Indian reservations, smaller local community groups.

So, you had this kind of cascading collaboration between the federal, state and local, specifically targeting on health education.

In 19 something, I can't recall exactly the date; perhaps 1982 or '81, under the Reagan administration, they created what is called the prevention block grants. And here, in an attempt to save money, they took categorical programs, of which the HERR grant was a health education categorical program, and mixed it in with other programs, other chronic disease programs, maybe local emergency medical care, tied a little band around that new preventive block grant, took 10 percent off. And then they said, okay, states, you can do any of these programs you want. And what that meant was that the categorical health education program, which states, if they want to participate in for HERR did, they no longer had to select that. They had to choose from amongst several programs.

And I think one of the interesting things that happened there is that not all states came back with their health education programs, but some did. And those that did created a capacity and strength to continue on. I think that's an important impact of the health education grants program. And we did a study subsequent to the block grant procedure that asked states: Do you still have health promotion? If so, how much money and resource is going into that, and how many people are engaged in health education activity?

And, indeed, it did show that the Health Education Risk Reduction Grants Program, the first of its kind, obviously, did stimulate the economic and personnel capacity in many states, not all, but many. And I think that was a big boost to health promotion.

And that's what we referred to as a multiplier effect. And when the CDC invests resources or when federal government, let's say, invests resources that go to the local level, and the local level adopts those, in this case, the state level adopts those programs and maintains them, they can get other resources. For example, let's say there's a program that deals with another chronic disease like cancer or lung disease. Then local entities like the American Cancer Society or the local state affiliate of the American Cancer Society can then collaborate with the State Health Department to address a matter of breast cancer screening or cervical cancer screening or whatever.

And so, that stimulus, as it were, to use a contemporary term, actually does work. It builds capacity. It gets programs in place. And, of course, when those programs are thoughtfully and well performed, people do get screened, and they do prevent, in the case of, say, breast cancer, breast cancer mortality.

Yes. There is variability in states. I can't name them off the top of my head. But some states do put more of a priority on prevention, on education, on health promotion than other states. Sometimes that's a function of the leadership of the state health department. Sometimes it's the activities that go on jointly with the health department and universities, for example. The Prevention Research Center's programs, for example, have been very helpful in working with state health agencies and local health departments in promoting health education, health promotion programs. And places where those entities exist tend to have more activity. So I do think that there is a benefit and a reward to states and localities where that activity is going on.

Health education in schools. I think that one of the sentinel events in health education, at least in my career; from the CDC beginning in the early '80s was the same time when the HIV epidemic began to spread. And as it turns out, one of the things that from a political standpoint government wants to be able to respond to this problem, HIV/AIDS.

And in the early '80s in our work in health education, school health education, did show, for example, that the health education to children aged, let's say, 10 or 11 about tobacco actually had an effect in lowering the adoption rate of smoking. In other words, if you were exposed to a comprehensive school health education program, the odds are that there would be a 13 percent less chance that you as a student would start smoking compared to those students that didn't have that program. And we

presented that information to them, the director, Dr. Jim Mason, who presented it as a part of the budget findings for the CDC review. And I think that was about 1983 or '84.

They were impressed with that. And when the HIV epidemic started to go, they came back and said: Well, you know, you said that health education had this effect on the prevention of the onset of tobacco, which, obviously, if the longer you delay the onset of smoking, the less likely you are to smoke. It's a preventive activity. Could this be true of HIV/AIDS? And, obviously, we thought, sure, why not? Theoretically, if you expose children and people to the causes of HIV/AIDS, give them education about it, you lower the risk of HIV/AIDS. And as a result of that, money was allocated from the federal government to CDC to states to -- under the auspices of a comprehensive effort to prevent the spread of AIDS, comprehensive school health education program to prevent the spread of AIDS. And that established, eventually, what became the division of adolescent and school health at CDC and was a major contribution, I think, to states.

One of the things that's interesting about that particular element is that the money not only went -- actually the primary bolos of money that went to states went to the Departments of Education. But a small part of it went to the Departments of Public Health so that they could have a coordinated effort in this effort to prevent the spread of AIDS.

I think it's important to put the HERR grants program in the context of everything else that was going on in public health. These are basically community-based programs. At the same time, the NIH -- NHLBI, rather, the National Institute of Heart, Blood and Lung -- the National Heart, Blood and Lung Institute, had funded several now famous cardiovascular disease programs at Stanford, Three Community Study, Minnesota, Pawtucket, and some money that also was contributed to the Finland heart health study.

So, at the same time that these other studies are going on, the HERR program is going on. And so you have to step back and say, well, what did we learn from collectively all of these programs. And one of them was, yes, behavior and education is important. It is very, very important. But, you know what? It happens in the context of community. And, therefore, these other issues such as health policies, such as the environment, such as the coordination of other groups working collectively together, when you get those in, you get a much bigger effect than education alone.

So, it's not that health education is important. It's very, very important. But if you really want to have a large impact, one of the lessons, as I say, from both the HERR grant program and these other community-based programs was really how ecological and complicated it is. And I think out of that grew the -- that kind of phenomenon grew a transition from, well, there's health education, and then there's health promotion, which involves all these other issues. So, I think it's important to keep, you know, that issue in perspective.

I think one of the important sentinel events for health education and health promotion domestically and globally has been the establishment of the behavioral risk factor surveillance system. It's important on several fronts. First, it's a system that states do. People sometimes say, well, the BRFS is a CDC program.

Well, it's a CDC program to the extent that it's coordinated by CDC, but it's actually implemented and applied in each of the states. And it started off with four or five states, and as it expanded, now all states have a behavioral risk factor surveillance system. And it's important too because what you get out of BRFS is data, and data drive political decisions. Data help you make priority choices. We know that the various states and areas within the states do not all have the same health priorities. There may be -- injury may be an important issue in one area, cardiovascular disease in another, and so on.

So, having behavioral risk factor surveillance system out there is very, very important. It's important politically because, if folks in California or Alabama or wherever want to talk to their legislators about high priorities, it isn't a matter this is the problem -- this is the U.S. problem, this is the problem here in our place. And by targeting specific numbers and having valid information about what the priorities are, it causes legislature -- we would assume that it increases legislative support for investment and programs to deal with the priorities that they are facing.

So, I think that the behavioral risk factor surveillance system is very important there. And it also provides markers for changeability. And the most dramatic example of BRFS as it's related to health -- education and health promotion is, obviously, obesity. When they began doing -- asking questions that were -- that enabled us -- you know, how much do you weigh? What's the girth size, and all that? When you were able to say that an operational definition of obesity looks like this and look at these maps, and here you can say, see, in 1970, it looked like this, and as the colors change, you can see that we have more obesity. And just using simple language like that to a decision maker says, wow. And then they ask the epidemiologic question. And that's all you want them to do. You want them to say: Why? And once a decision maker sees data in his or her place that says we've got a problem and they ask why about it, then you can step in and say, well, because we don't have physical education in schools. We don't have a lot of physical activity. Our neighborhoods prohibit walking, and we don't have access to fresh fruits and vegetables. If we did all of those things, we would have a chance. So, then you get some sort of a dialogue all based on those data.

So, I think the behavioral risk factor surveillance system is an important one. And we take a little bit of pride in that because, in 1983, we established something that was unheard of in, at least, the health education area, behavioral epidemiology. We established a branch called behavioral epidemiology and evaluation. And what we said was: We can't do everything. What is it we can focus on that we can measure with some precision?

And it turned out that Kim Powell, who was the chief of that branch, said we brought people in and said: Should we look at stress? Should we look at nutrition? They said: We ought to look at physical activity.

So, the first thing they examined was: What are the physical activity levels? What's the relative risk of low physical activity to mental health to whatever? And it was a very important step.

So, basically, in sum then, BRFS is important because it establishes good baseline information that has utility, not only for us practitioners, but also for policy makers who determine who's going to get what.

Not only is it functioning, I think it's fair to say that it served to spin off other surveys. The YBRS, which is the Youth's Risk Factor Behavioral Survey, samples schools for specific risk factors that children may be exposed to. Tobacco survey, which is based on the principles of the BRFSS, is in the U.S. and globally. And so, surveys all over the place through WHO and the like are a spin-off of this early BRFSS work.

The Health Education Risk Reduction grants program did clearly establish capacity and resources in states that weren't there before that were specifically aimed at health education. But that's an absolute fact. When in the Reagan administration they decided to create the block grants, it put that categorical Health Education Risk Reduction grants program at a little better risk because it was bounded in with other programs, which enables states politically to determine which of those programs they wanted to invest the preventive block grant resource in. So, as a result of that, some of the Health Education Risk Reduction grants program were discontinued.

When that happened from the standpoint our branch kind of managed the Health Education Risk Reduction program -- in other words, we no longer have that grant -- we said, why don't we create a technical capacity called Planned Approach To Community Health, which was basically the core of what the Health Education Risk Reduction grants was a program -- was about. So, we did. We created PATCH, Planned Approach To Community Health, and it's based on the -- basically, the principles of precede, proceed, model it, encourage states to use BRFSS data as a starting point. Go out to local communities, identify priority health problems, and see if you can get other resources from other groups to invest in those local resources. And let's measure them along the way. This was the PATCH program.

So, PATCH, then, which was basically the principles for the Stanford Four Community study, the Pawtucket study, the Finland study on cardiovascular disease prevention, all of those programs, had basically a basic logic model. What's the problem? Who has it? What are we going to do about it? Let's use data. Let's make sure that we put education in there and look at the various support systems.

So, these programs are all somewhat similar. They had different names, but they were similar. And this was designed to help state health departments develop the capacity, have some affiliation with CDC from a technical support system to be able to go out to work with their local counties or localities to continue to push what was happening globally through prevention programs, cardiovascular disease prevention programs, the former Health Education Risk Reduction grants programs, and so forth.

So, it's the beginning of community health, per se, which is today predominant. I mean, one part of the stimulus package was designed specifically to make sure that prevention through community-based approaches was a part of the new 2009 stimulus package.

So, I think that health education people and folks in the states can take some pride historically in making sure that that was at least on the agenda, was at least part of the agenda. When you think about

prevention, you can't think about it in the absence of health education, health promotion, community-based strategies.

I was a professor at the University of Utah. I was an advocate of health education and spoke out for it. I wasn't affiliated with government at all. And the director of the Utah Division of Health was James Mason, who subsequently became the director of the CDC. And at a public health meeting, I was extolling the virtues of health education and he came over. And Jim Mason is a very quiet, professional man. So, what I'm about to say is not the way he said it but it's kind of the way I took it. He said: Well, if you think this stuff is so important, why don't you come down to the real world in the public health department in Utah and do something about it. Get out of the academic center. He didn't quite say it that way, but that's how -- it was kind of a challenge.

And so I went to my dean, and I said: You know, I have an opportunity to take a leave of absence for a couple of years, go down and work on -- in the so-called real world. And I did that.

So, I went down to take over the directorship of the health education program in the State of Utah. And this would have been in 1979. And -- but I knew I couldn't do it alone because I'm not that capable. So, there were two other people that were in Utah. One was Greg Christianson, and the other was a fellow by the name of Gary Nelson. Now, Greg Christianson's career, I think, is rather noteworthy. It was a very important part of the behavioral epidemiology branch. He's an epidemiologist and did a lot of contributions to health education while he was at the CDC. Gary Nelson is currently the president of the Health Care Georgia Foundation and uses foundation resources to invest in local communities for prevention and health education. So, he's still playing. But at that time -- that was 30 years ago. So, we were all young, young pups.

And we developed the first state-based behavioral risk factor survey, the Utah version where we used random digit dialing. And all of this was at the stimulus of Dr. Mason.

So, I think those are two people that seemed to me to be important small -- you know, a lot of people don't know that, but they made huge contributions to the field. Dennis Tolsma was a very important person. And you've had him on the tape. But he and his work with Hod Ogden and a lot of folks associated with the CDC were very, very critical in establishing a platform that enabled other people to come in.

And I would say this as well regarding Hod and Dennis and all those other people. When I went to CDC in 1982, there were maybe three health education people in the whole organization -- in the whole of CDC. Most of the people who worked at CDC were either physicians who were epidemiologists or trained health personnel who served in managerial roles that worked in STD and HIV -- well, not HIV then, but STD prevention, lead control, things of that nature. They were called public health advisers. Epidemiologists rose to directorships. Public health advisers rose to administrative directors and leaders. And that's the way the place was organized. They didn't bring in people laterally. There weren't

sociologists, health educators, psychologists, anthropologists.

Today, we know that health is an ecological phenomenon, and you need the collective input from all of these people. And it was those people, the Dennis Tolsmas, the Hod Ogdens, the Jeff Copelands, who saw the importance of having ecological input from a lot of different disciplines that began to expand the capacity of the CDC. And I think at no point did they ever lose sight of the importance of the relationships that they would have with states. And I think some of that had an effect on the way states, for example, set up their prevention program for health education programs.

So, I think that's it. I know I've been a bit circuitous about naming people. It's hard to think of who might be left out, but those are a few that I can think of.