COMMUNITIES AND ACADEMIA WORKING TOGETHER:

Report of the Association of Schools of Public Health (ASPH) Prevention Research Centers (PRC) Blue Ribbon Panel

July 2008

ASPH
ASSOCIATION OF SCHOOLS OF PUBLIC HEALTH

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ASPH represents the 40 Council on Education for Public Health (CEPH) accredited schools of public health (SPH) in North America. ASPH promotes the efforts of schools of public health to improve the health of every person through education, research and policy. Based upon the belief that "you're only as healthy as the world you live in," ASPH works with the government and other professional organizations to develop solutions to the most pressing health concerns and provides access to the ongoing initiatives of the schools of public health. www.asph.org.

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I. Introduction

In early 2007, the Centers for Disease Control and Prevention (CDC) requested the Association of Schools of Public Health (ASPH) to help review CDC's Prevention Research Centers (PRC) Program.

ASPH subsequently convened the ASPH PRC Blue Ribbon Panel (BRP) to provide an assessment of the PRC Program and to develop a set of recommendations useful to CDC and various external stakeholders. Members of the BRP include representatives from schools of public health (with and without a PRC Program), preventive medicine programs, a state health department, and a voluntary non-profit health organization. (See Appendix A for the complete membership list.)

The BRP met three times: in March 2007, November 2007, and February 2008. Committee members reviewed numerous documents, articles, and reports related to the PRC Program and individual PRCs. The BRP also received input from PRC directors and CDC. In addition, the BRP chair separately briefed the PRC Directors on the Panel's efforts on two occasions, in November 2007 and March 2008.

This report reflects the BRP's work and conclusions. Its purpose is threefold:

- To describe the PRC Program and summarize its history.
- To provide an analysis of the Program's strengths and accomplishments.
- To make recommendations for future Program directions.

II. History and Program Description

A. Legislative History

The PRC Program was established by Congress in 1984. The authorizing legislation directed CDC to develop centers designed to "undertake research and demonstration projects in health promotion, disease prevention, and improved methods of appraising health hazards and risk factors, and [to] serve as demonstration sites for the use of new and innovative research in public health techniques to improve health." (Public Law 98-551).

Three centers were first funded in 1986; the Program now stands at 33 centers. (See Appendix B for a summary of the number of PRCs funded annually during the Program's 22-year history; see Appendix C for a complete list of PRCs currently funded.)

The PRC Program is located within CDC's Division of Adult and Community Health, which is part of the agency's National Center for Chronic Disease Prevention and Health Promotion.

B. PRC Requirements and Program Administration

To qualify for PRC funding, a center must have the following capacities:

- Multidisciplinary faculty with expertise in public health and working relationships with relevant groups in public health, medicine, psychology, nursing, social work, education, and business.

- Graduate training programs relevant to disease prevention.

- Core faculty in epidemiology, biostatistics, social sciences, behavioral and environmental sciences, and health administration.

- Demonstrated curriculum in disease prevention.

- Capability for residency training in public health or preventive medicine.

PRCs are permitted to propose any project in any research area that they and their community agree upon. Current core research themes include such important public health topics as cancer prevention and control; diabetes prevention; improving physical activity; and healthy aging. (See Appendix D for a list of selected core research projects for each of the 33 currently-funded PRCs.)

PRCs are selected through a rigorous competitive peer review process occurring every five years. The competition is open to existing PRCs, as well as eligible institutions without PRCs. Currently, PRCs are located in 25 schools of public health and eight medical schools with accredited preventive medicine residencies. The PRCs are managed by CDC through a cooperative agreement funding mechanism. This arrangement is used by CDC to enable the agency to have a more substantive role in the research conducted by the PRCs. In addition, it allows CDC to maintain an independent relationship with each PRC.

The CDC's PRC Program office serves as the central point for various management and oversight services, including program coordination, technical assistance and consultation, and quality control. As part of this effort, it has developed an infrastructure for the network of PRCs consisting of seven committees – Steering; Research; Policy; Program; Communications and Dissemination; Evaluation; and National Community. Members of these committees communicate and consult with the PRCs on a variety of issues and, in turn, provide important feedback to the PRC Program office. In addition, the PRC Program office enhances dissemination of PRCs' tested interventions and other successful strategies and strengthens the Program's partnerships and collaborations with programs and initiatives within and outside CDC. For example, since 1991, the PRC Program office has held annual meetings to share information about the PRCs' research with PRC Program stakeholders. The 2008 annual meeting was held March 25-27 in Atlanta, GA and drew more than 300 attendees, including individuals associated with all 33 PRCs and people representing numerous external stakeholders.

Additional information about the PRC Program is available at www.cdc.gov/prc.

C. Funding

At its establishment in 1984, Congress authorized $3 million for the PRC Program. However, the Program was not actually funded until 1986 when it received $1.5 million to support three centers. Some 20 years later, in 2007, 33 PRCS were receiving $29.1 million. (See Appendix E for a summary of the annual appropriation for the PRC Program.) Today, each PRC receives approximately $730,000 in core research funding.

The PRC Program office is also supported through the annual appropriations process to provide basic support services to the PRCs as well as manage and oversee the activities described above. In 2007, this office received $4.8 million.

In 1993, CDC began providing supplementary resources to the PRCs through an internal funding mechanism, the Special Interest Project (SIPs) Initiative. Since then, SIPs funding has served as a successful means to increase the levels of research activity within the PRCs. SIPs provide additional funds from CDC centers and offices to the PRCs for specific targeted research projects such as arthritis program evaluation, influenza vaccination education, and cancer risk prevention. PRCs compete and undergo peer review of their applications for the SIPs. SIPs funding has varied considerably over the years, and although there is no annual cap on SIPs funding, support is provided to individual centers only on a yearly basis through the annual appropriations process. In 2007, some $18.2 million was awarded for 61 SIPs at 18 PRCs. (See Appendix E for a summary of the annual funding level for SIPs.)

III. Program Activities and Achievements

A. Individual PRCs

The research work of each PRC is organized around a community participatory research framework. In this framework, researchers from the academic institutions, community committees, and other partnerships identify health needs, consider potential strategies, and set priorities for the research. This framework encourages applied research (in intervention, translation, and dissemination) that can target local or state populations or communities defined by characteristics other than geographic boundaries (e.g., Korean Americans, older adults, migrant farm workers). Examples of some projects conducted by PRCs include:

- University of Arizona PRC: Implemented and evaluated a set of interventions (e.g. screenings, health education, and walking support groups) to prevent and control diabetes among Mexican Americans living along Arizona's U.S.-Mexico border. Researchers are determining whether participation in more than one intervention increases the likelihood that participants will adopt and maintain healthy behaviors. In addition, community action boards are advocating for policies to help guard against diabetes, such as creating community walking and bicycle paths and removing soda and non-nutritious foods from vending machines at schools.

- University of Iowa PRC: Established the Youth Substance Abuse Prevention working group to develop effective strategies designed to reduce the prevalence of underage alcohol consumption and to help address social norms that often make underage drinking socially acceptable in rural areas. The group's activities include advocacy on behalf of statewide legislation requiring keg registration; supporting public service announcements

during prom and graduation season; and working with teenagers to develop a peer mentoring program.

- University of Kentucky PRC: Formed a project to engage communities in Appalachian Kentucky in developing strategies to reduce the incidence of colorectal cancer, one of the most commonly occurring cancers in the U.S. The program emphasizes research as well as targeted efforts to increase colorectal cancer screening.

- University of Washington PRC: Created the Physical Activity for Lifetime Success (PALS) project that builds on the center's history of helping older adults (aged 65 years or older) become physically active. Through increased physical activity, PALS aims to reduce symptoms of several chronic illnesses such as depression, diabetes, and heart disease. The project includes a special focus on older adults living in ethnically diverse and low-income areas.

While most PRCs partner with local communities, one PRC conducts research with another state (the Harvard PRC works with the state of Maine to reduce physical inactivity and obesity and improve nutrition) while another PRC disseminates research-based trainings to communities via the Internet (the University of North Carolina PRC offers online courses to practitioners in nutrition, physical activity, and chronic disease).

B. Thematic Networks

Beyond individual program activities, groups of PRCs are sometimes brought together (mostly through the SIPs Initiative) to collaborate nationally on specific health issues or specific research efforts. The six current thematic networks are:

- ***Cancer Prevention and Control Research Network (CPCRN)*** (University of North Carolina at Chapel Hill PRC, coordinating center) conducts research in community-based interventions in cancer prevention.

- ***Cardiovascular Health Intervention Research and Translation Network (CVHIRTN)*** (University of Rochester PRC, coordinating center) uses stakeholder input, research results, and proven interventions to reduce heart disease and death.

- ***Healthy Aging Network (HAN)*** (University of Washington PRC, coordinating center) explores the determinants of healthy aging among older adults and identifies interventions that promote healthy aging among the various communities associated with the PRCs participating in HAN.

- ***Latino Health Network*** (administered by the San Diego State University PRC, in collaboration with the University of California; not funded through the SIP Initiative) addresses health disparities in the US Latino population.

- ***Managing Epilepsy Well Network*** (Emory University PRC, coordinating center) examines research priorities related to self-managing epilepsy.

- ***Physical Activity Policy Research Network (PAPRN)*** (Saint Louis University PRC, coordinating center) looks at the effectiveness of health policies in encouraging physical activity in communities.

Previous thematic networks focused on programs and activities targeted on the topics of oral health, obesity, tobacco, school health and women's health.

Because each center offers a unique geographic location and community relationship, network researchers can simultaneously test interventions in different settings. The synergy and collaborative efforts that evolve from these networks enable the development of science-based interventions that may prove effective elsewhere.

C. Science-Based Public Health Strategies

In 2004, the PRC Program office began a review of the PRCs' tested interventions. Several have now been identified as having potential for nationwide use. A panel, comprising members of the PRC Program's scientific and leadership staff, considers the scientific evidence and develops case studies that characterize the interventions as "adoptable," "effective," or "promising."

An intervention is deemed "adoptable" if it was determined to be effective and had demonstrated the feasibility of disseminating it beyond the initial study group. An intervention is considered "effective" if it was determined to be effective, but had not yet demonstrated the feasibility of disseminating it beyond the initial study group. An intervention is held out as "promising" if it was determined to show some benefit, but was not yet found to be effective and, therefore, not ready for dissemination to other populations.

Within this framework, four PRC-developed interventions are viewed as "adoptable":

- Coordinated Approach to Child Health (*CATCH*) (University of Texas Health Science Center at Houston PRC): A program to promote physical activity, healthy food choices, and prevent tobacco use in elementary school-age children. *CATCH* has four components – Eat Smart School Nutrition Guide, Go for Health Classroom Curriculum for grades K-5 and 6-8, Physical Education, and Family Home Team activities. Health messages are coordinated among the four components. A three-year, randomized, controlled trial of the program in 56 intervention and 40 control elementary schools in four states (Texas, Minnesota, California, and Louisiana) resulted in children significantly increasing time (from 40% to 50%) spent in moderate to vigorous physical activity within physical education classes, as well as significantly decreasing consumption of fat (from 39% to 32%) in school meals. The program has been adopted by 1,500 schools in Texas and implemented in schools in at least seven other states.

- Enhance Fitness (University of Washington PRC): A physical activity program designed for seniors to increase their endurance, strength, balance, and flexibility. A recent analysis of the program shows that people who participate at least once a week have significantly fewer hospitalizations (7.9%) and lower health care costs ($1,057 in savings) than non-participants. In addition, over 99% of participants say they would recommend the one-hour *Enhance Fitness* classes to a friend.

- Not on Tobacco (*NOT*) (West Virginia University PRC): A smoking cessation program for teenagers (aged 14 to 18 years), developed in collaboration with the American Lung Association (ALA), includes a curriculum used by teachers, school nurses, counselors, and volunteers. It also addresses healthy lifestyle behaviors such as alcohol or illicit drug use. Thirty percent of the students who completed the program between 1999 and 2006

quit smoking altogether; 53% cut back. ALA has adopted *NOT* as a "best practice" program and is now disseminating it across the country. *NOT* has also been recognized as a model program by the National Registry of Effective Programs supported by the Substance Abuse and Mental Health Services Administration (SAMHSA).

- Planet Health (Harvard University PRC): A new curriculum for public middle schools designed to increase physical activity and consumption of fruits and vegetables. A recent economic analysis found that every dollar spent on the program translated to a savings of $1.20 in medical costs and lost wages when the children reach middle age. This represents a return on investment of 20%. Blue Cross/Blue Shield of Massachusetts now distributes *Planet Health* across the state.

One PRC-developed intervention is considered "effective":

- Program to Encourage Active, Rewarding Lives for Seniors (*PEARLS*) (University of Washington PRC): A program designed to reduce depression among seniors through social worker services provided in the home setting over a 19-week period. *PEARLS* has been credited with reducing depression in 43% of the seniors who participated in the program and eliminating all symptoms of depression in more than another 33%. The program is included on the SAMHSA National Registry of Evidence-based Programs and Practices.

Two PRC-developed interventions are now "promising":

- Cognitive-Behavioral Therapy Intervention for Trauma in Schools (*CBITS*) (University of California at Los Angeles PRC): A program designed to reduce post-exposure symptoms among school-age children who have experienced violence. Such students are provided mental health screening services and a standardized brief cognitive behavioral therapy treatment in their schools. At three months, participants in the early intervention group showed significantly fewer symptoms of post-traumatic stress disorder and depression. Parents reported fewer indicators of psychosocial dysfunction as well.

- Harlem Children's Zone Asthma Initiative (Columbia University PRC): An asthma initiative targeted to young children (ages 0-12) that includes home visits to assess the adequacy of existing primary care and asthma medication and the provision of a full range of environmental, social, educational, and medical interventions when indicated. Preliminary data show significant improvements in asthma management – asthma-related school absenteeism has decreased from 23% to 8% and emergency room and unscheduled physician visits have decreased from 35% to 8%.

D. Contributions to Academia

PRCs have contributed substantially to the three core academic missions of all universities – scholarship, education, and service. Among these accomplishments are the following:

- Publication of several hundreds of articles in peer-reviewed journals and other scholarly publications (books and chapters in books), including articles in the *American Journal of Epidemiology*, *American Journal of Public Health* (AJPH), *Health Affairs*, *Journal of the*

American Medical Association (JAMA), *Lancet*, and *Public Health Reports.* (See Appendix F for a selective list of publications from various PRCs.)

- Presentations (the delivery of papers and presentation of posters) at hundreds of conferences at which public health researchers, practitioners, and community leaders are brought together to discuss "lessons learned." Topics include: disseminating physical activity recommendations, colorectal cancer screening, the role of community health workers in screening for diabetes and depression along the US-Mexico border, Native American tobacco use prevention, and community health planning in rural areas. (See Appendix G for a selective list of conferences at which various PRC representatives have presented.)

- Cross-collaboration efforts among various public health disciplines as well as with other related fields represented in the university and among practice partners. These multidisciplinary efforts include collaboration among the health professional schools within the university and with neighboring universities; partnerships with organizations along the US-Mexico border; partnerships with health systems, libraries, schools for the deaf, tribes, foundations, health departments, and research institutes; and, cross-county collaborations. (See Appendix H for a selective list of cross-disciplinary activities carried out by various PRCs.)

- The research, development, implementation, and evaluation of specialized training for students (graduate and undergraduate), practitioners, and the community. PRCs play a special role in applying academic theory to real-world needs for health promotion and disease prevention and, consequently, have developed new academic courses and programs, including credit-bearing coursework in schools of public health and a new MPH track. (See Appendix I for a selective list of academic innovations based upon the work of various PRCs.)

IV. Program Evaluation

A. Annual Progress Reports

PRCs are required to submit annual progress reports to the PRC Program office, as indicated in the request for applications. The CDC project officers assigned to each individual PRC carefully review each report and provide necessary and appropriate feedback and technical assistance to the centers.

B. 1997 Institute of Medicine Review

At CDC's request, the Institute of Medicine (IOM) conducted a review of the PRC Program. The IOM review committee was charged to evaluate: (1) the overall quality and appropriateness of the health promotion and disease prevention research and demonstration projects carried out by the PRCs; and (2) CDC's management and oversight of the PRC Program.

The report, *Linking Research and Public Health Practice: A Review of CDC's Program of Centers for Research and Demonstration of Health Promotion and Disease Prevention*, was published in 1997. (See Appendix J for a copy of the study's Executive Summary.) In brief, the IOM Committee gave a favorable review of the PRC Program and acknowledged its achievements.

Indeed, it noted that "[o]verall . . . the PRC has made substantial progress and is to be commended for its accomplishments in advancing the scientific infrastructure in support of disease prevention and health promotion policy, programs and practices. . . . Given the breadth of the PRC program goals, the limitations on core funding, and the relative newness of some of the PRCs, the program's successes have been genuine and important."

Nonetheless, the Committee also identified a number of PRC Program elements in need of attention or improvement. Within the context of the PRCs' research and demonstration projects (charge #1), the Committee suggested that the Program provide a more structured focus on research methodology and priority setting, and that far greater emphasis be placed on dissemination and implementation activities. With respect to CDC's management and oversight operations (charge #2), the Committee recommended that the PRC Program sharpen its guidance on Program requirements and expectations; enhance its networking, communication and dissemination efforts; and establish criteria for a rigorous performance review of each PRC.

The IOM Committee also made specific findings and recommendations regarding various PRC funding issues. Most significant was the Committee's recognition of the inadequateness of the level of appropriations provided by Congress since the Program's inception and its proposal that the Program be fully funded.

The IOM study received significant attention from the PRC Program as well as the individual PRCs and became the basis for many of the improvements that have taken place over the last several years.

C. PRC Program Office Evaluation

In 2001, the PRC Program office began an evaluation effort that is designed to look at the PRCs as a collective network rather than a set of individual centers. This initiative, known as Project DEFINE (Developing an Evaluation Framework: Insuring National Excellence), grew out of the recommendations from the IOM Review and is still underway. It has two purposes: (1) to ensure that the PRC Program both is carrying out its legislative mandate and is accountable to its stakeholders; and (2) to identify areas for Program improvement and mechanisms for implementing those improvements, particularly in the area of management. A team made up of staff from the PRC Program office and external contractors (initially, COSMOS Corporation, and subsequently, MACRO International, Inc.) is conducting the evaluation.

The evaluation seeks to address the following four questions:

- What does the PRC program contribute to public health practice and policy by (a) conducting prevention research; and (b) training the public health workforce?

- How is community-based participatory research (CBPR) implemented across PRCs?

- How are communities and partners engaged in PRC activities and how does participation build community capacity?

- What are the similarities and differences across PRCs concerning infrastructure, organizational factors, and how do PRCs partner with communities and organizations?

Phase I of Project DEFINE – the planning portion of the project – was completed in 2003. Phase II – evaluation implementation – has been underway since 2004. The PRC Program office completed data collection and analysis of Project DEFINE Phase II in spring 2008. Individual PRC data were sent back to each site for their own use between May and July 2008. An overall report has been drafted and is under review by CDC and the Collaborative Evaluation Design Team (CEDT), an advisory group to the national evaluation. The overall Project DEFINE report is anticipated in fall 2008.

Although Project DEFINE is not complete, preliminary results on several dimensions of the PRC program are now available, including the following:

- Both PRC researchers and community members report that academic support for CBPR has increased. Furthermore, both groups feel that community involvement in PRC research is high, that such involvement contributes to personal growth and enhanced community capacity, and that it does not impede scientific rigor.

- Despite these positive outcomes, ongoing challenges related to the "town/gown" relationship between universities and the communities remain, including questions of cultural differences and trust.

D. 2006 – 2008 University of South Florida Study

From 2006 to 2008, the University of South Florida's PRC undertook an independent assessment of the views of CDC's research administration leadership about the research produced by the PRCs. The purpose of the study was to (1) identify attributes that CDC administrators believe are important in conducting prevention research; and (2) determine how CDC administrators rate the PRCs on each such attribute. Although the response rate was low, the preliminary results of this study, *Positioning the Prevention Research Centers*, indicate that overall, CDC administrators highly rate the performance and importance of the PRCs on all parameters measured. A final report will be released shortly.

E. 2008 PRC Blue Ribbon Panel Survey

As part of its review efforts, the Blue Ribbon Panel asked the current 33 PRC directors to complete a short survey. In March 2008, 21 such directors provided responses to the following two questions:

- Other than additional funding, what are your top three recommendations for increasing PRC Program effectiveness?

- Provide any additional comments or suggestions regarding the PRC Program.

Despite the Panel's request to exclude funding issues from their responses, many of the directors felt compelled to identify this as a fundamental and ongoing problem with the PRC Program. But the directors also provided some very specific programmatic concerns in their answers. Many of the key findings can be categorized and briefly summarized as follows (see Appendix K for complete results from the survey):

Program Requirements/Operations

- Provide more transparency regarding program operations.
- Increase the rigor of the core research projects.
- Revisit core components of the PRC program to determine relative importance of each component.
- Increase the number of visits by CDC staff to PRC sites.
- Improve the CDC PRC website.

Program Measurement and Efficiencies

- Establish valid markers for program progress and success.
- Reduce the reporting burden; focus on large evaluations.
- Strengthen the information system reporting process.

Research and Dissemination

- Standardize protocols for multiple centers working on the same projects in different communities.
- Review and revise (if necessary) community based participatory research criteria for effective/appropriate evaluation and information translation and dissemination.
- Identify opportunities for increasing university interest in community engagement.

Collaborative Efforts

- Strengthen ties among the PRCs by developing additional network opportunities, including dissemination efforts.
- Improve collaboration with the National Institutes of Health through its CTSA (Clinical and Translational Science Awards) initiative.
- Provide additional time/resources at the PRC meetings to share best practices and facilitate cross-PRC collaborations.

V. Findings of the ASPH PRC Blue Ribbon Panel

The Panel makes the following observations:

- Effective Response to the 1997 IOM Recommendations. Some 10 years since the IOM released its study on the PRC Program, the CDC has not only responded to the committee's recommendations, but also has made significant progress in adopting them. Perhaps of greatest importance, the PRC Program has been aggressive in fully integrating CBPR, and other community-based approaches, into the PRCs' guiding principles and practices. Other recommendations regarding information systems, dissemination and communication practices, and information sharing have been implemented as well.

- Encouraging Preliminary Results from the PRC Program Office Evaluation. Although Project DEFINE is not yet complete, some results are now available, particularly with respect to the use and value of CBPR. These results indicate that while a number of issues still require continued attention and focus (e.g., logistics, funding, cultural differences, and questions of "trust"), important progress has been made in incorporating the CBPR model into the work of the PRCs. They also appear to indicate that strong collaborations between the PRCs and their state and local health departments, non-governmental organizations, and local health systems have been instrumental in improving dissemination efforts. These findings are consistent with the informal feedback the Blue Ribbon Panel has received about these issues.

- Translating Public Health Science into Public Health Practice. Research -- and the translation of that research into programs and practices designed to improve the public health -- is the hallmark of the PRC Program. This has been the primary focus of the program since its inception and remains so today. In recent years, the principles and practices of community-based participatory research have been more fully integrated into the work of the PRCs, increasing the linkage between the centers and the communities they serve. In addition, a number of community interventions that have been developed and successfully implemented through the PRC Program are now considered "best practices," and others are likely to be added to this list in the future.

- Strong and Supportive PRC Program Office. This office has been instrumental in enhancing collaboration among the PRCs. It identifies PRCs' evidence-based strategies; disseminates research results on a national basis; and promotes the PRC Program within CDC. The office takes seriously its oversight, accountability, and management responsibilities; indeed, in recent years, it has placed even greater emphasis on these duties. In so doing, some PRCs have come to view the PRC Program office as being overly burdensome with respect to data collection and reporting requirements. It is important to maintain an appropriate balance between the principal activity of research and the assessment and evaluation requirements.

- Strong Partnership Within the Academic Community. PRCs necessarily draw upon the expertise of faculty with knowledge and experience in fields that can contribute to a more fully integrated approach to community-based public health research not only in schools of public health and medicine, but also those in other units within the university. The ensuing partnership frequently strengthens the relationship between the university and the community. However, universities have not always recognized the contributions PRCs have made in both improving the public health and enhancing community relations.

- PRCs Are Stretched to the Limit. PRCs are meeting the statutory and administrative requirements of the PRC Program, but they are being pushed and pulled in doing so. Data collection, reporting mandates, dissemination, communication and evaluation efforts, and cultivated community involvement -- in addition to the core research project (and affiliated research work such as SIPs) -- are all critically important components of the PRC Program. But with limited funding, it is increasingly more difficult for PRCs to do everything well. Moreover, it is sometimes difficult for PRCs to set priorities in meeting the various requirements or to understand which requirements, if any, are more important than others.

- Appropriated Funds Are Inadequate. As the funding history of the PRC Program makes clear, PRCs are being asked to do more for less. Core funding for the Program has averaged approximately $750,000 since 2005. (See Appendix E for a summary of the annual appropriation for the PRC Program.) Taking into account a 3% inflation rate over this time, that figure translates into approximately $664,000 in 2008 dollars. At the same time, PRCs have been called upon to increase their data collection, outreach, and dissemination efforts. This ongoing and increasing funding gap is clearly the number one concern of the PRCs.

  The SIPs Initiative has served to channel additional funds to the PRCs. Since 1993, funds to PRCs through this mechanism have grown. (See Appendix E for a summary of the annual funding level for SIPs.) But SIPs are also unreliable and, in some cases, funds are obtainable, if at all, at the end of a fiscal year when government agencies that participate in SIPs identify monies they want to spend expeditiously to complete certain research projects. The 1997 IOM study referred to the inadequate level of funding as a "critical barrier" to the Program's long-term success. Regardless of the additional, helpful monies from SIPs, that description remains true today.

  Despite these funding limitations, PRCs have effectively leveraged their core and SIPs monies to secure additional dollars from other, non-federal sources, such as foundations (e.g., W. K. Kellogg Foundation and the Robert Wood Johnson Foundation) to support their work. The PRC Program office encourages this kind of activity and offers support when appropriate. These efforts have resulted in significant financial assistance outside the basic PRC Program. Indeed, the PRC Program office estimates that the PRCs have generated between $25 and $40 million in additional funds from both governmental (e.g., NIH, AHRQ, SAMHSA) and non-governmental sources to help finance some 250 new research projects in the 2004 - 2009 funding cycle.

- Limited Knowledge About and Understanding of the PRC Program. The PRC Program has made great progress in "getting out the word" about the PRCs within the public health science and practice worlds. Yet, despite its 22-year history and many contributions to the field of public health, the PRC Program is still not widely known, understood, nor appreciated, especially among those with a vested interest – the Congress, the executive branch, and the academic community.

VI. Recommendations of the ASPH PRC Blue Ribbon Panel

The PRC Program has met with considerable success over the course of its 22-year history. It is the largest extramural research center program at CDC. It has made significant contributions to both the science and practice of public health. And, it has served as a model for brokering partnerships between academia and vulnerable communities in which the people of those communities now have an effective voice.

But in the Panel's view, the PRC Program is capable of doing even more. With a strong infrastructure in place, a committed group of PRCs (along with other potential institutions that want to compete for PRC designation), and an impressive track record that demonstrates the value of the PRCs, the Program should be able to grow and make even greater contributions to the field of public health.

That is not possible, however, without some adjustments to the Program's current operations. To strengthen the Program's work and, in turn, to further its mission, the Panel has identified six overriding concerns and makes the following recommendations for immediate action to address them:

- Complete Project DEFINE and Maximize Its Impact. This national evaluation of the PRC Program must be completed as soon as possible. The resulting recommendations must be considered and, as appropriate, its recommendations should be implemented fully and completely soon thereafter. Throughout the final review process, the PRC directors and other appropriate individuals should continue to be consulted.

- Enhance the PRC Network. Capitalize upon the network's power to grow it further. The thematic networks have had great success in leveraging the strengths of the PRCs. Additional official connections as well as more informal networking among the centers would advance the influence of the entire PRC Program – on top of helping to improve the health and overall well being of the communities served by the individual PRCs. PRCs seem eager to move in this direction. The PRC Program office should continue steps in this direction to benefit from such an opportunity.

- Increase Program Funding. The public health needs of the country demand that funding be provided to support an increase in both the number of PRCs and the amount of core research funding each PRC receives. Such a demand can be met. The capacity of eligible institutions -- both funded and unfunded -- to expand is great and is matched only by their enthusiasm for taking on this important public health work. Without additional funding, the program will hardly be able to keep pace with current programmatic requirements and priorities, let alone increase its efforts. The SIPs Initiative has been enormously helpful in furthering the goals of the Program, but is neither reliable in terms of dollars nor predictable in terms of focus. As well, limited federal resources make it increasingly more difficult for individual PRCs to leverage additional external funds.

  As a group, however, PRCs should do more to secure additional funding from external sources. Building off the "network" concept in which several PRCs are simultaneously funded to collaborate on a specific research project or target a specific population, PRCs should identify more opportunities that would unite them in such a way that national groups (including organizations such as ASTHO and NACCHO), foundations, and even industry would become more interested in supporting their activities.

- Achieve Better Balance Among Research, Community Work, and Evaluation Activities. Non-research activities such as reporting requirements and data collection should be kept to the minimum necessary to ensure appropriate PRC Program oversight and management. While the BRP fully recognizes and understands the need for these activities – and strongly endorses complete and timely compliance with any such requirements – it is concerned that they not be allowed to detract from the basic research work that lies at the heart of the PRC Program. Steps should be taken to measure the value of the information derived from these activities against the time lost in carrying out research programs and otherwise working with the communities served by the PRCs and, if appropriate, to make adjustments in the allocation of Program efforts.

- Enhance Collaboration. The key to the PRCs' success is their strong commitment to collaboration – most importantly, with their community partners, but with others as well. These efforts should be enhanced across the spectrum of relationships in which the individual PRCs are engaged. Indeed, the development of multiple and effective partnerships should be emphasized as a basic requirement of the PRC Program.

  In recent years, PRCs have improved connections with their various partners. They have labored hard to build and strengthen community relationships and their work is much the better for that attention. Similar efforts should now be made to augment the ties between PRCs and their local and state health departments. These agencies can be enormously helpful in promoting and supporting PRCs. In many instances, however, this is not happening to the fullest extent possible or desirable. Collaboration between PRCs and non-governmental organizations and local health systems is encouraged as well. Such relationships are critically important for dissemination efforts as well as community intervention development and service delivery.

  But here, too, perhaps more can be done by the PRCs on a national scale. Closer working relationships with nationwide organizations (again, using the "network" model) may provide prospects not only for additional resources, but also larger scale research efforts, and, in turn, opportunities to develop public health "best practices," as well as forums for disseminating research results. Such arrangements can only help to boost the reputation of the PRC Program.

  Closer collaboration between the PRCs and the PRC Program office should help to improve Program operations. The Blue Ribbon Panel's survey of PRC directors indicated a number of areas in which those in the field would like to be working directly with the PRC Program office – on data collection and reporting requirements; network development; information sharing; and priority setting, among others. In light of the PRCs' upcoming competitive renewal, consultation between universities with a strong interest in the PRC Program, but without a funded PRC, and the PRC Program office might also be appropriate both to encourage the best possible applications and to broaden the spectrum of research opportunities.

- Improve Dissemination and Communication Efforts. The PRC "story" – its many accomplishments and achievements – should be told more effectively and to a broader audience. At the local level, PRCs should further disseminate their findings to surrounding communities and beyond – the more their work is operationalized in a broader context, the greater attention PRCs will receive at the state and national levels, particularly policymakers. This is especially important as discretionary government dollars have become scarcer.

Effective dissemination activities at the local level translate into an increasingly positive account about the PRC Program that needs to be communicated to many other audiences as well – to the public health science and practice communities, of course, but also to the general public, academia, and organizations with an interest public health. These groups can be helpful in garnering support of all types for the PRC Program.

Toward this end, the program's communications strategy should be enhanced to showcase the many contributions of the PRCs, including their active engagement with their communities. For policymakers, it will be especially important to highlight the positive public health outcomes that have resulted from the PRCs' research and dissemination efforts.

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Dean James Curran (Emory University Rollins School of Public Health)

Ms. Sue Grinnell (Washington State Department of Health)

Dean David Guzick (University of Rochester School of Medicine and Dentistry)

Dean Robert Meenan (Boston University School of Public Health)

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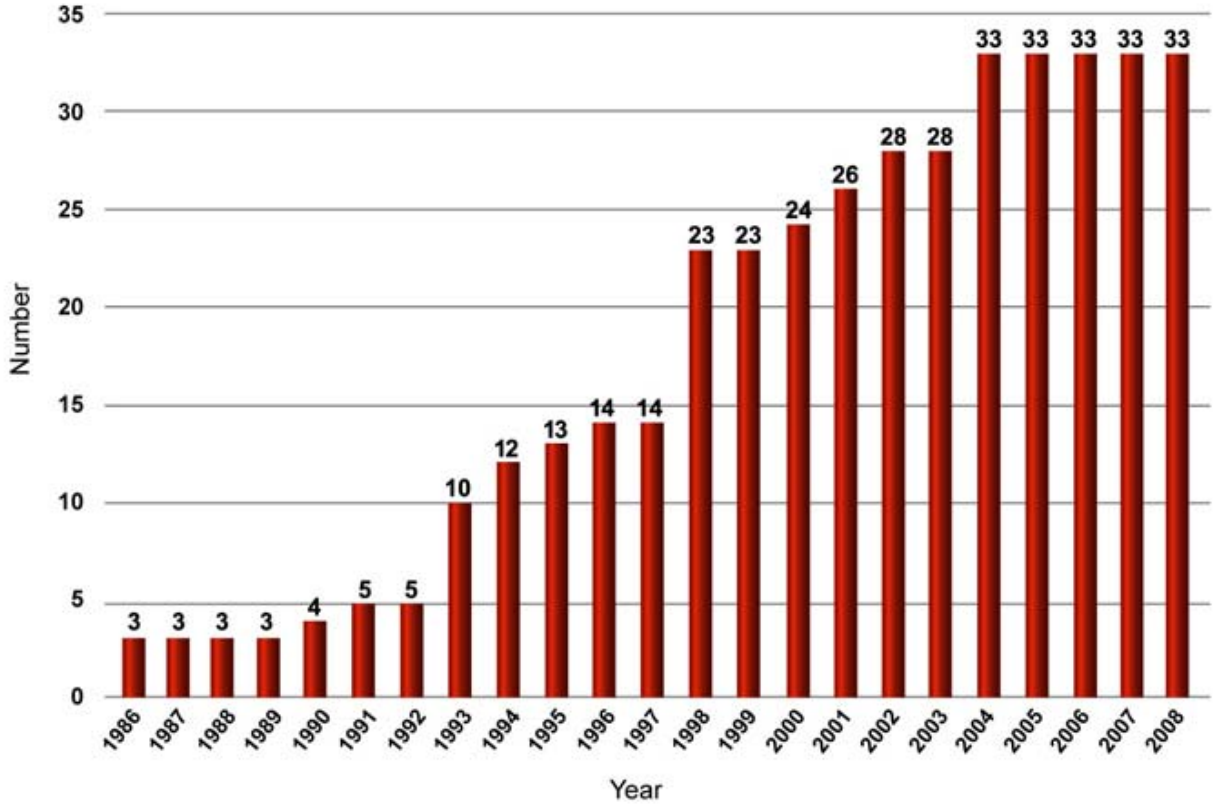
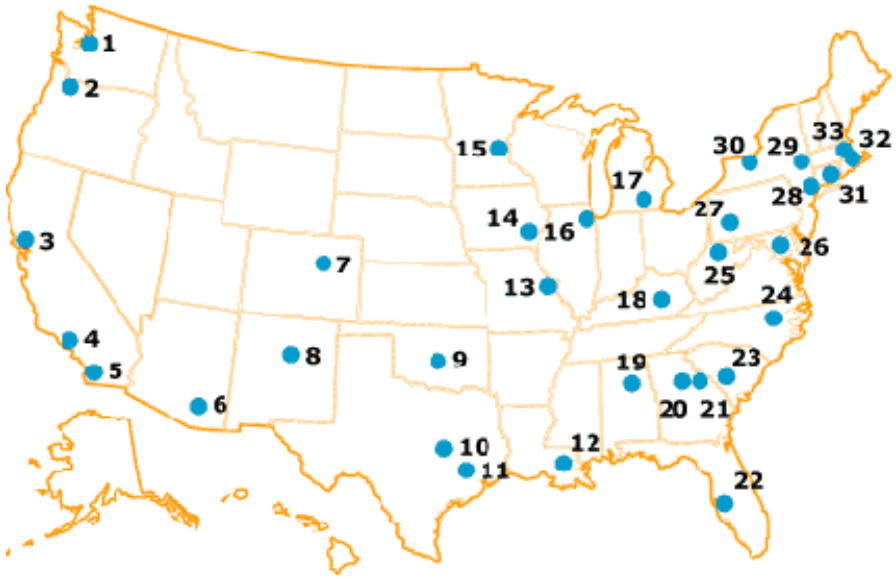
Appendix B: Number of Funded PRCs (1986–2008)



Appendix C: List of PRCs Funded in 2008 (alphabetical by state)



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Appendix D: PRCs: Selected Core Projects

1. **University of Alabama at Birmingham**
   Reducing health risks and disparities in Alabama's underserved, rural communities.
2. **University of Arizona**
   Preventing and controlling diabetes in communities on the Arizona–Mexico border.
3. **Boston University**
   Improving the health and well-being of Boston's public housing residents.
4. **University of California at Berkeley**
   Improving health in California's Korean American communities.
5. **University of California at Los Angeles**
   Involving parents in promoting health and preventing disease among adolescents.
6. **University of Colorado**
   Reducing the risk of overweight, and diabetes in the Rocky Mountain region of Colorado.
7. **Columbia University**
   Developing Web-site communications to promote health in minority communities.
8. **Emory University**
   Reducing health disparities and preventing cancer in rural southwest Georgia.
9. **Harvard University**
   Improving nutrition and physical activity among children and adolescents.
10. **University of Illinois at Chicago**
    Preventing diabetes in Chicago's low-income, underserved, minority communities.
11. **University of Iowa**
    Empowering community organizations in rural Iowa to improve the health and quality of life of community residents.
12. **Johns Hopkins University**
    Preparing young people in Baltimore to become healthy and productive adults.
13. **University of Kentucky**
    Preventing and controlling cancer among residents in rural Appalachian Kentucky.
14. **University of Michigan**
    Increasing the ability of communities to reduce health disparities and improve residents' health.
15. **University of Minnesota**
    Preventing and reducing risk behaviors among teenagers and promoting healthy adolescent development.
16. **Morehouse School of Medicine**
    Building the capacity of low-income, African American communities to promote health.
17. **University of New Mexico**
    Promoting the mental health and well-being of American Indian youth and their families.
18. **University of North Carolina at Chapel Hill**
    Reducing the risk for obesity among minority women in rural North Carolina.
19. **University of Oklahoma**
    Promoting healthy lifestyles among students in public schools.
20. **Oregon Health and Science University**
    Improving the health of American Indian, Alaska Native, and Native Hawaiian communities.
21. **University of Pittsburgh**
    Preventing disease and promoting healthy, active lives for older adults in Pennsylvania.
22. **University of Rochester**
    Promoting health and preventing disease among people who are deaf or hard of hearing.
23. **Saint Louis University**
    Reducing risk for heart disease, stroke, and cancer among residents in medically underserved, rural areas of Missouri.
24. **San Diego State University and University of California at San Diego**
    Increasing physical activity and improving health among Latinos in San Diego.
25. **University of South Carolina**
    Promoting and supporting physical activity in underserved communities.
26. **University of South Florida**
    Using community-based prevention marketing to improve community health.
27. **State University of New York at Albany**
    Preventing and controlling diabetes among underserved residents in the capital region of New York State.
28. **Texas A&M University**
    Preventing diabetes and other chronic diseases in underserved rural communities.
29. **University of Texas Health Science Center at Houston**
    Studying influences on children's behavior as they age to early adulthood.
30. **Tulane University**
    Improving health behaviors of New Orleans residents through neighborhood reconstruction and environmental change.
31. **University of Washington**
    Sustaining physical activity among older adults.
32. **West Virginia University**
    Improving health and quality of life for rural adolescents.
33. **Yale University**
    Preventing or reducing chronic disease among residents of Connecticut's economically disadvantaged cities.

Appendix E: Annual Funding Levels for the PRC Program and SIPs Initiative (1986-2007)*

Year	PRCs Funded	Congressional Appropriation	SIPs Initiative **
1986	3	$1,500,000	
1987	3	$1,500,000	
1988	3	$1,800,000	
1989	3	$2,000,000	
1990	4	$3,900,000	
1991	5	$4,300,000	
1992	5	$5,100,000	
1993	10	$5,400.000	$1,100,000
1994	12	$6,900,000	$3,300,000
1995	13	$7,600,000	$8,900,000
1996	14	$8,000,000	$9,300,000
1997	14	$8,000,000	$8,400,000
1998	23	$8,000,000	$5,900,000
1999	23	$13,400,000	$13,700,000
2000	24	$17,500,000	$13,800,000
2001	26	$25,000,000	$24,900,000
2002	28	$26,200,000	$19,000,000
2003	28	$26,800,000	$9,200,000
2004	33	$26,700,000	$16,700,000
2005	33	$29,700,000	$22,000,000
2006	33	$29,500,000	$22,300,000
2007	33	$29,100,000	$18,200,000

*Funds are rounded to the nearest 100,000
**SIPs funding did not start until 1993

Appendix F: Examples of PRC Publications in Scholarly Journals

Bearinger LH, Sieving RE, Ferguson BJ, Sharma V. *Global Perspectives on the Sexual and Reproductive Health of Adolescents: Patterns, Prevention, and Potential*. Lancet. 2007. 369(9568), 1220-1231. (Minnesota)

Blumenthal D, DiClemente R J. *Communtiy-Based Health Research: Issues and Methods*. January 2004; (1): New York, NY: Springer Publishing Company; 1-218. (Morehouse)

Brownson RC, Krueter MW, Arrington BA, True WR. *Translating Scientific Discoveries into Public Health Action: How Can Schools of Public Health Move Us Forward?* Pub Health Rep. 2006; 121(1): 97-103. (Saint Louis)

Clark SJ, Cowan AE, Stokley S, Bilukha O, Davis MM. *Physician Perspectives to Inform a New Recommendation for Meningococcal Conjugate Vaccine (MCV4*). J Adolesc Health. 2006;39:850-5. (Michigan)

Cohen D, Farley T A. *Social Marketing of Condoms is Great, but We Need More Free Condoms.* Lancet. July 2004; 364 (9428): 13-14. (UCLA)

Cohen DA, Ashwood JS, Scott MM, Overton A, Evenson KR, State LK, Porter D, McKenzie TL, Catellier D. *Public Parks and Physical Activity Among Adolescent Girls.* Pediatrics. 2006 Nov; 118(5): e1381-e1389. (Arizona)

Davis MM, Cowan AE, Marin M, Guris D, Clark SJ. *Physician Attitudes Regarding Breakthrough Varicella Disease and a Potential Second Dose of Varicella Vaccine.* Pediatrics. 2007;119:258-64. (Michigan)

Digenis-Bury EC, Brooks DR, Chen L, Ostsrem M, Horsburgh R. *Use of a Population-Based Survey to Describe the Health of Boston Public Housing Residents*. Am J Pub Health 2008; 98, 85-91. (Boston)

Eichner JE, Cravatt K, Beebe LA, Blevins KS, Stoddart ML, Bursac Z, Yeh F, Lee ET, Moore WE. *Tobacco Use Among American Indians in Oklahoma: An Epidemiologic View*. Pub Health Rep. 2005; 120:192-199. (Oklahoma)

Fergus S, Zimmerman MA, Caldwell CH. *Growth Trajectories of Sexual Risk Behavior in Adolescence and Young Adulthood*. Am J Public Health. 2007;97:1096-1101. (Michigan)

Hughes SL, Williams B, Molina LC, Bayles C, Bryant LL, Harris J, Hunter R, Ivey S, Watkins K. *Characteristics of Physical Activity Programs for Older Adults: Results of a Multi-site Survey.* Gerontologist. 2005; 45,5:667-675. (Pittsburgh)

Kaur JS, Dignan M, Burhansstipanov L, Baukol P, Claus C*. The "Spirit of Eagles" Legacy.* Cancer. 2006; 107 (8 Supplement):1987-1994. (Kentucky)

Kelley, GA, Kelley KS . *Effects of Aerobic Exercise on Lipids and Lipoproteins in Adults with Type 2 Diabetes: A Meta-analysis of Randomized Controlled Trials.* Public Health. 2007; 121:643-655. (West Virginia)

Kristal AR, Curry SJ. *A Randomized trial of a Tailored, Self-help Dietary Intervention: The Puget Sound Eating Patterns Study*. Prev Med. December 2000; 31 (4): (4): 380-389. (UIC)

Marcell AV, Ford CA, Pleck JH, Sonenstein FL. *Masculine Beliefs, Parental Communication, and Male Adolescents' Health Care Use.* Pediatrics. 2007; 119 (4), 966-975. (Johns Hopkins)

Marshall GN, Schell TL, Elliott MN, Berthold S , Chun C. *The Mental Health of Cambodian Refugees Two Decades After Resettlement in the United States*. JAMA. August 2005; 294 (5): (N.A.): 571-579. (UCLA)

Martin C, Njike V, Katz DL. *Back-up Antibiotic Prescriptions Could Reduce Unnecessary Antbiotic Use in Rhinosinusitis*. Journal of Clinical Epidemiology. April 2004; 57(4): 429-434. (Yale)

McCarty D, Zammarelli L, Wylie H, Greenlick MR. *Stakeholders in Recovery: Demands, Expectations, and Research Opportunities.* NIDA Science & Practice Perspectives. December 2005; 3 (1): 34-37. (Oregon)

McCree DH, Sharpe PA, Brandt HM, Robertson R. *Preferences for Sources of Information About Abnormal Pap Tests and HPV in Women Tested for HPV*. Prev Med. 2006 Sep;43(3):165-70. (South Carolina)

Sharkey, J.R. and Ory, Marcia G. *Severe Obesity and Depression Predict Perception of Increased Diabetes Severity Over 1-Year in Homebound Elders*. Diabetes. 2005, 54 (6, Supplement 1), A469. (Texas A&M)

Steinman L, Frederick J, Prohaska T, Satariano W, Dornberg-Lee S, Fisher R, et al. *Recommendations for Treating Depression in Community-Based Older Adults*. Am J Prev Med. 2007 Sep; 33(3):175-81. (Washington)

Stevens J, Murray DM, Baggett CD, Elder JP, Lohman TG, Lytle LA, Pate RR, Pratt CA, Treuth MS, Webber LS, Young DR. *Objectively Assessed Associations Between Physical Activity and Body Composition in Middle-School Girls: The Trial of Activity for Adolescent Girls.* Am J Epidemiol. 2007 Sep 12; 166(11): 1298-1305. (Tulane)

Thorpe KE, CS Florence, DH Howard, P Joski. (2004) *The Impact of Obesity on Rising Medical Costs*. Health Affairs 2004;W4:480-486. (Emory)

VanDevanter N, Messeri P, Middlestadt P, Bleakley A, Merzel C, Hogben M, Ledsky R, Malotte CK, Cohall RM, Gift T, St. Lawrence JS. *A Community-Based Intervention Designed to Increase Preventive Health Care Seeking Among Adolescents: The Gonorrhea Community Action Project*. Am J Public Health. 2005. 331-337; 95:2. (Columbia)

Wang YC, Gortmaker SL, Sobol AM, Kuntz KM. *Estimating the Energy Gap Among US Children: A Counterfactual Approach.* Pediatrics. 2006 Dec; 118(6):1721-33. (Harvard)

Appendix G: Examples of PRC Presentations (oral, poster, etc.)

Ancker JS. *A Combined Qualitative Method for Testing an Interactive Risk Communication Tool*. National Library of Medicine Informatics Training Meeting. June 25-27, 2007, Stanford, CA. (Columbia)

Allen, J.D. *Computer-tailored Intervention to Promote Informed Decision Making for Prostate Cancer Screening*. Centers for Disease Control and Prevention, Atlanta, GA,. August 16-18, 2007. (Harvard)

Belza B, *PRC-HAN Physical Activity Conference Planning Workgroup. Moving Ahead: Strategies and Tools to Plan, Conduct, and Maintain Effective Community-Based Physical Activity Programs for Older Adults*. PRC-HAN Physical Activity Conference; 2007 June; Seattle, WA: CDC; 2007. (Illinois-Chicago)

Belza B, Anderson L, Altpeter M, Ory M. *Strategies to Assure Maintenance of Evidence-based Physical Activity Programs*. 2007 Joint Conference of the American Society on Aging and the National Council on Aging. Chicago, IL. Winter 2007. (North Carolina)

Belza B, Anderson L, Ory M, Altpeter M. *Strategies to Assure Maintenance of Evidence-Based Physical Activity.* Joint NCOA/ASA Conference; 2007 March 7-10; Chicago, IL; 2007. (Washington)

Birnbaum N, McGloin T, Manzo K, Lowry-Chavis L, McCracken J L, Shorty L A, Dino G A, Noerachmanto N. *American Indian Not-On-Tobacco Pilot Evaluation Results Phase I - Spring 2004.* May 2005; Chicago, IL: 2005 National Conference on Tobacco or Health May 4-6, 2005. (West Virginia)

Brownson, RC. *Disseminating Physical Activity Recommendations: How Do We Enhance Research Utilization?* 18th National Chronic disease Prevention and Control Conference in Washington D.C. Febrary 19, 2004. Sponsored by the DHHS, CDC, Prevention Research Centers Program, and Chronic Disease Directors. (Saint Louis)

Chrisp, E, Romero, C., Cunningham-Sabo, L., Bennett, E., Werito, M., Arviso, K., Tenorio, T., Bigthumb, E., Yazzie, R. and Davis, S. (2006) Applying *Community Based Participatory Research Principles to the Dissemination of a School Based Health Promotion Intervention in American Indian Communities*. Roundtable presentation, APHA Annual Meeting & Exposition, Boston, MA. (New Mexico)

Davis, C.B., J.N. Laditka, S.B. Laditka, S. Corwin, S. Wilcox, C.B. Cornman, and the Healthy Aging Research Network (HAN). *"Keep the Brain You Do Have Working:" Attitudes about Brain Health in the United States*. Annual Scientific Meetings of the Gerontological Society of America. November 16-20, 2006. Dallas, TX. (Colorado)

Farag NH, Moore WE, Kobza C, Abbott K, Eichner JE. *Effect of Life Stress on Overall and Central Obesity Patterns in School Employees.* American Public Health Association Annual Meeting, Washington, D.C., November, 2007. (Oklahoma)

Fernandez ME. *Development of a Tailored Interactive Multimedia Intervention to increase Colorectal Cancer Screening among Hispanics along Texas-Mexico Borde*r. María E. Fernández. 2007 CDC Cancer Conference. Atlanta, GA. (Texas)

Finigan, E, Sutter, E. *Development of a Linguistically Accessible Health Survey for Deaf Students*. Conference Paper 136655, November 4 – 8, 2006, APHA 134th Annual Meeting and Exposition, Boston, MA. (Rochester)

Glanz, K. *Changing Health Behavior with Tailored Messages and New Communication Technologies*. Keynote Lecture at the 12th National Health Promotion Conference in Israel. Jerusalem, November 2006. (Emory)

Griffith, D.M., De Loney, E.H., Allen, J.O., Campbell, B., Lewis, Y., Sparks, A. *Costs of Participation for Community-Based Organizations: Building Stability and Capacity to Address Health Disparities*. (2006). Annual meeting of the American Public Health Association, Boston, MA. (Michigan)

Katz D L. *A Glimpse of Things to Come: Featured Abstracts from the 18th National Conference on Chronic Disease Prevention and Control*. Preventing Chronic Disease 2004. April 2004. (Yale)

Hosler AS. *Understanding Social Influences on Healthcare Disparities*. (as an opening plenary speaker) CDC 19th National Conference on Chronic Disease Prevention and Control, Atlanta, Georgia, 2005. (SUNY-Albany)

Kealey, M., Ivey, S., Satariano, W. *Engaging Older Adults to Be More Active Where They Live: Audit Tool Development*. 19th National Conference on Chronic Disease Prevention and Control. Atlanta, GA. March, 2005. (UC-Berkeley)

Marshall, S.J. (2006). *From Efficacy to Effectiveness: A Review of Pedometer Based Physical Activity Interventions*. Invited speaker, International Congress on Physical Activity and Public Health (ICPAPH), Centers for Disease Control and Prevention. April 17 – 20, 2006, Atlanta, Georgia. (San Diego State)

Pluto D. *Physical Activity Policy Research: A Network Approach*. Public Health Law Conference; 2005 June; Atlanta, GA. (South Carolina)

Roberts, C., Holt, C. L., Scarinci, I., Crowther, M., Bolland, J., Litaker, M. S., Southward, P., Coughlin, S., & Eloubeidi, M. (2007, November). Colorectal Cancer Knowledge, Perceived Barriers to and Benefits of Screening, Stage of Readiness for Screening, and Screening Behaviors Among Urban Church-attending African Americans: Findings From and Feasibility of a Self-administered Church-based Survey. Annual meeting of the American Public Health Association, Washington, DC. (Alabama Birmingham)

Samuels ME, Whitler E, Salver BK, Green S. *Community Health Planning in Rural Kentucky*. National Rural Health Association 2006 Annual Conference, May 17-19, 2006, Reno, NV. (Kentucky)

Sternman J, McLeroy KR. *Systems Methodologies for Solving Real-world Problems: Applications in Public Health Systems Science*. National Institutes of Health 2007 Symposia Series on Systems Science and Health, March 2007. (Texas A&M)

Tandon, S.D., Templeman, A., Mance, G., Mendelson, T., Byrd, B., Turner, A., & Sonenstein, F. (2007). *Development of an Intervention to Promote Adolescent Mental Health using Community-Based Participatory Research: Processes and Preliminary Findings.* Society for Prevention Research Annual Meeting May 30-June 1, Washington, DC. (Johns Hopkins)

Widome R, Sieving R. *Measuring Social Capital in Adolescents: A New Tool from the Lead Peace Evaluation Study*. 9th Annual MCH Summer Institute on Addressing Health Disparities, "Culture, Communications and Health." 2007. (Minnesota)

Appendix H: Examples of PRC Cross-Disciplinary Collaborations

University of Arizona PRC: Partners with U.S.-Mexico Border Health Commission, Pascua Yaqui Tribe, Mariposa Community Health Center, Arizona Area Health Education Centers, Southeast Arizona Medical Center, Tohono O'odham Tribal Health Department, Campesinos Sin Fronteras, Arizona Department of Health Services.

UC-Berkeley PRC: Partners with Alameda County Public Health Department, Asian Health Services, Asian Pacific Islander American Health Forum, California Department of Health Services, Dental Health Foundation, Healthy Aging Research Network, South Asian Public Health Association, and the UC Berkeley Center for Weight and Health.

Columbia PRC: Partners with Affinity Health Plan, Harlem Children's Health Project, New York Public Library, NPower New York, American Cancer Society, Children's Health Fund, Harlem Congregations for Community Improvement, Inc., Project Health, Settlement Health, Mount Sinai School of Medicine, Kaiser Family Foundation, New York Academy of Medicine, and the University of South Florida.

Emory PRC: Partners with the Southwest Georgia Cancer Coalition, (comprised of stakeholders from 33 rural counties) which, in turn, has forged partnerships with Darton College, Thomas University, Albany State University, Abraham Baldwin College, Valdosta State University, and Georgia Southwestern University.

Johns Hopkins PRC: Partners with the California Wellness Foundation, Campaign to Prevent Teenage Pregnancy, Healthy Teen Network, Society for Adolescent Medicine, Society for Research on Adolescence, Urban Institute, Maryland Department of Health and Mental Hygiene, Maryland Department of Juvenile Services, Maryland Healthy Schools Coalition, and the Maryland School Health Council.

University of Kentucky PRC: Partners with the Tri-County Cancer Coalition, the Tri-County Community Health Coalition, the Kentucky Cancer Consortium, the Center for Rural Health, and the University of Kentucky Family Practice.

University of Michigan PRC: Partners with the Greater Flint Health Coalition, Genesys Health System, University of Michigan at Flint, Genesee County Community Action Resource Department, and the Genesee County Medical Society.

Morehouse PRC: Partners with South Atlanta Redevelopment Corporation, Institute of Public Health at Georgia State University, Jane Fonda Center at the Emory University School of Medicine, Georgia Division of Public Health, Atlanta AHEC, Atlanta Public Schools, Fulton County Department of Health and Wellness, and Southside Health Care.

University of New Mexico PRC: Partners with over 100 communities and organizations, including the Indian Health Services (Headquarters West), New Mexico Department of Health, New Mexico School Tobacco Policy Workgroup, American Legacy Foundation, and Acoma-Canoncito-Laguna Community Health Representatives.

University of North Carolina PRC: Brings together UNC Schools of Dentistry, Medicine, Nursing, Pharmacy, and Public Health and partners with local health departments, community health centers, worksites, medical practices and hospitals, schools and other community agencies.

Rochester PRC: Partners with Monroe County Department of Health, Finger Lakes Health Systems Agency, RIT National Technical Institute for the Deaf, Rochester School for the Deaf, and DePaul Deaf and Hard of Hearing Program.

Saint Louis PRC: Partners with SLU Center for Tobacco Policy Research, SLU Center for Cultural Cancer Communication, SLU Health Center Research Lab, SLU Obesity Prevention Center, City of Saint Louis Department of Health, and the Missouri Department of Health and Senior Services.

University of Texas PRC: Partners with St. Luke's Episcopal Health Charities, Prevention and Advocacy for Teen Health Project, Harris County Public Health and Environmental Services, Texas Department of State Health Services, The Health Museum, UT MD Anderson Cancer Center, and UT Medical School.

Tulane PRC: Collaborates with Louisiana Cancer Control Partnership, Louisiana Breast and Cervical Health Program, Steps to Healthier New Orleans, Louisiana Public Health Institute, LSU Health Sciences Center, City of New Orleans Health Department, The University of New Orleans, YMCA of Greater New Orleans, and Second Harvest.

West Virginia PRC: Partners with WVU Cancer Center, WVU School of Medicine, WVU School of Dentistry, WVU School of Nursing, WVU Center for Rural Emergency Medicine, American Lung Association, Center for Oral Health Research in Appalachia, Coalition for a Tobacco Free WV, Rural Health Education Partnership, State Health Education Council of WV, and WV Bureau of Public Health.

Appendix I: Examples of Academic Innovations Introduced by PRCs at Schools of Public Health

- An ***Evidence-Based Public Health (EBPH)*** course was first developed in 1997 by the Saint Louis University (SLU) School of Public Health and the Missouri Department of Health and Senior Services. It was later expanded in collaboration with the CDC, the Chronic Disease Directors, as well as the World Health Organization (WHO). In its current configuration, the EBPH course is taught by the SLU PRC to public health practitioners to develop their skills in how to: use strategic planning processes and develop a concise statement of the issue under consideration; quantify the issue in accordance with basic principles of epidemiology and apply these principles to the available data; search the scientific literature and available databases to systematically review the evidence; assess the evidence and prioritize among options; develop a program action plan; and, evaluate programs and policies after they are implemented. Modules from EBPH are employed within various SLU school of public health courses. For example, a module on literature searching is used in the epidemiological methods sequence for MPH and PhD students. See http://prc.slu.edu/ebph.htm for more information on the course.

- A ***Nutrition Policy Seminar*** at the University of North Carolina at Chapel Hill (UNC) draws upon work undertaken at UNC's Center for Health Promotion and Disease Prevention and includes guest speakers from the state health department who collaborate with the PRC. The ***Prevention of AIDS***, a large, interdisciplinary, credit-bearing course serves students at both UNC and Duke University and involves faculty from a number of departments, was developed based on experience from the PRC. The PRC provides continued/limited funding for the AIDS course. See http://gateway.nlm.nih.gov/MeetingAbstracts/ma?f=102238153.html for more information on this course. In addition, the introductory course of an entrepreneurship certificate, ***Public Health Entrepreneurship***, developed in partnership with the Carolina Entrepreneurial Initiative at UNC's Kenan-Flagler Business School, is taught by the director of the PRC and draws on experiences with micro-enterprise development from the PRC's core research project, HOPEWorks. See http://www.sph.unc.edu/carolina_public_health_magazine/graduate_certificate_in_public_health_entrepreneurship_now_available_7394_1957.html for more information on the entrepreneurship course.

- A ***Physical Activity and Public Health (PAPH)*** course, developed at the University of South Carolina PRC, is the first Master of Public Health (MPH) program in the nation designed to prepare professionals trained in the science of physical activity and its promotion in populations. Conferring the MPH in Physical Activity and Public Health, the new public health track prepares degree holders to play an integral role as a community physical activity specialist on interdisciplinary teams whose primary focus is the promotion of healthful behaviors and the prevention of disease conditions in public health settings. The track offers two emphases: (1) Surveillance Emphasis – prepares students for employment as a physical activity research and measurement specialist in public health and private agencies; and the (2) Programmatic Emphasis – prepares the student for employment as a physical activity specialist in community health promotion and intervention settings. See http://www.sph.sc.edu/associatedean/pdfs/mph_paphHandbook.pdf for more information on the track.

- A number of social marketing training options are offered by the Florida Prevention Research Center at the University of South Florida (USF). Since these trainings have begun, other schools of public health (for example, Tulane's School of Public Health and Tropical Medicine and Saint Louis University's School of Public Health) have increased their social marketing offerings. Also, traditional MPH students from schools of public health beyond USF have enrolled in the ***Social Marketing in Public Health Field School*** to enhance their traditional studies for their degree and/or obtain a certificate in social marketing and public health. The field school offers a selection of courses in social marketing, focus group research strategies, and formative research methods. Past courses have addressed strategic planning, media expertise, special communications skills, and, consumer behavior theory.

Appendix J: Executive Summary, 1997 IOM Study of the PRC Program

Linking Research and Public Health Practice
A Review of CDC's Program of Centers for Research and Demonstration of Health Promotion and Disease Prevention

Michael A. Stoto, Lawrence W. Green, and Linda A. Bailey, Editors
Committee to Review the CDC Centers for Research and Demonstration of Health Promotion and Disease Prevention
Board on Health Promotion and Disease Prevention

INSTITUTE OF MEDICINE


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Executive Summary

Health promotion and disease prevention are central priorities in the Centers for Disease Control and Prevention (CDC) vision, *Healthy People In A Healthy World Through Prevention* (CDC, n.d.). To advance research in these areas, Congress authorized and CDC established a program of university-based Centers for Research and Demonstration of Health Promotion and Disease Prevention. Congress authorized the program to "undertake research and demonstration projects in health promotion, disease prevention, and improved methods of appraising health hazards and risk factors, and shall serve as demonstration sites for the use of new and innovative research in public health technique to improve public health" (PL 98-551). The prevention research centers (PRC) program [1] began in 1986 with funding to three universities. With periodic competitive renewals and expansions of the program, there are now 13 PRCs. [2]

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1 Public Law 98-551 created Centers for Research and Demonstration of Health Promotion and Disease Prevention. Throughout this report, the committee refers to these university-based centers as prevention research centers, or PRCs. In referring to the administration of the program by CDC, the committee uses the terminology "the PRC program."

2 A 14th PRC grant was awarded after the committee completed its final meeting.

Multidisciplinary faculty at these PRCs, located at schools of public health and academic health centers, focus on a series of related projects on a public health theme defined in terms of special populations, risk factors, or specific health conditions. The PRCs are expected to form partnerships to develop innovative ways to prevent disease and promote health, focus on high-priority public health issues, and conduct research and demonstration activities that result in improved public health practice. The PRCs are intended to serve as bridges between science and practice, and from academia to state and local health departments, health care providers and provider organizations, and community organizations, as well as with CDC. Evaluation research is embedded in many of the PRC interventions, and the centers also train public health professionals in applied prevention research.

PL 98-551 authorized the Secretary of Health and Human Services to provide annual funding at the level of $1 million per center for a total of 3 centers in 1985, 8 centers in 1986, and 13 centers in 1987. The actual annual appropriations from Congress, however, have fallen short of these authorization levels. Since the program was established, Congress has expanded the core PRC program from a total budget of $1.5 million to a total budget of approximately $7 million in fiscal year 1995. In 1993, CDC began providing supplementary funds to the PRCs through a Special Interest Project (SIP) funding mechanism as a way to increase the levels of research activity within the PRCs. The PRCs received a total of $9.5 million through SIP funding in 1995.

CHARGE TO THE COMMITTEE

In 1995, CDC asked the Institute of Medicine (IOM) to review the PRC program to examine the extent to which the program is providing the public health community with workable strategies to address major public health problems in disease prevention and health promotion. IOM established a 10-member committee to evaluate the PRC program. CDC asked the committee to evaluate (1) the overall quality and appropriateness of the health promotion and disease prevention research and demonstration projects being carried out at the PRCs and (2) CDC's management and oversight of the PRC program. The committee has not assessed the quality of the health promotion and disease prevention research and demonstration projects of individual PRCs. No comprehensive evaluation of the individual PRCs has ever been done. Rather, the focus is on CDC's plans, actions, evaluation and support of the overall PRC program.

A VISION FOR THE PREVENTION CENTERS RESEARCH PROGRAM

The committee's review and discussions with some of those associated with the development of the PRC program indicate that there are at least three ways in which the PRC program can serve CDC's purposes. First, in fulfillment of its mission as the nation's prevention agency, CDC could use the PRC program to undertake the research and development that any successful, forward-looking science-based agency must have. An increasing number of researchers are recognizing the importance of community factors among the determinants of health and the consequent potential for community-based interventions, as well as the value of community involvement in the conduct of health research – that is, setting the research goal or question, developing community-appropriate methodology, interpreting results, and disseminating findings. Through the PRC program, CDC could lead the way in generating needed knowledge about this new, community-based approach to research.

Second, CDC could use the PRC program as a way to build capacity for public health practice outside its Atlanta headquarters. The university-based PRCs, which have collaborative relationships with state and local health departments, community organizations, and other entities,

might serve as extensions of CDC's Atlanta-based activities in field settings that would otherwise be beyond the agency's reach.

Finally, CDC could use the PRC program as a way to work with disadvantaged communities– those with high proportions of poor and underserved individuals – on critical public health problems. By focusing its research efforts on issues relevant to particular disadvantaged communities associated with the PRCs, the program could develop new knowledge appropriate to similar communities nationwide.

As any complex program must, the PRC program needs to establish a vision for the future to allow it to succeed as it moves into its second decade. Many options are available. The vision should encourage PRCs and others who work in health promotion and disease prevention to expand their activities, evolving toward centers characterized by:

- focus on risk conditions and social determinants of health;
- an orientation toward the community;
- interdisciplinarity;
- a means for dissemination research in public health;
- an interactive process for establishing research priorities;
- a role in setting national research priorities.

THE RESEARCH AND DEMONSTRATION PROJECTS CONDUCTED BY THE PREVENTION RESEARCH CENTERS

The value of the PRC program is largely determined by the content and the quality of the research and demonstration projects conducted by the PRCs. The committee assessed the contribution of the PRCs' efforts in innovation, setting priorities, and dissemination and implementation activities.

Innovation

A research project could be judged innovative if it addressed an underserved or previously unreached population, or if it were to test previously tested methods on a different but important health problem. In these terms, the committee found that the research and demonstration projects conducted by the PRCs were indeed innovative.

The PRCs were less innovative in the area of research methodology and the development of new interventions. One way to enhance a PRC's ability to develop new interventions and research methods is to establish a methodology unit or otherwise identify a group of PRC personnel that is responsible for methodological development. Methodology units of this sort are also likely to increase the PRC's ability to raise research funding from sources other than CDC. Thus, the committee recommends that

- **PRCs should include methodology units or assigned personnel in support of research methods development as a core activity.**

Setting Priorities in the PRCs

In its interviews, site visits, and record reviews, the committee found little evidence of explicit criteria for selecting research projects in the individual PRCs. Specific criteria can help any research center set a coherent direction, and they can also improve the quality of the individual research projects selected. Thus, the committee recommends that

- **PRCs should clearly state their criteria for project selection and evaluation.**

The committee's review of the research portfolios of the individual PRCs suggests that the quality of research and demonstration projects that are being conducted is highly variable. Most of the PRCs do not have a well-defined process for evaluating the results of their research projects. The quality of research and demonstration projects may be enhanced by an internal quality control mechanism for reports, publications, research proposals, and other PRC products. Thus, the committee recommends that

- **PRCs should have an internal quality control mechanism such as a review panel for reports, publications, research proposals, and other PRC products.**

Peer-reviewed publications are an important means of reviewing the quality of projects as well as an important means of disseminating new knowledge in professional communities. The committee finds that, as a group, the PRCs produce too few peer-reviewed research publications relative to their resources and their maturity; PRCs should be encouraged to publish their findings in the peer-reviewed literature. Therefore, the committee recommends that

- **More of the findings of the PRCs should be published in the peer reviewed scientific literature.**

There are examples of projects that have had a clear impact on the community's health, as well as policies and practices in public health agencies, health service delivery systems, and other community organizations concerned about public health. The committee's impression, however, is that relatively few of the research efforts have produced an impact that reaches beyond the immediate community. To clarify the impact of the PRCs' research, the committee recommends that

- **PRCs should document the impact of their activities on public health research, practice, and policy, both locally and nationally.**

CDC has an opportunity to advance the science of community-based research through the PRC program. The committee's review of the individual PRCs, however, indicated that some are more oriented to this approach than others. Thus, the committee recommends that

- **The PRCs should adopt a community-based approach to their research and demonstration efforts.**

Dissemination and Implementation Activities

Research findings and products from the PRCs and CDC should be disseminated to all PRCs, their communities, and their regional populations; to the research and professional communities through scientific and professional literature; to the public health practice community; and to the general public. Thus, the committee recommends that

- **The PRC program, as a whole, should increase its focus on dissemination efforts.**

The impact of the PRC program can be enhanced through cooperative dissemination activities among the PRCs and between the network of PRCs and other health promotion organizations such as state and local health departments in the United States and elsewhere. Thus, the committee recommends that

- **PRCs should seek to be part of regional and national networks for prevention that include CDC, the public health practice community, and other relevant parties.**

In reviewing the activities of the PRCs, the committee found many instances of dissemination activities, but few projects focused on dissemination research. Since the university-based PRCs are attempting a variety of dissemination approaches to a wide array of public and professional audiences, and because academic institutions have some research capacity, they are in a unique position to carry out dissemination research. Thus, the committee recommends that

- **The PRCs should increase their dissemination *research* efforts.**

MANAGEMENT AND OVERSIGHT OF THE PREVENTION RESEARCH CENTERS PROGRAM

Vision and Goals

Through their research and demonstration activities, the PRCs can – and have – made significant contributions toward meeting some of the national goals and objectives of *Healthy People 2000* (USDHHS, 1991). CDC's strategic plan (CDC, 1994) makes mention of the PRC program, but it does not appear to feature the program as a resource or asset. To ensure that the PRC program remains relevant to critical current public health issues, the committee recommends that

- **CDC should ensure that the vision and goals of the PRC program are compatible, mutually supportive, and consistent with the agency's overall strategic plan and with *Healthy People 2000.* The PRC program's vision and goals should define, in a clear and comprehensive way, the contributions of the PRC program to national priorities.**

CDC defines prevention research in the application guidelines for the PRC program as research designed “to yield results *directly applicable* to interventions to prevent occurrence of disease and disability, or the progression of detectable but asymptomatic disease.” This definition, however, should not be interpreted as limiting the scope of research to disease prevention priorities, and it

should include health promotion. In order that the PRC program remain consistent with current theory and practice in health promotion and disease prevention, the committee recommends that

- **CDC should modify its definition of *prevention research* as articulated in the application guidelines for the PRC program to encompass the broader scope of health promotion research that is needed to address the underlying determinants of health (risk conditions) and to build the capacity of individuals and communities to "cultivate health," rather than to focus solely on those determinants with immediate application to disease prevention (risk factors).**

Thematic Focus

An academic center is more likely to build a cohesive program of research and to have a major impact on public health problems when the center develops a strong sense of its own identity. PRCs, however, are faced with a dynamic tension between criteria based on their themes and those defined by the SIP program and other funding opportunities. In order to clarify CDC's expectations regarding the PRC program's contributions, the committee recommends that

- **CDC should provide guidance to the PRCs about the role of the PRCs' themes in selecting core research and demonstration projects and SIPs.**

CDC's Role in Networking, Communication, and Dissemination

The PRC program can enhance prevention research and the public's health through improved communication and networking mechanisms. To achieve this goal, each PRC should be called upon periodically to report what it has learned that is new and warrants replication or adaptation and evaluation in other PRCs that serve different populations. In order to consolidate the information for public health policy being gained from the PRC program, the committee recommends that

- **CDC should provide more opportunities for the PRCs to meet collectively, share lessons learned, exchange information related to findings, activate their collective communication channels on behalf of worthy projects, and provide mutual support, especially from strong PRCs to fledgling centers.**

The added value of the PRC program is its focus on community-based research, and CDC should encourage the public health practice community and other agencies and sectors to take greater advantage of the resource represented by the PRCs in their region and elsewhere. Thus, to foster better connections between the PRCs and the communities they work with, the committee recommends that

- **CDC should develop strategies for improving community input into the PRCs.**

PRCs have not exchanged information in a systematic way, and opportunities for replication of investigations into dissemination and implementation have not been exploited. PRCs have not regularly and systematically reported their findings concerning dissemination and implementation to CDC, and CDC does not have a mechanism for assembling findings from the various PRCs in order to promote such activities. Thus, to improve the quality of dissemination research in the PRC program, the committee recommends that

- **CDC should set specific expectations for dissemination research in the PRC program and encourage the PRCs to communicate their findings concerning dissemination and implementation methods among themselves and to the broader public health community.**

Criteria for Evaluating Prevention Research Centers

The PRCs vary considerably in the extent to which they publish research, disseminate their findings, and interact with local and state programs and agencies. In many of the PRCs there is no clear mechanism to eliminate low-quality projects that are unlikely to yield generalizable or clearly usable results worthy of dissemination through publication. One option for improving the quality assurance procedures at CDC is a modification in the format of the PRCs' annual progress reports. Thus, the committee recommends that

- **CDC should require PRC progress reports to include information on research findings and publications.**

External peer review is a time-tested mechanism for evaluating a research program and identifying areas for improvement. To ensure appropriate scientific review of the PRCs, the committee recommends that

- **An external peer review of each PRC should be conducted in the year prior to the last year of its funding.**

The core funding of the PRCs is dedicated to developing community-based projects that enhance health, build and maintain strong working relationships with community organizations, and establish better-informed public health practice and research communities. In order to set expectations clearly and treat all of the centers fairly, the committee recommends that

- **CDC should establish criteria to evaluate the performance of a PRC over its five-year funding period.**

Funding for the PRC Program

Funding for the PRC program has never equaled the amounts initially authorized by Congress in 1986, and the current inadequate level of funding for PRCs seems to be a critical barrier to the program’s long-term success. Thus, the committee recommends that

- **The Congress should increase the appropriation for the core PRC program to the level authorized in PL 98-551 to allow for 13 PRCs to be funded at the $1 million level, as originally intended.**

Peer review has been largely responsible for the remarkable quality, productivity, and originality of U.S. science and technology. In order to ensure the quality and relevance of the research carried out by the PRC program, the committee recommends that

- **Core funding for the PRCs should be determined as a result of open competition, using the peer-review approach that is standard in most federally-funded research programs.**

In the SIP funding mechanism, CDC has found a creative means of supporting PRC research activities beyond the level provided by congressional appropriations. Nevertheless, as a funding mechanism it lacks a systematic approach to setting priorities, calling for proposals, reviewing proposals, and funding the accepted proposals (initial and continuing). Thus, the committee recommends that

- **Priorities for the SIPs should be set through a long-term, interactive process involving the PRCs, CDC, and the public health practice community.**

SIPs have the potential to create innovative opportunities for the PRCs consistent with their themes, but as currently structured, they are more likely to present distractions. By reflecting the capabilities and goals of the PRCs and the PRC program in SIPs, the SIPs are likely to produce innovative research and demonstration projects. Thus, the committee recommends that

- **CDC should assure that the capabilities and goals of the individual PRCs and the PRC program are reflected in the SIPs.**

Another way in which SIPs can advance the science of prevention research is through replication of promising studies in other regions and populations. Therefore, the committee recommends that

- **CDC should make available a portion of SIP funds to encourage collaborative networks, multicenter studies, or replication of promising studies in other regions and populations.**

CDC requires that PRCs use core funds for demonstration projects, collaboration with state and local health (or education) departments, and training, but it does not specify the proportion of funding that should be allocated to each activity. PRCs should have leeway in determining *how* they will achieve core objectives, but should be held accountable for demonstrating that objectives have been achieved. Thus, the committee recommends that

- **CDC should allow the PRCs to determine how to spend their core funds most productively for their varying organizational circumstances.**

SUMMARY AND CONCLUSIONS

By forging links with academia, CDC has created a gateway for access to a cadre of well-trained, university-based researchers who could serve to inform and collaborate with the agency and the public health community regarding health promotion and disease prevention. The PRC program also fosters the development of academic research in questions related to public health practice, community interventions, and the development of community links for translating research findings into practice.

Overall, the committee finds that the PRC has made substantial progress and is to be commended for its accomplishments in advancing the scientific infrastructure in support of disease prevention and health promotion policy, programs, and practices. The committee's review of the efforts of the individual PRCs has indicated that each of the centers has made some contributions toward one or more of the goals of the program, and in the committee's judgment, many of these activities would not have been undertaken in the absence of the PRC program. There are, however, substantial differences among the PRCs in the kinds of activities they have undertaken and the success realized, and only a few centers have made substantial progress on all fronts: research, dissemination, and developing connections with the community and public health practitioners. Given the breadth of the PRC program's goals, the limitations on core funding, and the relative newness of some of the PRCs, the program's successes have been genuine and important.

The committee's review indicates that CDC's management of the program has been creative in the face of limited resources relative to its mandate, dogged in pursuing the mandate over a 10-year period in a bureaucratic environment that was not created or structured for the management of university-based research programs, and skilled in enhancing a sense of community and networking among the funded centers in a time of disappointing funding levels. CDC has fulfilled its initial mandate of “establishing and maintaining centers collaborating through research and demonstration to help fulfill prevention goals consistent with regional and national priorities” (PL 98-551, 1984). By further strengthening the PRC program, the CDC can increase its capacity to contribute to local, state, and national efforts to improve the health of Americans.

Appendix K: 2008 PRC Blue Ribbon Panel Survey Results

Note: Survey comments have been categorized for organizational purposes of this report. As stated in the report, PRC directors were asked two open-ended questions to which the Blue Ribbon Panel received the following responses:

BRP

- The blue ribbon panel should indicate where there have been PRC improvements and advances since the IOM report
- I assume that the BRP will be producing a statement regarding what's next for the PRC program in terms of # of PRC's (especially given the increase in the #'s of public health programs) resources for PRC's and any additional observations regarding the health promotion first legislation

Program Requirements/Operations

- Increase the rigor of the core research projects
- Make it harder to continue beyond 6-8 years
- Fund only diffusion and dissemination of previously successful projects beyond 10 years
- Rethinking the core components of the PRC program – as it now stands PRC's are obligated to develop scopes of work for core research, technical assistance, communication, and dissemination. Perhaps these need to be ranked or weighted for importance so that resources for each of these areas would be helpful
- FOA and award selection required focus on community-BASED research as opposed to community-PLACED research.
- Might want to consider a more formalized approach to committees – some are large and unwieldy and often the elected chairs have not had much experience on the committee
- I have concerns about scheduling PRC meetings directly in conflict with APHA or other critical public health meetings
- More Special Interest Projects
- More non-special interest project CDC support for community based participatory research
- Allow carryover from one year to next for salaries in addition to supplies
- More visits by CDC staff to PRC sites
- More transparency is needed; there is them and us perception with lots going on "behind the scenes." This is a shared opinion of many centers
- If more funds are not available to address each of the areas very well, it would be helpful to understand which areas should receive appropriate attention and why

Program Measurement and Efficiencies

- Determine valid markers of program progress and success
- Work with PRCs in developing cross-site indicators of community impact or effects on community partners (could be voluntary)
- Clearer definition of what is considered an "effective" PRC
- Do evaluations for large projects only and avoid needless focus on evaluating everything
- Design smaller projects epidemiologic principles
- Remember one National Institutes of Health trial like the diabetes Prevention program cost 160 million to show a significant impact and all PRC's together get 14% of that amount – sorry to bring up funding, but it is true
- Reduce the reporting burden

- Get rid of the reporting system – it takes too much time and detracts from actually doing the work of the PRC
- Keep trying to improve the usefulness and efficiency of the IS
- Strengthening the information system reporting process

Research and Dissemination

- Multiple centers working on the same projects with standardized protocols in different communities
- Work to further develop PRC research capacity to study dissemination and translation.
- Review and revision (if necessary) of CBPR criteria for effective/appropriate evaluation and information translation and dissemination
- Work to advance the science of community-based participatory research.
- The PRC and the national community committee have broken new ground in this area and we need to continue to advance the study of the effectiveness of this approach
- Work to develop the networking capability of the PRC particularly in dissemination and research .This does require funding as working beyond ones community requires funding and effort. But the potential to improve population health through the impact of these 3 points is enormous
- Documented PRC history and ongoing research practice focus on community engagement and participation with clearly defined and justified community (ies) with which each PRC is engaged e.g., community needs assessments, clearly identified community health priorities, community reviews if of research projects (protocols, participants recruitment processes, etc) prior to research implementation
- The PRC's are currently doing some of the best work in the US on the US on these issues and we should build on that strength
- A greater recognition of the range of community involvement that is actually feasible and necessary for good health promotion research. Too often, an idealized view of CBPR is put forth without recognition of its serious challenges.
- Look for all opportunities for visibility and impact related to increased university interest in community engagement

Collaborative Efforts

- Close collaboration with National Institutes of Health about the CTSA [Clinical and Translational Science Awards] effort
- Strengthening ties and collaborations among PRCs through the development of more network opportunities such as the Latino network
- Spend more time/resources at the PRC meetings sharing best practices and facilitating cross-PRC collaborations
- Facilitating continued information among the PRC is vital

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