BRICK LANCASTER, MA, CHES
Chief, Program Services Branch
Office on Smoking and Health
Centers for Disease Control and Prevention

Changing focus of health education from 1960's (pamphlets to individuals) to present day priorities of science-based initiatives, policy development, program integration and cultural change.
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I'm Brick Lancaster, and Brick is my real name. It's my middle name. And I am Chief of Program Services for the Office On Smoking and Health at the Centers for Disease Control and Prevention. It's in the National Center for Chronic Disease Prevention and Health Promotion, and I've been there for about seven years. And I've actually been at CDC -- it will be 16 -- 17 years this July. And before that, I was health promotion director in Arizona Health Department. I wasn't a "Fed" then. And I was there for seven years. And then before that, I was at a local health department as an associate director of the Health Department in Kent County in Grand Rapids, Michigan. And then before that, I was health educator for six-county rural health department in the middle of Michigan.

And almost all of that was health education/health promotion, and then I'm a manager for a lot of other things. But it's been my career all the way along, including health education and then -- health education and health promotion and all those changes of names.

When I first got at my first local health department, I had received a Master's degree in health education at Central Michigan University, and that's where the local health department was in six counties. And my role in those days -- and that's mostly what the health educators did in the '60s, and '70s -- was a lot of communication, working with partners, getting information out to the communities, doing training, those kind of things. We -- during that time, there were several big things starting up with WIC, which was the Women, Infant and Children program. There was a lot of focus on infectious disease and not as much on chronic disease in those days.

And -- but I had everything under my wing. So, I've done everything from oral health to HIV to other areas like that. (There wasn't any HIV in that first local health department.)

And the other thing that I did a lot of was partnership building and working with the communities in six counties on public health issues, and whether it's immunization or safety or any of those areas that were really focused on at that time. But the real thing in the '70s and again in the '60s before that was more of information, doing communication media things. That was really a focus there.

And then in the '80s and the '90s, there was the start of going more for more population-based things with policies and systems change. And there was a big switch there, and that was part of the dicey things of how health education and then health promotion and health education would, not just be pointed at somebody doing folders and slides and those kind of things, but really working with the

politics and behind the scenes and working with partners who can have policy. Policy there would be smoke-free environments, that kind of thing.

The Health Education and Risk Reduction Program -- funding that came from the CDC, I was at the State Health Department in Michigan at that time. And also during part of that time, I had moved over to Grand Rapids for the local health department. And that was a really exciting thing for health educators to be able to get acknowledged. And one of the things before that we are in the behind the scenes and all that kind of stuff and you were not acknowledged for what you did. And that really set the -- set it up with the whole context of how we've been working since then with that.

The Health Education Risk Reduction Program really got covered over by a block grant, and it went away. So, we had to scramble as far as the health education community to really keep going on those areas that we were working on and with working in communities and focusing on some broader issues.

The Healthy People 2000 really put a goal for everything in public health. And I was involved in some of that from a state point of view, and I was involved with developing some of those things and there was a separate section in those days about health education/community education. With that coming down from the federal government and across the country, it really put some leverage for lots of folks in public health but particularly for the health education community. And that also continued in Healthy People 2010, and it's still room as far as we are starting to work on Healthy People 2020.

And so there is still a lot of those links in there. But it really headed a strong point of acknowledging again the need for health education and health promotion. And one of the difficulties was, how do you measure? Where is the data? Because a lot of that was how were they going to understand whether we made it to that point or not.

So, there were a lot of things that we had to learn, and, again, that helped us get more linked up with the evaluation community and the surveillance people and how -- what the impact was on health education/health promotion across the board with chronic diseases risk factors, those kind of areas. So it was a major leap for us.

It did provide an opportunity for the health education community to work with evaluators and researchers, but mostly evaluators. And there really was a focus on that. And one of the problems we had was, say, at CDC or the National Institutes of Health, really they were focusing on just research type of things on delivery of programs.

So, what it enabled us to do was to finally sit down at the same table with researchers, with evaluators.

And there was an earlier piece back before that on health promotion. For 1990 and again the health education community was working with the Department of Health and Human Services at that time. We were building up this whole idea of healthy people.

So, we've been in -- We've been asked in and some of the leaders in those days who were at the federal level like Larry Green, who is a big major health education guru, he was there. And so we really got locked in and linked in to all those areas.

And, again, going back to Nixon, President Nixon and that whole report on health education, a committee on health education, it was around '72-'73, it was again a big jump for an acknowledgment for the health education community.

I work in the chronic disease center, Chronic Disease and Health Promotion Center. So, our focus -- and this is something interesting to me historically. It took many years to get acknowledged as a center. And this is -- it's been 21 years -- or 20 years with the National Center for Chronic Disease Prevention and Health Promotion, and very little attention was going towards the leading causes of death that are the chronic diseases and the various risk factors.

So, it -- the big changes that have happened when I got to CDC in 1992, one of the big issues is more population-based efforts, and instead of going for individual health education or health promotion for individuals, it must be a lot broader.

So, that's a time in the late '80s but early '90s where a policy and systems change are really the big leverage point. And tobacco probably started that, and a lot of folks have and are still looking at that as far as other programs go. But you have much more of an impact in reducing tobacco use or exposure by raising taxes. And if you raise the tax in the respective states, that does have an impact, particularly on young people, when the price goes up, and it also gives additional funding sometimes with the governor of whatever states would do it that would help fund more programs in tobacco.

But also another one is clean indoor air policies, which, again, we have got now, just in this last year or so, a strong science base on the impact of smoke free environments. And many many states are going that way. And the latest information on that is that there has been a reduction within the first six months of having that in a state, the heart disease problems went down. And that's a whole other discussion.

But a lot of the big things that are critical right now and we are looking at the big areas for the Chronic Disease Center at CDC is tobacco. Then you have the growing epidemic of obesity and how does that work and what are the policy systems change things there. What are the links between the population-based programs and the healthcare system. And the healthcare systems where there are lots of links with cancer, heart disease and stroke and obesity, there is a focus on healthcare, but we also going to have to go to the broader public health view of things and not be so clinical.

So, one of the big changes is there is not a lot of clinical focus happening. It's moving more into the other areas of population-based programs.

I think the other thing that's major right now that has an impact on a lot of the project officers in the various programs at CDC are health educators or health promotion. It depends on when they got their

degrees. It's program integration. And how are we going to -- and this is a priority for Janet Collins. How are we going to break down the silos of the individual programs and get them to work together to enhance and leverage what they are doing? So, an example would be with the Office On Smoking and Health has the QuitLines in all the -- supporting that in all the states. And now the diabetes program is linking up their program initiatives by linking them up with the respective cessation programs and QuitLines. And the same thing is happening with heart disease and stroke and with other areas.

So, there is a lot of linkage going on. And what other crosscutting things? I think the big area which is cross-cutting is health disparities, health related disparities. And that's another major priority for, not only the Healthy People 2020 and the 2010, is how do we get the -- how do we do the right thing working with populations that have health disparities? Now -- and it's not just racial and ethnic. There is low SCS in the tobacco area. LGBT, lesbian bisexual, transgender groups have very high use of tobacco and other areas. And -- but they don't have enough guidance on how to reach those populations. But the major health disparities are that.

And then another area included in that is, how are we working with tribes and the tribal nations? And there are several programs, including the Office On Smoking and Health have programs working out with tribal support centers. And, again, working on cultural change, how to work instead of us parachuting in as health educators or health promotion people, how do you work with the leadership there on what's culturally appropriate for them.

And so those are some of the major initiatives and priorities that are happening, but it's really going much more into the policy systems change and environmental change and those kinds of things.

Healthy People documents over the years have supported a lot of what health promotion/health educators are doing across many areas. I know that the science base is critical. And the Healthy People 2010, and others are linked to that, but there are a lot of other areas of best practices. And it depends on the program, but the science base of the Institute of Medicine, the reports from other science-based programs, whether it's for obesity and other areas, there is a lot of work done on how do we build the science base for what we are doing. And that's really one of the big -- one of the key issues that we all have to work on because not all the programs with health promotion/education have best practices like the tobacco program does. But they are now working on that.

And, again, that links up with the National Institutes of Health and other research areas on getting to the how-to's. And it's always been a gap between, say, what Healthy People says and actually what are the next steps? How do you do it? And where are the gaps? One of the things that the health education community has been working on for quite a while is providing input to the researchers about what we need.

And so within the society of public health education, one of the journals is about health promotion practice, and that's a journal that's got rave reviews. And they focus not on the research part, but the practice: How do you do that? And there is an area in there called "The Circle of Research and Practice." And it's set up that way. And I've been the associate editor of that with another colleague, and we are

really looking in there about what are the links between the programs that you do, the practice that you have as a health educator or health promotion director, or whatever, and the research folks.

So, there are a lot of crosscutting discussions now that really were not as well-developed back in the '80s and early '90s. So, there is a big and much better link with the research community on the how-to's but also the challenges getting them to focus on that rather than upper, higher-level things on research, and it doesn't get to the community-based programs. How do we build the science base for reducing health disparities? How are we doing that? And that's still a struggle for us that we keep working on from the health promotion community.

From my point of view, the priorities for health promotion going into 2010 and beyond are several areas: One is reducing, if not getting rid of, health disparities, and that's a big goal and has been for Healthy People and as well as the Chronic Disease Center, as well as the various health education organizations like the Directors of Health Promotion and Education and the Society for Public Health Education. That's very important.

The other priority is really moving forward into broad population based policy and systems change which is much broader and environmental change. And so that's another area.

The other area is program integration, getting the various programs who have links with each other whether it's tobacco and heart disease and stroke, or the obesity program with diabetes, or with tobacco because there is new research on that as far as the links with that. So that one is a very important priority.

And the other area is, how do we build the science base for health promotion and education at the community level? And really the base of everything, the foundation of everything in public health from my point of view -- and it has been with the health ed community -- is at the community level. You know, the funding we have at CDC mostly goes to states who are then to work with local health departments and communities and coalitions. The other priority is that the community level work and how to build the best practices for various programs.

What I mean with improving the research and best practices is the type of research we need is at the community level on what's the impact of coalition building. What's the impact of policy systems changes? And one big question we have is, does the same things you do for tobacco or for, like, in community development and those kind of things, are they the very same actions that you would do for all the other programs, or are there special areas? The same thing with priority populations. Just because we have this way in best practices, say, for tobacco, how does that fit in Indian country or how does that fit with African/ American or Hispanic/Latino cultures. And there are a lot of questions on that. And are they the same? Are they tweaked a little bit?

So, that's a big area that we need more research on. And the research really needs to be practice based and how we can do things rather than just identifying what the problems are. There is another way of

putting it. It's one thing to identify the problems, but we've got to know how to deal with the problems and we need more science based on that.

The solutions for getting best practices at various levels is really to work with the communities, with the other programs and partners. CDC can't do it all and none of the feds can. So, the one key thing there is how do you build partnership with the Robert Wood Johnson Foundation or the American Heart Association or the Cancer Society.

The focus on getting more best practices is really determining what are the questions. And a lot of that has to come from, and we need to have it come from the communities and the practitioners who are out there. So, one of the issues that I found with CDC is, we would like to get more feedback from the communities, from the state health department, from partners. But at the same time, a lot of folks at the state level or organizational or community level say, you are the CDC, tell us what we should do.

And so there is that -- that balancing of we want to hear, we need the input, we need the flexibility from you about what are the real needs, what's missing. And we aren't going to parachute in and tell you this because we need to hear from you before we know how we can provide some assistance there along with our partners.

So, there has to be a strong partnership at the federal level, the regional level, the state level and the community levels. And you have leaders in all those areas, and how do you identify them, how do you get them involved. And that will help develop best practices or what the needs are in best practices as well as implementing programs that we already know work, and that's one of the challenges. We know what works in a lot of areas, but how do you get the leadership at the community level or at the state level to buy into that? And how are you working with that with cross-collaboration?

One of the big challenges I had in my career and most of the health education folks - not really being acknowledged as a major player in public health departments. That didn't happen until the late '80s, '90s. And a lot of areas still, particularly at the state health departments, it's still been difficult.

So, one of the challenges is how do we get acknowledged enough so that the policy makers and the decision makers will provide support both individually and program wise but also with funding? And how do we work with other organizations to build that and leverage that?

So probably one of the biggest frustrations is we know what to do in a lot of areas and all we need to do is have support for funding and how do we build the community up with training and also the whole health education/health promotion focus from students coming into the field. And back in the old days, you used to have training for people getting a Masters in health education and other areas and you had to do some fieldwork. And that's gone away most of the time. But that was an exciting time for those of us in the field to have a student whose getting a Master's degree or even a Bachelor's degree working with us, and you have new ideas that they might have but also we had an additional person who we can work with.

When I was the health education director for the six county Central Michigan District Health Department, I was the only health educator. So, I was acknowledged as part -- I was at the same level as the nursing director and the environmental health director, and that was rare in those days in the '70s to have that acknowledgment to be at that level. So that didn't happen a lot.

So I was blessed with having leaders who also had a health education background or a physician that really bought in and understood what health education was all about. They set it up that way.

And so that's been tough and it continues to be. One of the challenges that's happening in health education is the name and health education/health promotion, risk factor, those kind of things, has really held up some of the things because you've got -- at some time over the years, you had the school health education people bumping into the public health education people. And there were many groups and organizations that we tried to work together over the years, including doing the health promotion -- Healthy People developments, but how do we get people to play well with each other in the health education community.

Another example of that was, when health promotion started being used, in mid '80s and from the auto charter in Canada, and the European folks really went after health promotion which was more social justice and broader policy-related things. That was new to the U.S. And a lot of people, when they heard of health promotion, they thought that was putting out public service announcements. So there was a lot of confusion for many years about that.

The other interesting thing, there is a whole separate group, professionals for workplace health promotion. And they jumped on the term "health promotion" before the health education community did. Most of the people who were working in worksite health promotion, they changed it to health promotion in the '80s, were mostly into exercise physiology -- exercise and weightlifting and that kind of stuff, not broad health promotion related things.

So, that slowed a lot of stuff up over the years, particularly in the '80s and early '90s - just over use of the terms. And there was Hod Ogden, who was one of the gurus, said in the early '90s that that was one of the problems. We had five or six or seven professional organizations rolling around with each other and we needed to get together and just have a basic understanding and definition of what we were doing. It helped us with enhancing the training that the universities were doing and enhancing the technical assistance that we were providing from CDC which is -- or from the other program areas such as Directors of Health Promotion and Education or Society of Public Health Education and others.

In the late '70s, the federal government set up several things as far as having a bureau of health education. And that morphed into several other things and areas like that. And that really was the first time, other than Nixon's document, that we were able to connect with, in the health education community. So, a lot of leaders in health education and that was primarily in the Society of Public Health Education in those days.

The Society of Public Health Education has been around for 60 years. And the Association of State and Territorial Health Promotion and Education, ASTHPE was what is was, didn't come around until the early '80s if I am remembering correctly, and then they changed the name to Directors of Health Promotion and Education.

So, those organizations, professional organizations, did have links with the federal development. And the feds reached out for that as well. So there was participation with that.

One of the passions -- one of the reasons why I have passion for health education and promotion, and even though I am a manager at an upper level at CDC and that kind of stuff, but the passion is that the community of health promotion, health education is strong. And they may have different points of view on some things, but it's really what keeps me going, why I still am a member of a lot of -- two or three of the organizations, including the American Public Health Association that had a health education group back in the early 1900s. But it was -- just the passion of having a great community of health education and health promotion folks that are at the local level all the way up to the big gurus.

And the other thing that really impressed me when I was just starting is how open that people like Larry Green or Marshall Kreuter or others, the Dennis Tolsmas, that really reached out. You could have access to all you wanted. It doesn't matter. And the same thing happens now. If I get a call from a health educator from out in the middle of North Dakota, I'll sit and listen and talk with them.

So, there is a lot of mentoring culture that's always been there as far as I am concerned. And it's very important, and that's really one of my passions - mentoring and because that's how I grew up with all the Dennis Tolsmas and others with helping me. And they didn't blink an eye. If you need help, we can give you help.

And so there is a lot of cross- connection in mentoring. I think that's one of the big passionate issues that keep me going in this area - being a health promotion/health educator in a managing level.