

# From the Schools of Public Health



## On ASPH

### COMMUNITIES AND ACADEMIA WORKING TOGETHER: REPORT OF THE ASSOCIATION OF SCHOOLS OF PUBLIC HEALTH PREVENTION RESEARCH CENTERS BLUE RIBBON PANEL

RUTH J. KATZ, JD, MPH

In early 2007, the Centers for Disease Control and Prevention (CDC) requested that the Association of Schools of Public Health (ASPH) conduct an outside review of the agency's Prevention Research Centers (PRC) Program. ASPH subsequently convened the 11-member PRC Blue Ribbon Panel (BRP) to provide an assessment of the PRC Program and to develop a set of recommendations for use by both CDC and other stakeholders and supporters of the Program. Members of the BRP included representatives from schools of public health (with and without a PRC), preventive medicine programs, a state health department, and a voluntary nonprofit health organization.

The BRP's findings and proposals were presented in a report, *Communities and Academia Working Together: Report of the Association of Schools of Public Health Prevention Research Centers Blue Ribbon Panel*,<sup>1</sup> that was submitted to CDC in July 2008 and publicly released in August 2008. The purpose of the report was threefold: (1) to describe the PRC Program and summarize its 22-year history, (2) to provide an analysis of the Program's strengths and challenges, and (3) to make recommendations for future Program direction.

#### BRP DELIBERATIVE PROCESS

The BRP met three times—in March 2007, November 2007, and February 2008. Throughout its deliberations and in preparing the final report, BRP members

reviewed numerous documents, articles, and reports related to the PRC Program and individual PRCs, including materials on Program requirements, administration, and funding. Special emphasis was placed on reviewing and analyzing the research and community-based activities of the PRCs as well as various evaluations of the Program that had been conducted previously. The BRP also received input from individual PRC directors and PRC Program staff from CDC. In addition, the BRP chair separately briefed the PRC directors on the BRP's efforts on two occasions, in November 2007 and March 2008.

#### PRC PROGRAM HISTORY AND DESCRIPTION

In 1984, Congress enacted legislation directing CDC to develop a network of academic health centers—PRCs—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.”<sup>2</sup>

To achieve this goal, the law established minimum standards that PRCs must meet, including a multidisciplinary faculty (in addition to core faculty in the various basic public health disciplines), a dedicated disease prevention curriculum, graduate training programs related to disease prevention, and the capacity for residency training in public health or preventive medicine. The legislation restricted eligibility for PRC designation to accredited schools of public health and schools of medicine or osteopathy with an accredited preventive medicine residency, in recognition of their strengths and expertise in each of these areas.<sup>2</sup>

PRCs work as interdependent associations of community, academic, and public health partners that conduct prevention research—some 400 projects each year—and promote the wide use of practices proven to promote good health. In general, PRCs support two types of research—core research projects and special interest projects (SIPs). All PRCs are required to conduct core research that is designed around a public

Articles for *From the Schools of Public Health* highlight practice- and academic-based activities at the schools. To submit an article, faculty should send a short abstract (50–100 words) via e-mail to Allison Foster, ASPH Deputy Executive Director, at [afoster@asph.org](mailto:afoster@asph.org).

health theme (e.g., cancer prevention and control, healthy aging, and diabetes prevention). Many PRCs also receive SIP funding for targeted research projects that CDC identifies each year (e.g., influenza vaccination education, cancer risk prevention, and arthritis program evaluation). In addition to these individual PRC efforts, several PRCs are simultaneously funded to collaborate nationally as “networks,” focusing together on a specific public health issue or a specific population (e.g., the Cardiovascular Health Intervention Research and Translation Network, the Physical Activity Policy Research Network, and the Latino Health Network).

Regardless of the source of funding or whether a PRC acts independently or in collaboration with its sister organizations, the research work of each PRC is generally organized around the principles and practices of community-based participatory research (CBPR). The CBPR framework encourages applied research that targets local or state populations, or communities defined by characteristics other than geographic boundaries (e.g., Korean Americans, older adults, and migrant farm workers). Under this approach, PRC researchers work with community groups and other local partners in identifying important public health needs of the targeted populations, developing potential strategies for meeting those needs, and setting research priorities. PRCs are expected to disseminate their research findings to the communities in which they operate (and beyond, if appropriate).

PRCs are selected through a competitive peer review process that occurs every five years. The competition is open to existing PRCs, as well as eligible institutions without PRCs. PRCs are managed through a cooperative agreement by CDC’s Division of Adult and Community Health, which is part of the National Center for Chronic Disease Prevention and Health Promotion.

Three PRCs were funded in 1986. The Program now includes 33 centers around the country (located in 25 schools of public health and eight medical schools with accredited preventive medicine residencies), making it the largest extramural research center program at CDC. In 2007, funding for the Program was \$29.1 million, with each PRC receiving approximately \$730,000 in core assistance. The PRC Program office, which provides basic support services to the PRCs and carries out management and oversight activities across the Program, received \$4.8 million. (Additional information about the PRC Program is available at [www.cdc.gov/prc](http://www.cdc.gov/prc).)

## BRP FINDINGS

The BRP report included eight major findings:

### **Effective response to the 1997 Institute of Medicine (IOM) recommendations**

Some 10 years since the IOM released its study on the PRC Program, CDC has not only responded to the recommendations made, but it has also made significant progress in adopting them. Perhaps of greatest importance, PRCs have been aggressive in integrating CBPR and other community-based approaches into the PRCs’ basic operating principles.

### **Encouraging preliminary results from the PRC Program Office evaluation**

Preliminary results from Project DEFINE (Developing and Evaluation Framework: Insuring National Excellence), an evaluation planning project undertaken by CDC, confirmed the findings from the 1997 IOM study that PRCs have made considerable progress in incorporating the CBPR model into their work. The results also indicated that a number of other issues (e.g., cultural differences, questions of trust, and logistics) require ongoing attention and focus.

### **Translating public health science into public health practice**

Research—and the conversion of that research into programs and practices designed to improve the public health—is the hallmark of the PRC Program. A number of community interventions that have been developed and successfully implemented by the PRCs through their research initiatives are now considered best practices, putting the PRC Program in the forefront of public health translational research. This record of achievement could be improved if the Program was able to tap into the unused capacity in the accredited schools of public health and eligible schools of medicine and osteopathy.

### **Strong and supportive PRC Program Office**

This Office has been instrumental in enhancing collaboration among the PRCs, disseminating their work, and promoting 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, the PRC Office has come to be viewed by some PRCs as being overly burdensome with respect to data collection and reporting requirements, to the detriment of their research work.

**Strong partnership within the academic community**

PRCs draw upon the expertise of faculty with knowledge and experience in numerous fields—not just public health and medicine—who can contribute to a more fully integrated approach to community-based public health research. The ensuing partnerships frequently strengthen 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 projects and affiliated 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, and limited guidance from the PRC Program Office regarding priority setting often exacerbates the problem.

**Appropriated funds are inadequate**

Increasingly, PRCs are being asked to do more for less. Since fiscal year (FY) 2005, core funding for the Program has averaged approximately \$750,000 for each PRC. Taking into account a 3% inflation rate over this time, that figure translates to approximately \$664,000 per PRC 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 PRCs. Although the SIP initiative has served to channel additional resources to the PRCs, this funding mechanism is unreliable because it is made available—if at all—only on an annual basis and only at the end of a fiscal year. Nonetheless, PRCs have been able to leverage their core and SIP monies effectively in securing additional dollars from other federal agencies (e.g., the National Institutes of Health, Agency for Healthcare Research and Quality, and Substance Abuse & Mental Health Services Administration) and nonfederal organizations such as foundations (e.g., the W.K. Kellogg Foundation and Robert Wood Johnson Foundation) to support their work. Indeed, the PRC Program Office estimates that the PRCs have generated \$25 million to \$40 million in additional funds from these sources to help finance some 250 new research projects during the FY 2004 through FY 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, or appreciated, especially among those with a vested interest—the Congress, the executive branch, and the academic community.

**BRP RECOMMENDATIONS**

To strengthen the Program’s work and, in turn, to further its mission, the BRP made six recommendations to address several overriding concerns that hamper the Program’s ability to achieve greater success.

**Complete Project DEFINE and maximize its impact**

This national evaluation of the PRC Program must be completed and its ensuing recommendations must be appropriately implemented as soon as possible. Throughout the final review process, the PRC directors and other appropriate individuals should continue to be consulted.

**Enhance the PRC network**

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—in addition to helping to improve the health and overall well-being of the communities served by individual PRCs.

**Increase program funding**

Without additional funding, the PRC Program will be unable to keep pace with current programmatic requirements and priorities, let alone increase its efforts. The SIP initiative has been enormously helpful in furthering the goals of the Program, but it 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, PRCs should identify more opportunities that would unite them in such a way that national groups (including organizations such as the Association of State and Territorial Health Officials and the National Association of County and City Health Officials), 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 these activities are critically important and any such Program requirements must be met fully and in a timely fashion, they should 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 operations against the time lost in carrying out research programs and other community-based work associated with the PRCs and, if appropriate, to make adjustments in the allocation of Program efforts.

**Enhance collaboration**

As they have with their community partners, PRCs should undertake efforts to augment ties with their local and state health departments. These agencies can be enormously helpful in promoting and supporting PRCs. 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.

PRCs should also enhance their collaborative efforts on a national level. Closer working relationships with nationwide organizations (again using the network model) may provide prospects not only for additional resources, but also large-scale research efforts, and, in turn, opportunities to develop public health best practices, as well as forums for disseminating research results.

Stronger collaboration between PRCs and the PRC Program Office should help to improve Program operations. 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.

**Improve dissemination and communication efforts**

The PRC “story”—its many accomplishments and achievements—should be told more effectively and to a larger 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 from policy makers. This is especially important as discretionary government dollars have become scarcer. PRCs should speak directly to other audiences as well, including the public health science and practice communities, 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, especially their active engagement with their community partners. For policy makers, it will be especially important to highlight the positive public health outcomes that have resulted from the PRCs’ research and dissemination efforts.

**CONCLUSION**

The BRP believes the PRC Program has met with considerable success over the course of its 22-year history. The Program 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, helping the people of those communities now have an effective voice in addressing important public health issues.

Nonetheless, in the BRP’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. The adoption and implementation of the BRP’s recommendations will help significantly in achieving this goal.

---

A copy of the full report, *Communities and Academia Working Together: Report of the Association of Schools of Public Health (ASPH) Prevention Research Centers (PRC) Blue Ribbon Panel (BRP)*, may be downloaded from: URL: <http://www.asph.org/userfiles/PRC-BRP-Report.pdf> or a hard copy may be requested by contacting Kate Howe at [khowe@asph.org](mailto:khowe@asph.org).

The report of the ASPH PRC BRP was supported by Cooperative Agreement Number 300430 from the Centers for Disease Control and Prevention (CDC). Its contents are solely the responsibility of the authors and do not necessarily represent the official views of CDC.

Ruth J. Katz served as Chair of the ASPH PRC BRP and is the Walter G. Ross Professor of Health Policy and former dean at The George Washington University School of Public Health and Health Services in Washington, D.C. ASPH also acknowledges the contributions of the following PRC BRP members: James Curran, Dean of Emory University Rollins School of Public Health in

Atlanta; Sue Grinnell, Office Director, Community Wellness and Prevention, of the Washington State Department of Health; David Guzik, Dean of the University of Rochester School of Medicine and Dentistry in Rochester, New York; Robert Meenan, Dean of Boston University School of Public Health in Boston; Randy Schwartz, Senior Vice President for Strategic Health Initiatives, American Cancer Society, New England Division; Harrison Spencer, President and CEO of ASPH; Ciro Sumaya, Cox Endowed Chair in Medicine and former dean of Texas A&M Health Science Center School of Rural Public Health in College Station, Texas; Patricia Wahl, Dean of the University of Washington School of Public Health and Community Medicine in Seattle, Washington; Stephen Wyatt, Dean of the University of Kentucky School of Public Health in Lexington, Kentucky; and Elleen Yancey, Associate Clinical Professor and Director of the Prevention Research Center at Morehouse School of Medicine in Atlanta, Georgia.

Address correspondence to: Ruth J. Katz, JD, MPH, The George Washington University School of Public Health and Health Services, Office of the Dean, Ross Hall, Ste. 106, 2300 I St. NW, Washington, DC 20037, tel. 202-994-5179; fax 202-994-3773; e-mail [ruthkatz@gwu.edu](mailto:ruthkatz@gwu.edu).

## REFERENCES

1. Association of Schools of Public Health. Communities and academia working together: report of the Association of Schools of Public Health (ASPH) Prevention Research Centers (PRC) Blue Ribbon Panel. Washington: ASPH; 2008. Also available from: URL: <http://www.asph.org/userfiles/PRC-BRP-Report.pdf> [cited 2008 Dec 12].
2. Health Promotion and Disease Prevention Amendments of 1984, Pub. L. No. 98-551, 98 Stat. 2815 (Oct. 30, 1984).