Northwest Public Health

Spring/Summer 2013 Volume 30 Number 1

Public Health Leadership for Changing Times

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Meta-Leadership

It seems that the only constant in contemporary public health is change. The recently released Global Burden of Disease study, from UW's Institute of Health Metrics and Evaluation, documents that risk factors, such as obesity, and chronic conditions, such as heart disease, have supplanted infectious disease as leading threats for much of the world. Infant mortality is down and we are living longer, but our later years are plagued by a constellation of age-related disabilities and illnesses. Short-term trends shift rapidly, too. In January 2013, weeks after the tragic shootings in Newtown, Connecticut, a Pew Research Center poll showed that a majority of Americans supported a range of gun control measures—a dramatic shift of public opinion on this pressing public health issue.

"Upstream" determinants of health—social circumstances, neighborhood environment, food access and quality, housing and transportation infrastructure, and global environmental change—have never been more important. Barry Commoner's first Law of Ecology—that "everything is connected to everything else"—could also be the first law of contemporary public health.

Public health leadership in these changing times must reflect that reality. We need to embrace, and lead through, change. We need to lead outside the public health silo, in arenas ranging from community development to energy policy. Our prototypical organizational setting needs to be the multi-stakeholder coalition rather than the specialized public health team. We need to "lead up" to senior policymakers. We need to lead through persuasion rather than the exercise of power. We will often be in crisis situations and outside our comfort zones; we need self-knowledge and insight to perform well in these situations.

The concept of "meta-leadership," developed in the context of emergency preparedness and response, offers a fruitful approach to meeting these challenges. This concept emerged from the National Preparedness Leadership Initiative (NPLI), a joint venture of Harvard's School of Public Health and Kennedy School of Government.

Among the hallmarks of meta-leadership is an emphasis on collaborative activity and connectivity of effort. It requires leaders to step out of their silos and in turn persuade others that it is in their best interest to do the same to accomplish an overall mission. Meta-leadership builds relationships between people, transforming cultures that may have traditionally championed independent decision-making into cultures that value cooperation. The impact lies not just in the outcome, but also in the collaborative process needed to get there.

Meta-leadership can work especially well when the goal is a form of social good, aligning people who work in different sectors (public, private, community-based, for example) and/or on different levels of a hierarchy. It has been used within the Centers for Disease Control and Prevention and by emergency preparedness and response agencies.

As you read this issue of *Northwest Public Health*, I hope you enjoy reflecting on the theme of public health leadership in changing times and learn from the stories presented about models of leadership appropriate to your work. Lead on!

Howard Frumkin, Dean
UW School of Public Health

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The mission of the journal is to provide a forum for practitioners, teachers, researchers, and policy makers in public health to exchange ideas, describe innovations, and discuss current issues.
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Public Health
Taking the Lead

Most national public health conferences and major activities of the past few years have had the dual themes that we are in a time of stress but also a time of new opportunities. This issue of *Northwest Public Health* focuses on the ways that the field of public health can play a leading role in improving the health of communities. Although we face real challenges, it is also true that as a field, public health is uniquely positioned to make a difference with strategic use of policy, evidence-based interventions, and community partnerships.

This issue contains articles illustrating thoughtful and innovative public health activities across the region, and also presents interviews with three public health leaders from our region who have had prominent national roles. It is noteworthy that this region has produced national public health leaders beyond our modest proportion of the country's population. We invite readers to consider why that might be the case and also to reflect on how to build upon the legacy of these leaders.

Several articles in this issue broadly define the scope of public health roles and tools to include behavioral health and housing as part of the public health mission. Other articles focus on innovative ways immunization programs—which remain a fundamental public health activity—can find success and funding.

Two pieces examine how putting the right data in front of the right people can facilitate policy change. Another article shows how helping those affected by health inequities to tell their own stories leads to systemic change. Accreditation is presented as an opportunity for organizational empowerment, and we close the issue with a brief glimpse into the perspectives of four recent undergraduate public health students.

We invite you to be part of the conversation about public health leadership. For the past 10 years, the Northwest Center for Public Health Practice (NWCPHP), which publishes *Northwest Public Health* on behalf of the UW School of Public Health, has sponsored the Northwest Public Health Leadership Institute. This program has provided tools and skills for emerging public health leaders across the region.

As part of its tenth anniversary, the Leadership Institute has started a blog called *Take the Lead*. This blog provides a venue for exploring leadership questions that are relevant to public health professionals. You can access the blog at www.nwcphp.org/take-the-lead. We invite you to use this forum to share your ideas about public health leadership with other public health professionals.

Finally, I'd like to announce that the journal will have a new editor-in-chief in the coming months. Tao Sheng Kwan-Gett, MD, MPH, assumed the directorship of NWCPHP in March 2013 and will also be taking on the role of editor-in-chief for the journal. I have greatly enjoyed my association with all the contributors and readers who have helped bring this journal to its current state of quality and relevance. Thank you for your engagement in this shared commitment to improve the evidence base for public health practice.

Susan Allan, Editor-in-Chief
UW School of Public Health

Integrating Public Health and Urban Planning

By Brendon Haggerty

Does neighborhood form predict physical activity? Can proximity to healthy food make a difference in diet? Will cooling centers save lives? Even for experts in public health and urban planning, it is challenging to trace the causal pathways that connect the built environment to a health determinant or outcome.

Research that documents these causal pathways is of high value for the creation of effective public health policy. At least, this has been the experience of Clark County Public Health (CCPH), a local public health department in southwest Washington that has recently used research findings to guide comprehensive land use planning.

In early 2011, CCPH partnered with the Community Planning Department of Clark County to inform the next update of the Clark County *Comprehensive Growth Management Plan*. The resulting document, known as *The Growing Healthier Report*, summarized research literature, described current conditions, and recommended policy changes. In June 2012, the Board of Clark County Commissioners endorsed *The Growing Healthier Report* as the document that would guide the update of the *Comprehensive Growth Management Plan*.

The updated *Comprehensive Growth Management Plan*, to be completed by 2016, will include policies to improve health in eight topic areas that were identified in *The Growing Healthier Report*. These areas are housing, transportation, parks and open space, economic development, safety and social cohesion, access to food, environmental quality, and climate change.

In preparation for *The Growing Healthier Report*, CCPH provided a series of background reports summarizing research literature and data on Clark County for each of the eight topic areas. These background reports described pathways from policies, such as zoning or transit plans, to outcomes, such as physical activity and obesity. Drawing from published research, CCPH provided information to the Board of Clark County Commissioners that characterized the likelihood that various conditions in the local built environment were affecting health.

Integrating Research With Local Data

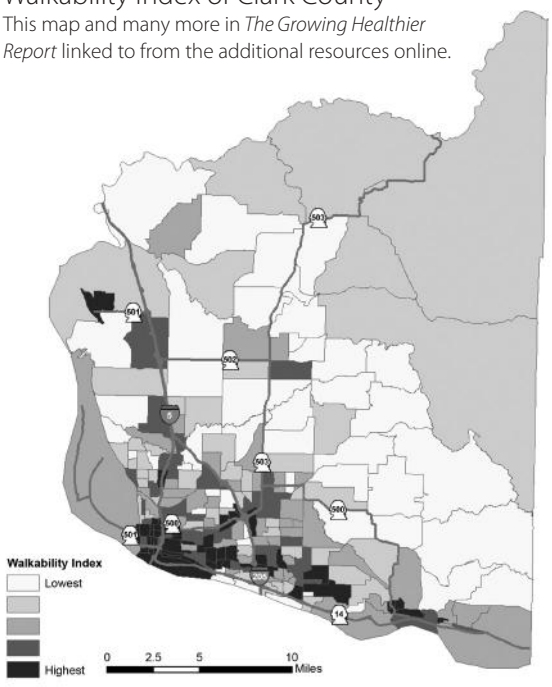
To provide the commissioners with compelling information, it was important that CCPH illustrate research findings using data from Clark County. Three examples of this approach are given below.

Walkability index

Research shows that certain characteristics of urban form are associated with higher levels of physical activity. CCPH calculated a walkability index following a method developed by Lawrence Frank, James Sallis, and other leading researchers of health and urban form. The index combines measures of street network connectivity, land use mix, residential density, and building site coverage. A 2009 study conducted by Sallis and others found that living in neighborhoods with a higher walkability index was associated with meeting physical activity recommendations at least one more day per week. CCPH included a walkability index for Clark

Walkability Index of Clark County

This map and many more in *The Growing Healthier Report* linked to from the additional resources online.



Vancouver Main Street in Clark County and clock tower (opposite page). Both photos courtesy of Brendon Haggerty.

County in *The Growing Healthier Report* to show which areas of the county had a high need for pedestrian infrastructure or a high potential for walkability. This tool was especially useful given the lack of a reliable inventory of county-wide sidewalks.

Mapping the food environment

Research suggests that proximity to food influences a person's diet. The availability of unhealthy food compared to the availability of healthy food is an important measure of the food environment. CCPH assessment staff worked with CCPH food inspectors to categorize each of the roughly 1,200 food retail establishments in Clark County. Categories included supermarkets, grocery stores, produce markets, farmers markets, convenience stores, fast food restaurants, and full-service restaurants. Staff then geocoded each establishment and mapped half-mile network buffers around each to estimate the population within walkable distance. They found that although about 41 percent of residents lived near a fast food restaurant or convenience store, only about 17 percent lived near a grocery store or supermarket. This knowledge helped identify areas of the county that were underserved by healthy food retailers. Potential policy changes that build on these findings include limiting fast food near schools or in areas with a high density of unhealthy food options. CCPH has already used these findings to implement a healthy corner store program.

Linking climate change modeling and health

Climate change is a public health emergency, and data show that increases in extreme heat, disease vectors, and severe weather events are already affecting the health of the residents of Clark County. To obtain this data, CCPH partnered with the Northwest Center for Public Health Practice (NWCPHP) at the University of Washington. (Downscale models of climate change are challenging to acquire, so local health jurisdictions can benefit from working with academic partners to obtain these models.)

Researchers working with NWCPHP analyzed historic data on morbidity and mortality in Clark County on extreme heat days. They found an increased risk of death and hospitalization on extreme heat days, especially among older age groups. Applying these findings to county-level climate models, researchers estimated by 2045, under a moderate warming scenario, Clark County can expect 19 deaths per summer due to climate change. Such information is useful to policy makers who could potentially allocate resources for climate change mitigation strategies such as building energy retrofits, as well as adaptation efforts such as designating cooling centers.

Conclusion

Because it based its policy recommendations on current condition reports and research, *The Growing Healthier Report* became a powerful communication tool for advancing health promoting policies. In the months since the Board of County Commissioners acted to advance the recommendations in *The Growing Healthier Report*, community groups have drawn on the report's findings for their advocacy activities.

CCPH staff chose to conduct literature reviews internally rather than relying on off-the-shelf compilations completed by other organizations. This approach helped establish CCPH staff as local experts and gave staff members a common understanding of key issues. However, guidance documents from organizations such as the National Association of County and City Health Officials or the American Planning Association can be an ideal starting point for those seeking a greater familiarity with current research. ■

Additional resources at
www.nwpublichealth.org

Author
Brendon Haggerty, MURP, is an urban planner at Clark County Public Health in Vancouver, Washington.

Informing Public Health Policy

By Sami Jarrah

Author
Sami Jarrah, MPH, is Strategy and Policy Analysis Manager for Integrated Clinical Services at the Multnomah County Health Department in Portland, Oregon.

Acknowledgments
Aaron Katz, CPH
Cindy Watts, PhD, MA

State legislatures often enact policies that greatly affect the public's health. With this in mind, what kinds of information do legislators find compelling and helpful as they deliberate important public health initiatives?

To investigate this, the author surveyed Oregon legislators who had voted on House Bill 2726*. In 2009, Oregon legislators passed this bill, a menu-labeling law with significant health implications. The bill required chain restaurants to post calorie information for food items on menus, menu boards, or food packaging along with a statement describing the recommended daily nutrient intake. The goal was to enable healthy choices by providing Oregon consumers with point-of-purchase nutritional information.

To assist the passage of HB 2726, public health advocates mobilized voters and shared empirical evidence. Most often, this evidence focused on Oregon's obesity and diabetes epidemics and how a menu-labeling law could reduce those population health problems.

Surveying Legislators

From August to November 2010, Oregon legislators completed online and paper surveys. The response rate was 55 percent, with 47 out of 85 legislators participating.

The survey invited the legislators to share information anonymously about their deliberations over HB 2726. The survey included eight questions and an "other comments" field. Questions asked legislators to identify their primary reasons for voting either in favor of or in opposition to HB 2726. Answer choices were based on policy research and reasons cited in the popular media. For legislators who voted in favor of HB 2726, options included empirical evidence describing the efficacy of menu labeling in reducing obesity rates, consumers' right to know, the reliability of Oregon's public health experts, and importance to constituents. Legislators also identified what evidence, if any, would have or did influence them to vote in favor of HB 2726.

Voting "Yay"

Among respondents, the two most common reasons legislators voted in favor of HB 2726 were a belief in consumers' right to know point-of-purchase nutritional information and awareness of empirical evidence that suggests menu labeling decreases obesity levels.

Respondents from both parties and chambers listed these as their top two reasons.

Among respondents who voted in favor of HB 2726 (n=37), the third most commonly cited reason for doing so was that they believed that HB 2726 was important to their constituents.

Voting "Nay"

Among survey respondents who voted in opposition to HB 2726 (n=10), the most commonly cited reasons varied depending on political affiliation. Republican respondents generally opposed the legislation and most often reported that it was not the government's role to influence individuals' food choices. Another commonly identified reason among Republicans was that the government should not interfere with restaurant owners' operations. Although only three Democrats in the study population opposed the legislation, these Democratic legislators each cited different reasons: insufficient empirical evidence, cost, and HB 2726 not being ambitious enough.

*HB 2726 has since been preempted by federal menu labeling provisions in the Patient Protection and Affordable Care Act.

Convincing Opponents

Among opponents to HB 2726, respondents generally agreed that the most helpful decision-making resource would have been access to convincing empirical evidence suggesting the effectiveness of menu labeling. Importantly, among HB 2726 opponents, a face-to-face visit with public health leadership was the second most commonly identified decision-making resource that could have influenced a vote in favor of the legislation.

Other tactics that opponents listed as potential "game changers" included support for the bill from the Oregon business community, demonstration of constitutional authority by HB 2726 supporters, empirical evidence from other jurisdictions that had already implemented menu labeling, empirical evidence about the obesity epidemic, and testimony from consumer advocates.

Values vs. Information

According to the internationally known epidemiologist Alfred Sommer, legislators make policy decisions through the dual lenses of values and information. Values are formed through interactions of many factors, including belief systems, social and economic interests, ideology, and historical context. In this study, the data indicate that a significant percentage of policymakers, both HB 2726 supporters and opponents, valued empirical evidence. In fact, 60 percent (n=6) of HB 2726 opponent respondents indicated they might have supported the bill if they were presented with clear and compelling empirical evidence that menu labeling definitively reduces community obesity rates. In the end, evidence mattered.

The data illustrate that other legislators opposed HB 2726 because of values. This is likely the case for the 30 percent (n=3) of HB 2726 opponents who indicated no evidence could convince them to support the legislation, and also for the 60 percent (n=6) and 40 percent (n=4) of legislators who indicated, respectively, that the government has no role in influencing personal diet choices or in interfering with restaurant owners' operations. The data suggest that opposition to HB 2726 was based primarily on ideological disagreements with the public health policy.

Decision-making resources that would have been or were helpful:

	Political Party (%)*	
	Democrat (n=32)	Republican (n=15)
Evidence suggesting effectiveness of menu labeling	63	33
Talking points to defend position to constituents and lobbyists	19	13
Fiscal analysis demonstrating if HB 2726 saves Oregon funds	38	13
Face-to-face visits with public health leaders and experts	41	20
Analysis of Oregon voters' opinions on HB 2726	19	20

**Percentages do not total 100 due to non-response or to respondents choosing multiple responses.*

Implications

Evidence played a key role in influencing legislative support for HB 2726, but other factors—appealing to and mobilizing constituents, forming relationships with legislators, working with the business community—can be crucial for passing progressive public health policies. While a public health policy toolbox must include reliable and understandable evidence of efficacy, it must also include more. Evidence matters, but it's not enough. ■

Additional resources at
www.nwpublichealth.org

Accreditation as Opportunity for Organizational Empowerment

By Lindsey Krywaruchka, Denny Haywood, Jane Smilie

Authors
Lindsey Krywaruchka, BSBA, is the Coordinator for the Office of Public Health System Improvement in the Public Health and Safety Division of the Montana Department of Public Health and Human Services.
Denny Haywood, MBA, is a Performance Management Consultant for the Office of Public Health System Improvement at the Montana Department of Public Health and Human Services.
Jane Smilie, MPH, is the Administrator of the Public Health and Safety Division of the Montana Department of Public Health and Human Services.

September 2011 was a landmark month for the public health system in the United States. The Public Health Accreditation Board (PHAB) released the final version of its accreditation standards for state, local, and tribal public health departments. Public health departments that wanted to participate in the voluntary accreditation process could use these standards to not only apply for accreditation but improve overall performance. This broader vision is expressed by PHAB on their website: "Accreditation through PHAB provides a means for a department to identify performance improvement opportunities, to improve management, develop leadership, and improve relationships."

Although PHAB created the standards for accreditation, each health department that uses them is responsible for designing processes to measure and document their organization's performance against the standards. This responsibility provides an opportunity for organizations to create systems, which, in addition to being useful for accreditation, can improve overall leadership and management.

After the PHAB standards were released, the Public Health and Safety Division of the Montana Department of Public Health and Human Services committed to the accreditation process. The process is currently led by a management team that is staffed by the Division's executive leadership team. The Division Administrator leads the management team.

To create an action plan, the management team first completed a review of the Division's perceived conformity with the PHAB standards. While the management team felt strongly that the work being done by Division staff was of high quality, the team struggled to consistently quantify this performance across the entire Division because evaluation and management processes varied from unit to unit. After some deliberation, the team prioritized the creation of a standardized management system called the integrated management system (IMS). The IMS would employ methods that had been successfully used in other organizations, and the team hoped the system would give all Division employees the opportunity to fully contribute their skills and expertise to the accreditation process.

The IMS would be guided by these principles:

- First and foremost, the system must manage work to achieve improvements in the health status of Montanans;
- The system must be developed with input from Division staff, be user-friendly, and not create unnecessary burdens or bureaucracy;
- Key components should include a standard cause-and-effect logic model, a standard work plan, and a regular system of reporting progress for each and every program within the Division; and,
- The system would enable all staff to lead because it would give all Division staff a role to play in the leadership process.

Building an Integrated Management System

The first phase of building an IMS was to pilot the process within one program within the Division. Throughout the pilot, the management team solicited feedback from program staff to assure the process was viewed as beneficial and not simply more paperwork.

The process began with a facilitated work session. Program staff answered questions such as "What health outcomes are you trying to achieve?" and "What work is being done to achieve those outcomes?" Answers to these questions identified core activities. (The Division defines a core activity as "a discrete unit of work with a common purpose—a one-time project or continual work process that requires a work plan.") A single program in the Division can be responsible for multiple core activities.

From this work, staff created a program logic model. The logic model created explicit, agreed-upon linkages between the core activities of the program, the desired outcomes for each core activity, and ultimately the health outcomes the program was attempting to affect. In addition, the logic model showed how the work of the program aligned with the Division's strategic goals. Working from the logic model, staff then used a standard work plan template to develop a work plan for each core activity.

After completing the pilot project with one program, all programs within the Division's Chronic Disease Prevention and Health Promotion Bureau

went through this process. During this second phase of IMS implementation, 12 programs participated, resulting in 12 standardized logic models and 84 work plans. After phase two was completed, the management team met with the program managers who had been using the IMS. Program manager feedback was positive and cited the benefits of a standardized approach to planning, tracking, and evaluating their work.

As of this writing, implementation of the IMS throughout the entire Division is 80 percent complete. It is projected that the Division will submit its accreditation application in March 2013.

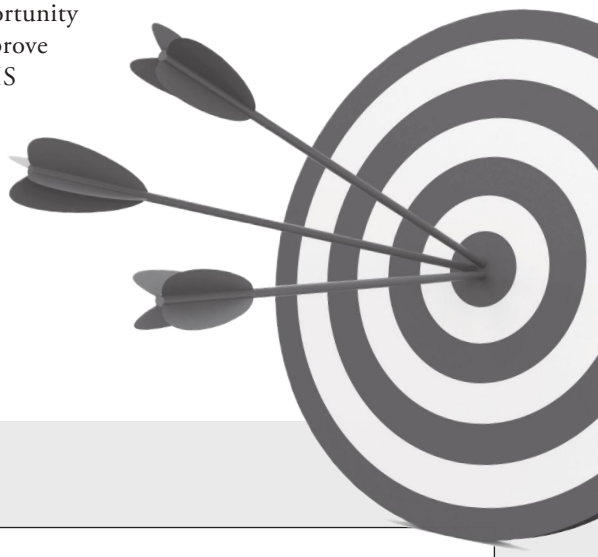
Leading with an Integrated Management System

The IMS manages work and tracks performance across the Division. When it is fully in place, the system will equip upper-level managers, as well as frontline staff, to lead by keeping outcomes in mind as they perform day-to-day work. Program staff can see their contributions not only to the work of their program, but also to the overall outcomes of the Division. The result is a system of leadership that begins with the management team setting the strategic direction for the Division and cascades down through clearly defined operational plans developed by all Division program staff.

Regular review of progress, as it is defined and charted by the IMS, is essential for this system to work. The Division's management team has created a schedule for this review and hopes that this process will give all staff the opportunity to

- facilitate dialogue between program staff and management at all levels;
- take a structured "time out" to identify and resolve operational performance problems early on;
- proactively remove barriers to performance or change direction if needed; and
- ensure high productivity and continuous quality improvement.

Accreditation provides an opportunity for public health agencies to improve performance. Building an IMS to standardize and track performance not only supports accreditation standards but builds high performance and shared leadership throughout public health organizations. ■



Core Activities

Early Stage Cancer Detection

Goal: Age and income eligible Montanans have access to breast, cervical, and colorectal cancer screening.

Metrics:

- Quarterly number of women screened for breast and cervical cancers.
- Quarterly number of men and women screened for colorectal cancer.
- Quarterly number of American Indian women screened for breast and cervical cancers.

Maintain Cancer Data Systems

Goal: Complete and quality cancer data are readily available.

Metrics:

- Annually achieve NAACCR Gold Certification for data quality, completeness, and timeliness.
- Annual percent of breast and cervical screening data (MDE data) that meet all 11 core performance indicators.

so that

Cancer Program

Goal: Fewer Montanans experience late stage cancer and fewer Montanans die of cancer.

Metrics:

- Biannual percent of Montanans who are up-to-date with colorectal cancer screening. Data source: BRFSS
- Biannual percent of Montanans who are up-to-date with breast cancer screening. Data source: BRFSS
- Biannual percent of Montanans who are up-to-date with cervical cancer screening. Data source: BRFSS

Confidence and Responsiveness

Carol Moehrle, RN, *has been the Director for the North Central District Health Department in Lewiston, Idaho, since 1992. She is currently Chair of the Public Health Accreditation Board (PHAB) Board of Directors and served as President of NACCHO* in 2010–11.*

How would you describe the current opportunities in public health?

We live in an exciting time for local public health. Here are a few opportunities that I see:

- We have the mysterious Affordable Care Act on our horizons. We have the opportunity to redefine ourselves and choose a new strategy for influencing prevention and improving population health in our country, but first we need to decide where we fit in this new plan.
- We have strong CDC leadership. We have a like-mindedness of federal, state, and local public health officials and organizations. If all of us work together, we will have the leverage we need to improve population health.
- We have a nationally recognized set of standards and measures for tribal, state, and local public health to be held accountable to. With the launch of PHAB, all of public health has the opportunity to demonstrate the outstanding work being done and to show our populations that we meet the nationally recognized standards.

What do we in public health need to do differently to take advantage of these opportunities?

We need to tell our story. We need every citizen to know and understand what public health is and what we do for communities. Even after decades of great public health work, it's frustrating to think that much of our population does not know or value what public health does with them and for them.

Do you have concerns about the field of public health today?

Having been in the director position for many years, I have witnessed the ebbs and flows of our public health workforce. Our public health workforce is smaller than it has been in my entire career. I worry about the future of our current employees and sometimes find it difficult to match a new vision of public health with the current staffing.

Do you have concerns about the health of the population?

I know our population is very resilient, and we find ways to support each other to maintain our health. But yes, I have concerns about the health of the population. We all know that health outcomes take years to change, and we have done a great job documenting much progress in certain areas, like high blood pressure. But when you look at the historical trend data, we still have not made a measurable impact on improving the overall health of our population.

How might public health become more relevant and effective in communities?

We need to be confident in the role we play. The importance of what we do is linked to economic development as well as health outcomes. Public health can become more relevant in communities if we continue to use data to tell our story. We need to help our communities align their policies around health, and data is a great anchor for this discussion. Public health can no longer tell people what to do. We must listen and be responsive to understanding the public's expectation of health and help them implement change. ■

*National Association of County and City Health Officials (NACCHO)

Challenging Ourselves

Lillian Shirley, MPH, MPA, *has been the Director of Multnomah County Health Department in Portland, Oregon, since 1999. She served as President of NACCHO* in 2011–12.*

How would you describe the current opportunities in public health?

Public health can leverage our core competencies so that communities will use these to frame what they value and need. Data collection and epidemiology can assist in community protection. These aspects of public health are being requested in a lot of jurisdictions. This work does not have to be done by public health, but we must show our added value by convening and providing epidemiology analysis.

What do we in public health need to do differently to take advantage of opportunities?

We need to challenge ourselves, look at the big picture, develop systems thinkers, and analyze programs from a perspective of the whole environment. Also, we need to be more flexible in our practice and partnerships to achieve our goals.

What are existing trends or environmental conditions that could be leveraged to improve population health?

We have to think in terms of what to leverage. What do we care most about measuring? How do we work more with system impacts and outcomes? Our focus must be on outcomes and not just activities in the implementation of the Affordable Care Act.

Do you have concerns about the field of public health today?

We have to look at health equity and access issues. If you look at some of our health outcomes across jurisdictions, they don't look that bad until you begin to "peel the onion." Looking across the spectrum, individual outcomes vary. I want to support poor and vulnerable families. How do we get whole communities and jurisdictions behind goals that support these populations? Our workforce needs will be monumental in the coming decade. Do our curriculums support the preparation of new skills and approaches?

In recent years, you, Carol Moehrle, and John Wiesman have been elected to serve as NACCHO's President. Why do you think our region has been prominent in this way?

We practice our craft in an environment that allows for experimentation, and we all have had boards that invested in our professional development. We also practice in a region that has a culture of innovation. We are not overwhelmed by numbers, conditions, or disasters. We have been able to focus.

How might public health become more relevant and effective in communities?

Communication plays a role in making public health relevant. After 9/11, we got up to speed with risk communication. But we also need to get the public health story out, and we are getting better at this. In my department, we hired someone who came from media to help so we can tell our story in a way that folks can hear.

A big part of public health leadership is to make sure people who work in public health are healthy and can model healthy behaviors and attitudes. Sometimes we get weighed down and focused on what we can't do. If we focus on what we can do, that ripples down and creates an environment for positive change. ■

*National Association of County and City Health Officials (NACCHO)

Where Can We Do the Most Good?

John Wiesman, DrPH, MPH, *is the incoming Washington Secretary of Health. Wiesman served as Director of Clark County Public Health in Vancouver, Washington, from 2004 –2013. He is currently President of NACCHO*.*

How would you describe the current opportunities in public health?

Right now we have a number of important opportunities with health care reform. First, we can increase our partnerships with non-profit hospitals by assisting them with their required community assessments. And for those of us who have multiple hospitals in our jurisdictions, we have an opportunity to take a leadership role in encouraging a single assessment process that has a coordinated health improvement plan.

Second, we need to take our population health experience to the tables at which accountable care organizations and the triple aim (improved patient experience/outcomes, improved population health, and reducing per capita costs) are being addressed. Our expertise in addressing the social determinants of health is going to be critically important to our health care partners as they focus even more heavily on quality as their payment systems switch from procedures to patient outcomes.

Third, we have systems and chronic disease prevention knowledge that should influence where hospitals invest their community benefit dollars, as those dollars are freed up from covering bad debt and uncompensated care.

Fourth, we need to increase our public health informatics resources to fully engage in health information exchanges to mine the data that can improve our knowledge of population health and help in designing prevention efforts to address the issues we find.

We in the field of public health like to do it all. This will not work for today's environment, and so we need to assess where we can do the most good. Part of defining this is to develop a minimum package of public health services that should be provided in every jurisdiction. This is critical to forming our brand identity, which, if strengthened, should assist us in our policy and legislative efforts. The minimum package must come with appropriate funding and the understanding that the minimum package may not cover all the services a health department will need to provide.

Do you have concerns about the field of public health today?

Our systems of providing health care, behavioral health, oral health, population health, human services, and education are fragmented. We need to address this and improve population health by working across institutions and systems.

Retooling our workforce is something in which we must invest time, talent, and financial resources. Similarly, succession planning must be folded into our workforce development efforts. It is important that we take a leadership pipeline approach in which we support developing frontline staff for their first supervisor position, supervisors for their first job managing managers, and so on.

When you look at local public health across the country, do you see common pitfalls and issues for the field that are mirrored in many jurisdictions?

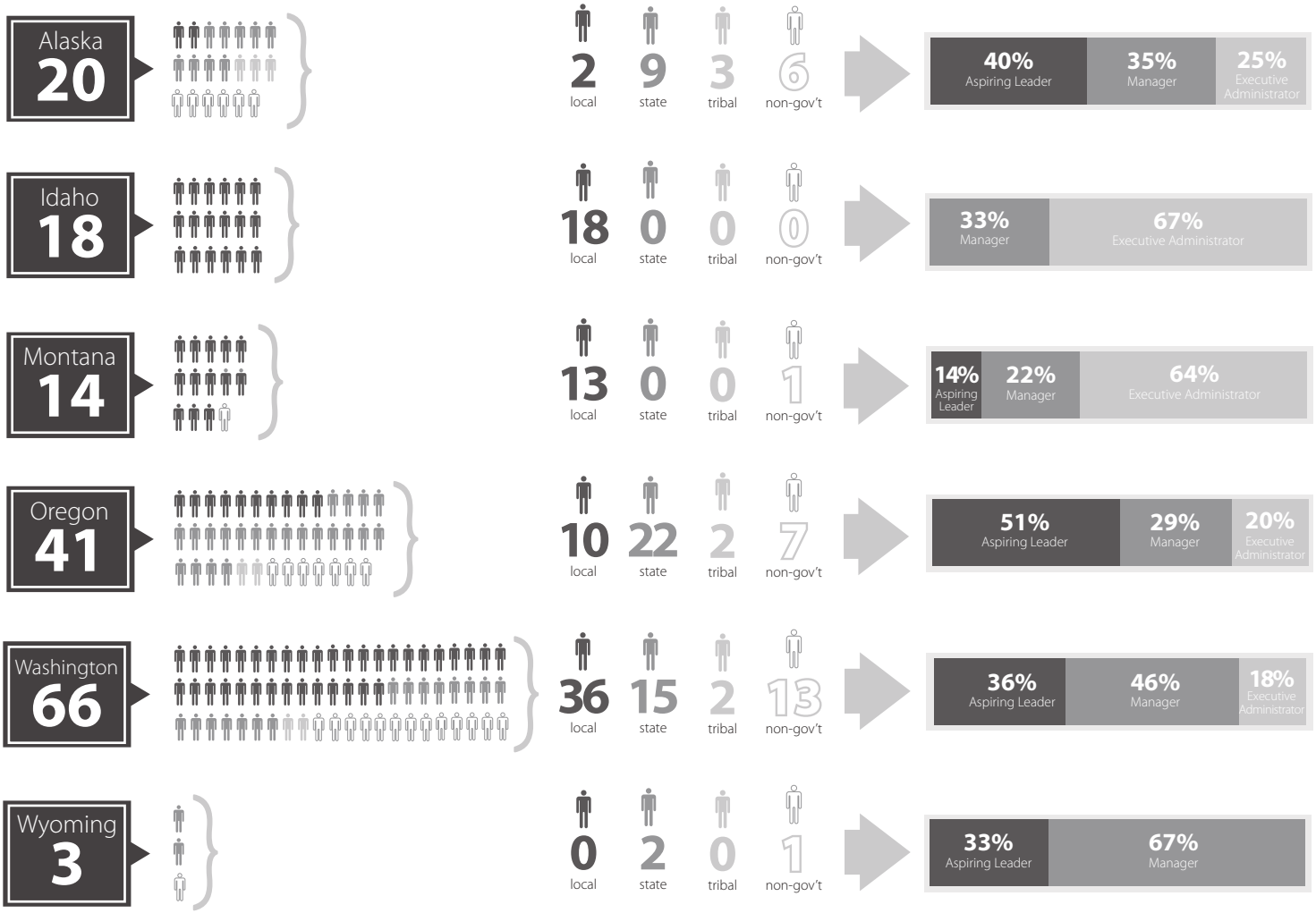
I think this goes to the themes I have already raised: a lack of brand identity, a chasm between public health and medical care systems, and a workforce that needs preparation for new realities. If we address these things, we will be more relevant and effective. ■

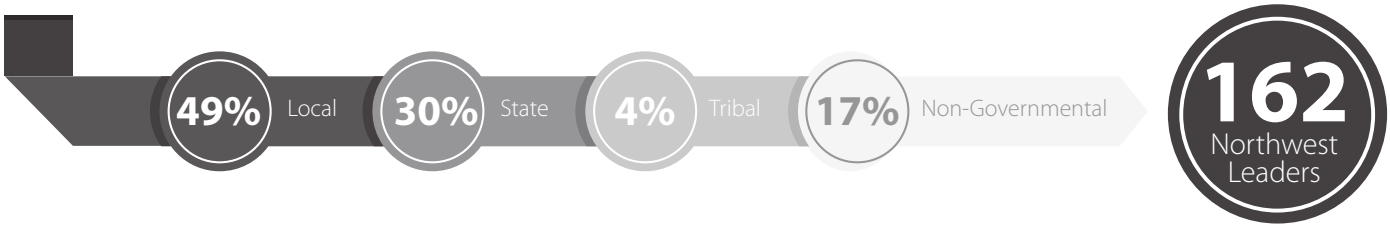
*National Association of County and City Health Officials (NACCHO)

Ten Years of the Northwest Public Health Leadership Institute

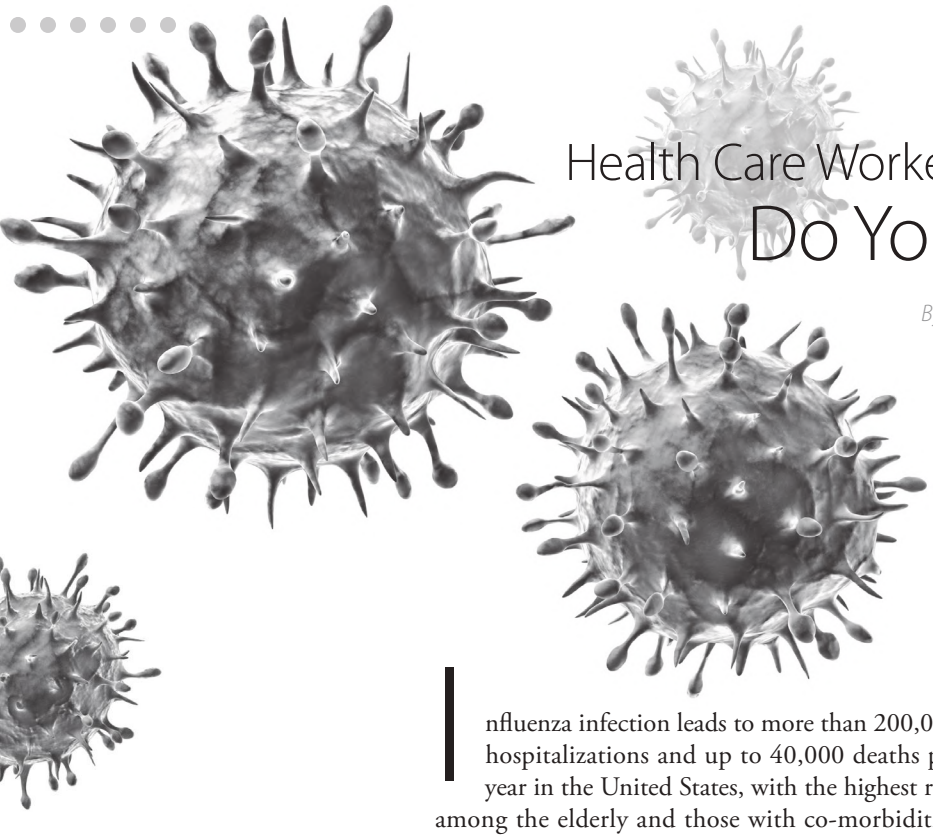
Since 2003, 163 leadership scholars have participated in the Northwest Public Health Leadership Institute, a program run by the Northwest Center for Public Health Practice at the University of Washington. The information below shows the state, sector of public health, and approximate level of leadership experience for the scholars at the time of admission.

With the exception of one scholar from California who is not represented in the data below, all scholars have been from the states of Alaska, Idaho, Montana, Oregon, Washington, and Wyoming. Information about the Institute is available at www.nwcphp.org/leadership-institute.





Information provided by the Northwest Center for Public Health Practice, compiled by Latrissa (Trish) Neiworth, and designed by Missie Thurston.



Health Care Workers and Influenza Vaccination: Do You Need a Mandate?

By John B. Lynch, Kathy Mertens, Estella Whimbey, Timothy H. Dellit

Influenza infection leads to more than 200,000 hospitalizations and up to 40,000 deaths per year in the United States, with the highest risk among the elderly and those with co-morbidities. These same populations are those most often in need of health care and found in health care settings. Consequently, many have called for increased vaccination of health care workers (HCW) to protect vulnerable populations.

As early as 1981, the Centers for Disease Control and Prevention (CDC) recommended influenza vaccination of HCWs, but this recommendation was not widely implemented. Since the 2009 H1N1 pandemic, national organizations have become more vocal about HCW vaccination, with some recommending influenza vaccination as a condition of employment. Yet mandating influenza vaccination for HCWs may interfere with workplace morale and lead to legal actions.

Influenza infection leads to more than 200,000 hospitalizations and up to 40,000 deaths per year in the United States.

Harborview Medical Center (HMC) and the University of Washington Medical Center (UWMC) (located in Seattle, Washington and part of the UW Medicine Health System) have offered influenza vaccine free to all HCWs, volunteers, and community partners for many years. In 2006, approximately 45 percent of HCWs underwent voluntary vaccination. This rate increased to 62 percent for the seasonal vaccine during the 2009 season, although only 37 percent received the H1N1 vaccine.

To Mandate or Not?

In 2010, given the importance of influenza prevention and the slow improvement in vaccination rates, HMC and UWMC implemented a formal vaccination program.

HMC and UWMC leadership were aware of a successful program using mandatory influenza vaccination of HCWs at Virginia Mason Medical Center in Seattle, Washington. At that facility, influenza vaccination was a requirement for continued employment, leading to more than 98 percent vaccination coverage of HCWs.

Following the experience at Virginia Mason Medical Center, other medical centers have used similar policies with excellent outcomes. In addition, national organizations including the Infectious Disease Society of America, the American Academy of Pediatrics, and the American Academy of Family Physicians, have published recommendations in favor of mandatory vaccination. In these programs, alternatives to vaccination are generally limited to medical contraindications and, in some non-mandatory programs, a recommendation for unvaccinated HCWs to wear surgical masks during the influenza season.

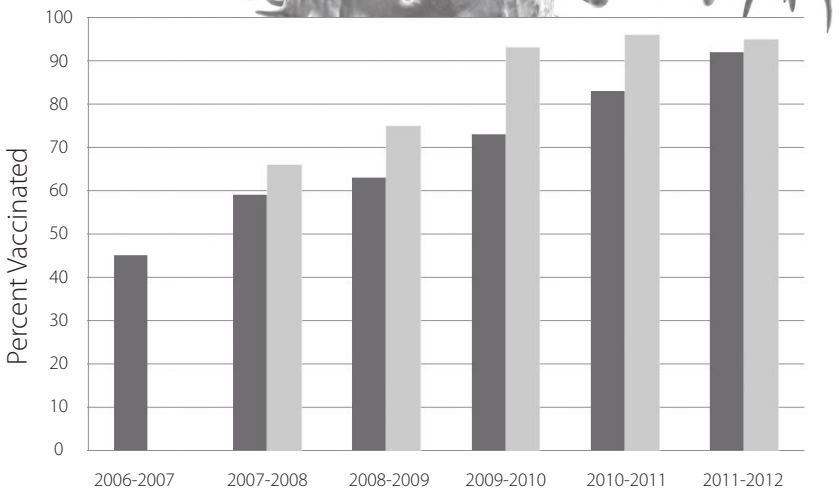
Due to concern about employee-employer relationships and lack of data on patient outcomes in mandatory programs, leadership of HMC and UWMC chose not to implement an influenza vaccination mandate before investigating the effectiveness of other strategies. In the fall of 2010, HMC and UWMC held concurrent two-week "health fairs" that offered free influenza vaccination to all attendees. The fairs also provided required annual tuberculosis screening and respirator fit testing. The goal was to have "one-stop shopping" for HCWs to meet all their yearly employee health screening requirements and encourage influenza vaccination.

The campaign was accompanied by an advertising campaign and electronic messages. HCWs could

attend public meetings or individualized sessions. Compliance in the program was mandatory at both centers and was accomplished by one of the following:

- Vaccination at the hospital or another facility
- Completion of an online educational module and a declination form. This option included both medical declinations and declinations for all other reasons (philosophical, religious, etc.)

As a result of the health fairs, HCW influenza vaccination increased from 62 percent in 2009 (for the seasonal vaccine) to 83 percent at both centers, with approximately 1,600 HCWs out of 12,000 declining vaccination for non-medical reasons. Influenza vaccination of the faculty physician groups was approximately 95 percent at both centers.



Influenza vaccination rate at Harborview Medical Center from 2006 to Spring 2012. Rates were similar at University of Washington Medical Center.

Building on Success

Although influenza vaccination rates among HCW improved with formalization of the process and a requirement for compliance with the program (either vaccination or completion of the declination process), the number of total declinations for all reasons remained high. For the 2011–12 season, HMC and UWMC added one-on-one education, data collection on declinations, and teams of vaccinators who roamed throughout the hospitals, increasing the convenience of vaccination for HCWs and decreasing the overall cost of implementation. With this model, nurses on wards could spend part of a shift roaming instead of dedicating entire shifts to the fair.

Unlike the prior year, vaccination was not linked to respirator fit testing or tuberculosis screening, both of which require additional time and funding. For the 2011-12 season, HCW compliance could be achieved by one of the following:

- Receipt of influenza vaccination and documentation of vaccination
- Written documentation of medical contraindication by a primary care provider or evaluation by employee health nurse or physician using CDC guidelines
- Completing an online influenza educational module followed by a 10–15 minute appointment with an employee health nurse or physician

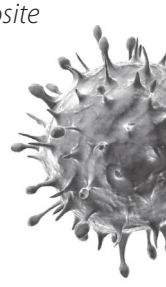
The one-on-one session used a structured data collection instrument that included questions about influenza vaccine safety, ethical responsibilities of health care workers, and protection of patients. After completing the form, employees were asked if they wanted to be vaccinated. If they continued to decline, they were asked to explain why. All reasons were accepted and recorded, and the employee was considered compliant with the program. Data on declinations will be used to modify future online trainings and one-on-one education. The reasons given for declinations were diverse, but most commonly focused on concerns about the safety and efficacy of the vaccine.

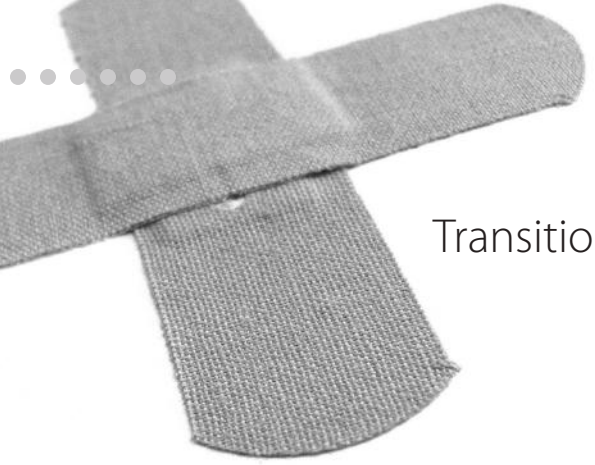
The addition of the one-on-one education session led to a 50 percent decrease in declinations for non-medical reasons and an overall HCW vaccination rate of 93 percent at both centers. An increase to over 90 percent HCW vaccination, in the absence of a mandate and in a large medical center, has not been previously documented in the literature. The use of a novel one-on-one education session appears to be a viable alternative to influenza vaccination as a condition of employment.

Prevention of influenza infection remains a high priority at HMC and UWMC. Accrediting bodies, such as The Joint Commission, are increasingly aware of HCW vaccination rates at individual hospitals. In January 2013, the Centers for Medicare and Medicaid Services will begin to require reporting of HCW vaccination status at all hospitals via the CDC National Health Surveillance Network. In the coming years, HMC and UWMC will continue to refine vaccine program policies that are both effective and acceptable to employees. ■

Authors
John B. Lynch, MD, MPH, is the Medical Director of Employee Health at Harborview Medical Center.
Kathy Mertens, RN, MPH, is the Administrative Director of Employee Health at Harborview Medical Center.
Estella Whimbey, MD, is the Medical Director of Employee Health at the University of Washington Medical Center.
Timothy H. Dellit, MD, is the Medical Director of Infection Control at Harborview Medical Center.

This page and opposite page, H1N1 virus.





Transition to a Public-Private Partnership for Childhood Immunizations

By Kathryn Bergh

Washington State has a universal purchasing system to promote access to recommended childhood immunizations. Under this system, the Washington State Department of Health purchases all vaccines recommended for children under the age of 19 and distributes them to vaccine providers at no cost. This system has significant benefits, including access to federal contract rates that are typically 15–60 percent lower than private purchasing alternatives. Universal purchasing also increases provider participation in the immunization program by reducing administrative burdens, thereby expanding access for families.

Washington's universal purchasing system is currently a result of effective public-private collaboration, but for many years the system was run with state funds. This support ended when the Washington State Legislature voted to end funding for the program, effective May 2010, as part of broader budget cuts.

Aware of the coming change, a group formed in June 2009 to discuss options for maintaining a strong system and to organize an Immunization Congress. The planning group included representatives from the legislature, the Department of Health, physician groups, local public health, school nurse organizations, and health plans. The group adopted guiding principles, researched vaccine financing and delivery models in other states, and developed policy options.

In September 2009, the group presented its findings at the Immunization Congress that it had organized. The meeting was attended by over 60 people from a broad spectrum of stakeholders, including representatives from vaccine manufacturers and the governor's office. The group presented three options:

- A dedicated tax on health plans or providers
- Voluntary contributions by health plans to the Department of Health
- Voluntary contributions by health plans to a private purchasing consortium

As Congress attendees discussed these options, a fourth option emerged, which was widely supported. Under this model, private contributions would be made to a designated fund administered by the Department of Health. This model would make it possible for the program to be eligible for federal contract rates while keeping private funds separate from other Department of Health funds.

After the Immunization Congress, the planning group added more members and redefined itself as a leadership group. The group also increased its stakeholder engagement efforts. Although the Congress had created momentum for preserving a universal purchasing system, it became clear that legislation was necessary to address concerns that some providers and insurers might not fully participate if participation in the program was voluntary. On March 23, 2010, then-governor Christine Gregoire signed House Bill 2551 into law, establishing the Washington Vaccine Association (WVA), a nonprofit organization funded by mandatory payments from health plans and other payers. By outlining the rights and responsibilities of the payers, the legislation increased confidence that the system would be administered in a fair way.

The WVA completed its second full year of operations in June 2012 and is broadly regarded as a success. The Department of Health's ability to purchase vaccines was not disrupted by the creation of the WVA, and the assessments collected from payers have been sufficient to pay for all start-up costs and vaccines included in the program. Starting February 1, 2012, the WVA lowered the amount that insurance companies must pay per vaccine.

Key informant interviews with members of the planning and leadership groups were conducted to identify factors that contributed to the successful formation of the WVA. Responses consistently identified four factors as vital to every stage of the transition process:

• *Broad stakeholder engagement:* The inclusion of representatives from across the spectrum of groups affected by the childhood vaccine program ensured that all relevant interests and concerns could inform the discussion.

• *Emphasizing a shared purpose:* As diverse (and occasionally conflicting) stakeholder interests emerged, it became essential to establish a strong foundation of shared interests and mutual benefit. Guiding principles and a purpose statement helped to keep stakeholders unified and invested when challenges surfaced.

• *Strong champions:* The leadership group was composed of individuals who were dedicated to childhood immunizations, and their passion and energy played a key role. Support from key legislators and the governor also enabled the passage of legislation that allowed universal purchasing to continue.

• *Strong relationships between representatives of major stakeholder groups:* Many members of the group had a long history of successfully working together. This history created trust among the members and helped them to work efficiently and effectively.

The Immunization Congress was a pivotal event because it solidified these factors and generated momentum. Key informants identified several elements that contributed to the success of the Congress:

• *Speakers from similar programs in other states:* Presentations by representatives from two states with universal purchasing systems helped convince stakeholders that maintaining a universal purchasing system was a realistic goal.

• *Detailed analysis of the options:* The extensive research of the planning group enabled the presentation of several alternatives along with their respective strengths and weaknesses.

• *Skilled facilitator:* A facilitator helped the group effectively prepare for the Congress, including the development of a structure that communicated a clear mission and focus to attendees.

• *Attendees from across the stakeholder spectrum:* Securing feedback and support from diverse groups paved the way for eventual consensus.

Despite the diverse strengths of this group, its successes also depended upon two other factors that should be considered before beginning a similar effort:

• *Strong precedent for the proposed system:* At the time of the transition, Washington had been a universal purchasing state for over 20 years. The necessary infrastructure and technical expertise were already in place and the Department of Health's vaccine purchasing and delivery processes were well established.

Author
Kathryn Bergh completed the MPH/MPA program at the University of Washington in 2012.

• *Immediate action was not required:* The legislature enabled previously-allocated funding for the universal purchasing system to continue through April 2010 by dropping the vaccine for human papillomavirus from the list of vaccines included in the system. This action reduced costs, delayed the end of state funding, and provided time to secure grant funding. These factors made it possible to plan and hold the Immunization Congress, build consensus, draft legislation, raise nearly $8 million, and otherwise ensure a seamless transition. ■

Supporting Behavioral Health in Rural Idaho

By Susan M. Esp, Elizabeth "Lee" Hannah

Additional resources at
www.nwpublichealth.org

Multiple factors affect the health of individuals and communities. Current determinants of health addressed by the World Health Organization's 2020 goals include social factors, physical environments, policymaking, and individual behaviors. Behavioral health, defined here as including both substance use disorders (including alcohol) and mental health disorders, is an additional determinant of physical health that is often disregarded or minimized by current health determinant models. According to L.G. Gamm, S. Stone, and S. Pittman, behavioral health disorders affect approximately half of the population in the United States over a lifetime and are among the most impairing of chronic diseases.

Substance Use Disorders

The National Center on Addiction and Substance Abuse at Columbia University reports that adolescent substance abuse is the number one public health issue in America and that it has reached epidemic proportions. According to the Idaho Health and Welfare, Idaho Youth Risk Behavior Survey, (2010–11), 46 percent of high-school students in Idaho report current use of addictive substances. This number exceeds the prevalence rates of many other health risk behaviors that are considered epidemic among teens in the United States. Substance use disorders, particularly alcohol abuse, are major contributors to the three leading causes of death among adolescents—accidents, homicides, and suicides. Substance use disorders also increase the risk of potentially fatal health conditions in adults including cancer, heart disease, and respiratory illness.

Mental Health Disorders

Mental health disorders influence the onset, progression, and outcome of other co-morbid diseases. In addition, mental health conditions have been correlated with health risk behaviors such as substance abuse, tobacco use, and physical inactivity. Idaho data from the 2010–11 National Survey on Drug Use and Health indicates that rates of past year serious psychological distress were higher in Idaho than the country as a whole, particularly among the age groups of 12–17 and 18–25. Idaho prevalence rates of depression for these two age groups have been among the highest in the country since 2004. Physical health problems that can arise from poor mental health include heart disease, chronic lung disease, injuries, HIV, and other sexually transmitted diseases.

Rural Challenges

Idaho is a predominantly rural state with a population of approximately 1,600,000. About 40 percent of the population lives within the metropolitan area of Boise. The rest of the population lives is in smaller cities and towns, or in frontier areas. While the prevalence of behavioral health disorders appears to be similar in rural and urban areas, those living in rural areas are more likely than urban residents to see primary care practitioners for behavioral health conditions. This is particularly

relevant among those who are poor, elderly, in a minority group, using alcohol, or mentally ill.

According to R.C. Kessler and others, approximately half of all treatment for common behavioral health disorders—such as substance abuse, depression, anxiety, and attention deficit hyperactivity disorder—occurs in primary care settings. Some research findings from C. Collins and others suggest that as many as 70 percent of primary care visits stem from psychosocial issues. Research by J.M. Geller indicates that patients in rural areas access a health care provider for behavioral health conditions less frequently than they might need to due to being uninsured or underinsured. Use of behavioral health services may also be stigmatized by cultural attitudes and beliefs. This stigma may be more strongly felt in small, isolated communities.

According to information provided by the Idaho Office of Rural Health and Primary Care, all 44 counties in Idaho have been designated as federal Mental Health Professional Shortage Areas and 41 counties have been designated as either a geographic or population Primary Care Health Professional Shortage Area. Due to a critical shortage of behavioral health providers in many rural Idaho communities, some level of integration or collaboration of behavioral health and primary health services appears to be critical. Although currently there is no single "right way" to integrate services and supports, there are a number of model programs and steps that can be taken in moving towards integrated care. A logical place to begin is within the Federally Qualified Health Centers. New health care reform laws require that, beginning in 2014, all insurance plans must include treatment for substance use disorders and mental health disorders, including preventative care.

Primary care integration is recommended to facilitate the changes that need to occur by 2014. A framework that could facilitate this integration is identified by C. Collins, D. Hewson, R. Munger, and T. Wade. In this framework, eight practice models are defined along a continuum of integration. In a fully integrated care system, both behavioral health and primary care providers share the same facility, have opportunity for face-to-face communication, and share common financing and documentation procedures. Full integration has the added benefit of minimizing paperwork and loss of information as it is passed from provider to provider, but may not be appropriate for all settings. The practice model used should be determined by careful review, available technology, and financial resources.

The medical health home is a common concept in integrated care. The medical health home is one of the centerpieces in the current national health care reform effort as defined in the Patient Protection and Affordable Care Act. By law, participating programs must target patients with two or more chronic health conditions and must address behavioral health disorders.

Finally, the use of information technology has great potential for designing and facilitating integration efforts in rural communities. This includes the use of telepsychiatry, online resource guides for physicians, and online behavioral health education programs for patients.

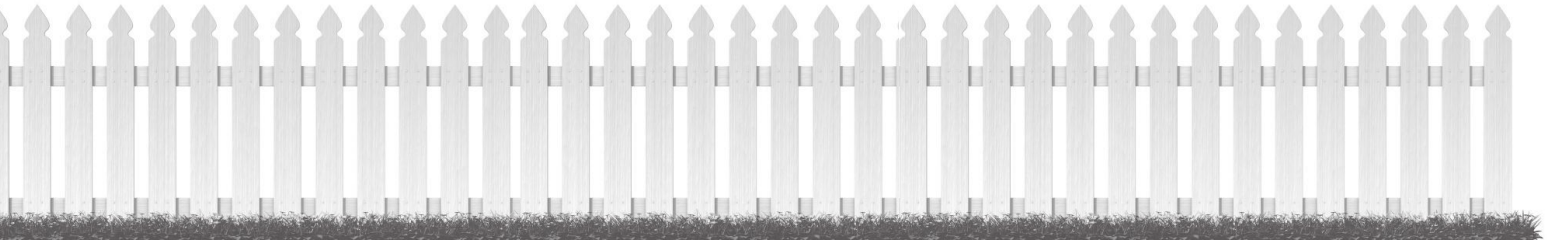
Improving the screening and treatment of behavioral health problems in primary care settings is a viable and efficient way to ensure access to behavioral health treatment in rural communities. Access to behavioral health care services is an important step toward improving the health of individuals and communities. ■

Authors
Susan M. Esp, PhD, LCPC, is an Assistant Professor, Community and Environmental Health, Boise State University.
Elizabeth "Lee" Hannah, DVM, MPH, is an Associate Professor, Community and Environmental Health, Boise State University.

Photo below of the Palouse courtesy of Charles Martyn.

Housing and HIV/AIDS: A Public Health Opportunity

By Christy Hudson, Annick Benson-Scott



Ten years ago, an article in the *American Journal of Public Health* reminded the public health community of the intersection between housing and health, emphasizing the role of racial and socioeconomic disparities in both areas. In the article, James Krieger and Donna L. Higgins reminded readers of the progressive history of the public health profession and a continued responsibility to address housing as an important social determinant of health.

Like millions who live with chronic disease, persons living with HIV/AIDS are often low income and may also experience physical disabilities, mental illness, and substance use disorders. These conditions can present barriers to accessing health care and housing. To address these barriers, federally funded HIV programs, such as the Ryan White HIV/AIDS Treatment Extension Act and the Housing Opportunities for Persons with AIDS program, provide support services, such as housing, as a health intervention.

Authors
Christy Hudson, MSW, is currently the Grants and Capacity Building Coordinator for the HIV Care and Treatment Program of the Oregon Health Authority. Annick Benson-Scott is the HIV Community Services Manager for the Oregon Health Authority.

The Case for Housing

To be effective, HIV medications need to be taken as prescribed 95 percent of the time. Proper adherence to HIV medications decreases concentrations of the virus in the blood, reduces the risk of transmission, and improves health outcomes. Numerous studies demonstrate that access to safe, secure, and stable housing provides a foundation for treatment adherence to HIV medications.

Research by David Buchanan and others, published in 2009, shared the results of a randomized controlled trial conducted with 105 HIV-positive participants who were being discharged from a Chicago hospital. The study found that participants in scattered-site permanent supportive housing were significantly more likely to have intact immunity (defined as alive with CD4 > 200 and viral load < 100,000) and undetectable viral loads (p=.04 and p=.051 respectively) at 12-month follow-up as compared to participants who received discharge planning as usual.

Housing also decreases the risk of transmission because people who are stably housed are less likely to engage in risky activities of survival. A multi-site behavioral survey, conducted by Daniel P. Kidder and others with 8,705 HIV-positive respondents, found that although housed individuals were more likely to be sexually active, housing instability was significantly predictive of multiple sex partners, sex exchange for housing or money, and unprotected sex, even when controlling for substance use.

Admittedly, the provision of housing is a resource-intensive undertaking. To look at the cost effectiveness of housing as an intervention, a study among 315 persons served with permanent supportive housing conducted by David L. Holtgrave and others showed that preventing as few as five transmissions to HIV seronegative partners made the intervention cost-effective.

Policies and Programs

In 2011, after 30 years of a national HIV epidemic, the Obama administration released the first National HIV/AIDS Strategy. The administration's policy recommendations specifically included the need to address housing stability as an important health intervention. This recognition supports the perspective that meeting the basic needs of persons living with HIV/AIDS is as important as the medications and treatments they require to stay alive.

A regional example of the use of housing to improve health outcomes is the Oregon Housing

Opportunities in Partnership Program, a permanent supportive housing program for people living with HIV. Begun in 2001 and currently administered by the Public Health Division of the Oregon Health Authority, the program serves about 160 households annually. The mission of the program is to help HIV-positive individuals and their families obtain and maintain housing stability to ensure access and retention in care and treatment.

The program provides rental assistance, and in partnership with local health departments and non-profit organizations, delivers case management and supportive services aimed to address barriers to housing stability and treatment adherence. Although there is no maximum on the amount of housing assistance an individual could receive, the average stay in program-supported housing is 37 months with the majority of individuals transitioning to permanent stable housing.

The program has successful outcomes. In 2012, 93 percent of clients maintained permanent stable housing, and 95 percent had regular contact with an HIV medical provider. This rate of contact for persons living with HIV is higher than the statewide rate of approximately 75 percent. The program leverages multiple Department of Housing and Urban Development funding streams and works closely with local housing partners to develop referral networks and partnerships. The formation of these relationships has provided an opportunity to participate as an active partner in the fight against homelessness and to advocate for a vulnerable population that still experiences significant stigma and discrimination.

Housing and Reform

The current era of health reform is a promising one for establishing housing as a public health intervention, not only for HIV-infected individuals but for those with tuberculosis infection, viral hepatitis, or obesity. As the health care system prepares for the implementation of the Affordable Care Act, the United States Department of Housing and Urban Development is also experiencing considerable change with the implementation of the Homeless Emergency Assistance and Rapid Transition to Housing Act. This legislation has the potential to create opportunities for innovative housing programs. With mechanisms like these, the public health community is well positioned to play a role in promoting housing as a cost-effective intervention for improving the health of vulnerable populations. ■

Additional resources at
www.nwpublichealth.org

Photos on this page from the International District on the MOVE event, October 2011. Courtesy of Julie Swanson.

Mapping Our Voices for Equality (MOVE):

Stories for Healthy Change

By Samantha Benson, Natasha Freidus, Afsaneh Rahimian, Nicole Sadow-Hasenberg, Seth Schromen-Wawrin

Communities with poor health outcomes often find it difficult to influence the policies, systems, and environments that affect them. To change this, a project in Washington State is giving these communities effective ways to make their voices heard.

Mapping Our Voices for Equality (MOVE) received startup funding from Public Health – Seattle & King County's Communities Putting Prevention to Work (CPPW) initiative in the summer of 2010. MOVE combines grassroots organizing with new media technology so that communities can produce digital stories and strategically use them for health.

MOVE began as a partnership of four community organizations. Two community health clinics—Sea Mar and International Community Health Services (ICHS)—joined with Entre Hermanos, a nonprofit serving the Latino LGBTQ community and Creative Narrations, a small multimedia training company. Since the project began, five additional partners have joined MOVE.*

MOVE partners follow four core strategies:

- Strategy one: facilitate the production of community-based digital stories.
- Strategy two: use these stories to create policy, systems, and environmental changes.
- Strategy three: share stories and access to storytellers.
- Strategy four: replicate the MOVE model.

Strategy One

At the heart of MOVE is the knowledge that stories can be tools for change. With this in mind, MOVE partners work with community members to produce digital stories that show the consequences of health inequities as well as the positive transformations that result from grassroots organizing. These stories are short, autobiographical narratives that are recorded in the storyteller's voice and woven together with photographs, video clips, and music.

MOVE trains staff at partner organizations to work as trainers in digital story production. These trainers take a flexible approach to story production, providing workshops for groups or working one-on-one with storytellers. In all cases, storytellers have full editorial control. MOVE trainers have facilitated the production of over 100 digital stories in English, Spanish, Cantonese, Mandarin, and Vietnamese.

Strategy Two

One of MOVE's primary dissemination strategies has been to host community forums. These forums connect story producers with key audiences. To date, MOVE's partner organizations have hosted four community forums.

ICHS, one of the original MOVE partners, jointly with the local community development authority, held the first MOVE forum in October 2011. Over 100 community members attended to express their concerns to Seattle City Council members and Seattle's Department of Parks and Recreation about a proposed budget reduction for the International District/Chinatown Community Center. This proposed reduction would cut weekly access to the center from 45 hours to 25 hours. The Chinatown-International District has the lowest amount of greenspace per capita of any neighborhood in Seattle, so indoor opportunities to be physically active are critical.

**A current list of partners is available at http://mappingvoices.org/note/51.*

Additional resources at
www.nwpublichealth.org

When the proposed cuts became known, MOVE staff identified center users who had compelling stories. A MOVE trainer worked with youth from Wilderness Inner-city Leadership Development (WILD) to interview an active senior citizen who used the International District/Chinatown Community Center.

The resulting digital story explained how the center provided physical activity opportunities to seniors. A month after the forum, the City Council announced a final, revised budget which reinstated ten of the hours slated to be cut.

Strategy Three

Using an interactive map, MOVE makes the digital stories easily accessible on its website, www.mappingvoices.org. The map is populated with digital stories, photographs, and other videos. Visitors can also browse by language, organization, and topic. Between the launch of the website on October 20, 2011 and September 18, 2012:

- www.mappingvoices.org received 7,583 visits by 4,554 unique visitors.
- The digital stories have been viewed 6,147 times, primarily by residents of King County.
- An estimated 4,000 additional individuals have viewed the website and stories in group settings throughout King County. Ninety percent of the screenings have been in low-income community settings, including health fairs, organizational summits, conferences, and diabetes education classes.
- Eighty-five storytellers have produced stories. Seventy-five of these are from linguistic or racial minorities. Seventeen stories are told by youth, and eight by elders.
- Fifty-one organizations throughout King County have participated in digital story production and screenings.
- MOVE kiosks have been set up in two clinic waiting rooms.

Project staff also use social media and basic marketing strategies to disseminate the stories. Staff also share the stories directly with clients, partners, and funders.

Strategy Four

As MOVE transitions to a post-CPPW funding model, it is expanding in scope. MOVE now includes stories on women's health and hepatitis B. In early 2013, MOVE began to incorporate stories of cancer prevention, LGBT issues, and more. MOVE has also expanded beyond King County to include Yakima County and potentially all of Washington State.

MOVE partners now are technical assistance providers to other grassroots organization interested in the MOVE model. The team provides tools, services, and training to organizations wanting to create their own stories on a fee-for-service model. MOVE staff are also exploring collaboration opportunities with other national mapping models.

Results

In addition to the hours restored at the International District/Chinatown Community Center, MOVE stories and forums have influenced other policy, system, and environmental changes.

- A small business owner in South Park (a "food desert" neighborhood in Seattle) decided to open a produce shop as a result of a MOVE forum.
- The 2012 Washington State Legislature restored funding to the Washington State Quitline following cuts that closed the program. Restoring the Quitline, particularly the Spanish-language line, was a specific objective of MOVE.
- In response to a MOVE forum at Concord International Elementary School in Seattle, parents and teachers discussed strategies for better nutrition and access to physical activity. The school subsequently adopted policies that are resulting in less food waste and improved classroom performance.

More efforts are needed to better understand how digital stories can be used for education, civic engagement, and health promotion, but those involved in MOVE have experienced firsthand that digital storytelling is an effective grassroots tool for improving the health of communities. ■

Authors
Samantha Benson, MPH, is a Research Coordinator at the University of Washington in Seattle.
Natasha Freidus, MCP, is Co-Director of Creative Narrations, a company that provides training and consulting in the use of media for social change.
Afsaneh Rahimian, PhD, is a Program Manager at the Center for Community Health and Evaluation, Group Health Research Institute in Seattle.
Nicole Sadow-Hasenberg, MPH, is Strategic Communications Coordinator for Seattle-King County's Department of Public Health's Communities Putting Prevention to Work initiative.
Seth Schromen-Wawrin, MUPM, is the Data and Outreach Manager for Creative Narration's Mapping Our Voices for Equality project in Seattle.

To learn more about MOVE, visit www.mappingvoices.org.

Leading With Public Health:
An Undergraduate Perspective

Organizations such as the Association of Schools of Public Health are just beginning to track enrollment in undergraduate public health programs. Specific national enrollment numbers are not available but early reports indicate that there is a rising interest in undergraduate public health degrees and that a significant trend is underway. For example, at the University of Washington, the number of students in the undergraduate public health major has doubled within the past year.

To provide a glimpse into what is motivating this increase, four recent public health undergraduate students at the University of Washington share their thoughts.

Marta Galan: I have chosen to embrace the mission of public health. For me, the mission of public health is to promote health to all communities so that all individuals can reach their highest potential. Looking at the public health problems of today, I have an urgency to become equipped to effectively address health inequities. In my future work as a public health professional, I hope to become a voice advocating for underserved and marginalized populations.

Marta Galan graduated with a BS in Public Health in Autumn 2012.

Nicole Rover: I am interested in working in public health because I want to do my part to ensure the health of all citizens. Public health uses a multidisciplinary approach to improving the health of communities, and I am excited to be part of this interconnected system. I plan to use a full range of my skills and interests in my work. For example, I hope to use my passion for dance to disseminate health education about the physical, mental, and social health benefits of exercise.

Nicole Rover will graduate with a BS in Public Health and a BA in Dance Studies in Spring 2013.

Marissa Simko: I view the study of prevention-based interventions as an essential first step toward improving health and quality of life for populations. The interdisciplinary nature of public health facilitates a wide range of perspectives within a diverse group of professionals. This is a strength. Collaboration can create beneficial solutions for society's health problems. Combining a public health foundation with a nursing career, I hope to provide more holistic, comprehensive care to my patients and the population in general.

Marissa Simko will graduate with a BS in Public Health in Spring 2013.

Angela Williams: I originally planned to study Clinical Nutrition so that I could educate individuals how to reduce their risk of chronic health conditions. After several student internships, however, I realize that unequal access to healthy, affordable foods prevents many people from acquiring the very foods they have been told to consume. This realization has prompted me to pursue a degree in public health policy. In my future work, I hope to reduce health disparities by increasing access to healthy foods.

Angela Williams graduated with a BS in Public Health in Autumn 2012.

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—Susan Allan, MD, JD, MPH