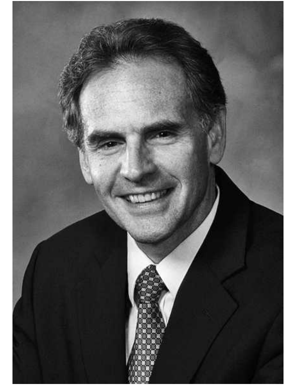


Editor's Notes

A Billion and Change in Federal Grants for Health Promotion

Abstract. *The U.S. Department of Health and Human Services announced $1.01 billion in funding opportunities for health promotion in fiscal year 2011 and selected winners for the first phase of these programs. These included $100 million over 5 years for 10 state Medicaid programs to develop incentive-based strategies, $900 million for 61 community-level programs through the Community Transformation Grants, and nearly $10 million to help employers develop comprehensive workplace programs.*

Despite all of the partisan wrangling on health care reform and the budget deficit ceiling fight, the U.S. Department of Health and Human Services was able to announce $1.01 billion in grant-funding opportunities for health promotion before the September 30, 2011 end of 2011 fiscal year. All of these emerged from programs created by the Affordable Care Act. The grant opportunities, grant recipients, and some thoughts on the strengths and weaknesses of these opportunities are summarized below.

Medicaid Incentives for Prevention of Chronic Disease

The Centers for Medicare and Medicaid Services (CMS) announced a grant opportunity of up to $100 million for state Medicaid programs to develop incentive-based strategies to engage Medicaid recipients in programs to quit smoking, lose weight, and prevent or better manage high cholesterol, hypertension, and diabetes. This grant program emerged directly from section 4108 of the Affordable Care Act. States receiving these grants are required to provide treatment programs for an experimental group of Medicaid recipients for at least 36 months during the period of August 1, 2011 to December 31, 2015. The opportunity was announced February 23, 2011; letters of intent were due April 4; full proposals were due May 2; award winners were to be informed on August 1, 2011; and funding was to be available immediately. Grants were expected to be awarded to 10 states in the amount of $5 to $10 million each. CMS ended up awarding grants to 10 states, with total funding of $85 million. The states that won grants are California, Connecticut, Hawaii, Minnesota, Montana, Nevada, New Hampshire, New York, Texas, and Wisconsin. More details on the grant opportunity can be found on the CMS Web site: https://www.cms.gov/MIPCD/. Additional details on the programs of the winners will be posted at that site as they are developed.

This grant program has several strengths. First, it addresses an area that is critically important to the physical health of the American people and the financial sustainability of the states and the nation. Tobacco use, inactivity, and poor nutrition cause an estimated 70% of all chronic diseases, and these diseases account for an estimated 75% of medical costs for the full population, 83% for Medicaid populations, and 96% for Medicare populations.[1] Furthermore, rates of smoking, overweight, and chronic diseases are especially high among the low-income populations eligible for Medicaid. Based on the most recent years for which data are available, Medicaid spending by the federal government totaled $273 billion dollars in 2010,[2] and spending by state governments totaled $127 billion in 2009. This represents more than 7.3% of the $3.7 trillion total federal budget and 9.9% of the $1.55 trillion in budgets for all of the state governments (Note that the 7.3% represents the total spent by states for Medicaid after subtracting the portion contributed to state governments by the federal government. If the portion covered by the federal government were included, the total would be 21.1% of state budgets).[3] This level of spending on Medicaid, not to mention the inevitable annual increases, will be difficult, if not impossible, for states and the federal government to maintain in the future. As such, this grant program has the potential to be very cost effective; savings of only .03% are required for Medicaid to break even on its $85 million cost. Indeed, savings of only 4.3% would be required to break even if $200 in new health promotion spending were provided to EACH of the estimated 58.1 million Medicaid recipients in the United States. A second strength of this program is that grant proposals had to be submitted by the directors of the state Medicaid programs, the state officials who administer programs at the state level and are in a position to integrate health promotion strategies they discover to be effective for state Medicaid programs. A third strength is that the timing expectations to implement

Am J Health Promot 2012; 26[3]:iv–ix
DOI: 10.4278/ajhp.26.3.iv
Copyright © 2012 by American Journal of Health Promotion, Inc.

programs are reasonable. States have 5 years to implement a 3-year program/experiment. Partial funding is available for up to 15 months before the study period to refine operational protocols, hire staff, and engage program participants. Fourth, funding per state could be as high as $10 million, with no matched funding requirement. This level of funding is sufficient to cover the salaries of qualified staff as well as treatment programs costing $200/year for 3 years for several thousand program participants in each state. Finally, the application provided very clear guidelines on what was expected in the proposal and numbers of points awarded for each area. Importantly, the application required a very rigorous methodology, including an experimental or quasi-experimental design, power analysis to determine sample sizes, propensity scoring for selecting comparison groups, and detailed backup documentation, including samples of forms to be used for informed consent with study participants. Strategies had to show documented evidence of effectiveness. I suspect that this level of rigor made it difficult for most states to prepare a proposal and will make it difficult for some states to implement their programs as planned. However, states that execute their programs/experiments as planned should have results with strong internal validity.

The only real weak element in the specifications of the grant proposal was that only 15% of the budget could be allocated to administration, which includes program evaluation and transmittal of individual patient-level data directly to CMS. Few states have the ability to transmit individual-level data because of the complex relationships they have with Medicaid providers and intermediary insurers; therefore, most states would need to spend considerable resources developing this capacity or would at least be unable to estimate how much it would cost to develop this capability.

At least two factors limited which states applied for these grants. First, states were required to be offering all of the preventive services authorized by Medicaid by the time they started their experiments. Some states are not yet offering the full range of preventive services and have not confirmed the dates on which they will do so. Second, some states led by Republican governors have been vocal in their opposition to the Affordable Care Act, from which this program emerged. This has influenced their engagement in its various programs and the positions taken by their staff. For example, Mary Taylor, the Lieutenant Governor and Director of Insurance for the state of Ohio posted a letter on her blog on June 24, 2011, that said, ''I will do everything I can to protect Ohio's citizens and job creators from this catastrophic law''[4] (referring to the Affordable Care Act). Ohio did not submit an application.

CMS plans to hire an outside evaluation group to measure the impact of this program on health conditions and Medicaid use and costs but had not released a request for proposal to providers by November 14, 2011, when I wrote this article.

Community Transformation Grants

The Community Transformation Grant (CTG) program from the Centers for Disease Control and Prevention (CDC) offered $900 million over 5 years. This grant program emerged directly from section 4201 of the Affordable Care Act. It was designed to help communities prevent heart attack, strokes, cancer, and other leading causes of death or disability through evidence- and practice-based policy and environmental, programmatic, and infrastructure changes in states, large counties, tribes, and territories. More specifically, this program required grant recipients to focus on changes in weight, proper nutrition, physical activity, tobacco use, emotional well-being, and overall mental health and to be able to show reductions of at least 5% by the fifth year in obesity through nutrition and physical activity interventions, death and disability due to tobacco use, and death and disability due to heart disease and stroke. Funding for these grants comes from the Prevention and Public Health Fund (Prevention Fund), which emerged directly from section 4002 of the Affordable Care Act. Program implementation grants of $500,000 to $10 million for the first year were available to communities ready to implement programs. Also, capacity-building grants of $50,000 to $500,000 were available for communities who needed to develop human capital, skills, partnerships, and infrastructure and then develop an implementation plan. Eligible applicants included state, local territory and tribal government agencies, as well as state and local nonprofit organizations. Cost sharing and providing matching funds was not required, but leveraging other resources to promote sustainability was strongly encouraged. The opportunity was announced May 17, 2011, letters of intent were due June 6, full proposals were due July 15, award winners were to be informed on September 15, 2011, and funding was to be available immediately. Up to 75 awards were expected to be made in 2011, with disbursement of $102 million expected before the end of fiscal year 2011. Details on this grant opportunity can be found at the grant Web site.[5]

Winners were announced on September 27, with a total of $103 million to be awarded in fiscal 2011; 35 awards were implementation grants ranging from $500,000 to $10 million for the first year and 26 were capacity-building grants ranging from $147,000 to $500,000. A list of winners can be found at the HealthCare.gov Web site.[6]

This grant program has several important strengths. The most important is probably the stated goal of actually transforming communities, rather than merely doing more of the same health education programs that would have more limited impact. This lofty goal was reinforced by the requirement of the implementation program grants to focus efforts on policy, environmental, programmatic, and infrastructure interventions; showing evidence of an existing coalition of partners; coordinating with multiple sectors such as transportation, planning, education, health care delivery, agriculture, and others; having a leadership team with multisector leaders; being able to make a persuasive case of how interventions will produce 5% improvements in the target outcomes over the course of the program; and having a well-articulated sustainability plan to explain how the effort would extend beyond the grant-funding period. A second important strength was the opportunity for groups who are not yet organized to apply for capacity-building grants. Like most grant opportunities, the 2-month period of time

allotted to prepare and submit a grant after the announcement was simply not enough time to develop a plan and coalition from scratch. The only groups who could meet this deadline were groups that knew about this grant opportunity well in advance, had already developed a program plan and assembled a coalition and leadership team to implement it, and then used the 2-month period to refine their proposal to meet the grant specifications. The capacity-building option gave communities the opportunity to pull themselves together to be able to apply for a grant to implement their plan when the next round of funding is announced. In fact, this capacity-building process may actually be more transformational in relative change terms than implementing the programs. A fourth important strength was the fact that nonprofit organizations were allowed to apply, in addition to government agencies. Typically, only government agencies are allowed to apply for this type of federal grant.

Despite all of the positive aspects of this program, I have several concerns, all of which are related to the idea of transformation. First, I did not see anything in the proposal specifications that required the applicants to demonstrate how their approach would be truly transformational, any examples of existing programs that have been transformational, or even a definition of what constitutes transformation. I worry that partisan critics may criticize this program as just ''another failed economic stimulus'' if it produces only incremental, and not transformational, improvements in health. Second, I am worried that $10 million/year for a state or large county and $900 million for the entire nation may not be enough to be transformative. For example, the Los Angeles County Department of Health was awarded a grant of $10 million/year to transform the health of a county with 10 million residents. The annual budget of this department is $850.8 million.[7] How much impact can we expect from an additional $1 per resident? It might have been wise for the CDC to spend $10 million and 1 year to determine what approaches are likely to be transformative and then spend the remaining $890 million on proven approaches. Of course, there is a high likelihood that the remaining $890 million would have been eliminated by deficit hawks (Democrats and Republican) trying to cut spending of any kind or Republican members of Congress determined to repeal anything related to ''Obamacare.'' Second, the application had a technical requirement that I would characterize as a fatal flaw. All of applications to serve the population of a county required a letter of support from the health department for the county, all of the cities within the county, and the state health department. Although it seems obvious that health departments should be part of any plan to improve the health of citizens, writing the rule this way creates two challenges. First, this might subject some applicants to the political pressures of their state or county. For example, a coalition preparing a grant application to serve Duval County, Florida, was having trouble getting a letter of support from the state health department, with rumors that Republican Governor Rick Scott was reluctant to apply for funds related to the Affordable Care Act. The group eventually did receive a letter of support from the Florida Surgeon General after they engaged the media in this issue.[8] Second, this requirement puts the county or state government in a power position over local community groups in applying for grants. I am aware of a number of cases in which coalitions of nonprofit organizations decided to terminate their efforts to prepare applications when they learned that the county health department was intending to submit an application. Although state and county health departments play a key role in their communities, I just do not see them being transformative as long as they are subjected to political pressures of their elected officials and the bureaucratic nature of government. The exception of course is places like New York that have passionate support of a very powerful mayor. Another concern is that it would be very difficult for a county or state health department to not try to use the grant funds to plug budget holes caused by existing budget cuts. Unfortunately, 44 of 61 grants (72%), including 29 of the 35 implementation grants (83%) went to city, county, state, or tribal health departments. Collectively, $82.4 million of the $103 million grant total was awarded to these state and county governments.

The impact of the program will be evaluated through a $60 million 7-year evaluation contract awarded to Research Triangle Institute (RTI).[9] RTI will examine the extent to which residents in the CTG communities are exposed to policy and environmental changes and the impact of these changes on health behaviors and chronic diseases. RTI will also examine the long-term health and economic costs and benefits of specific policy and environmental interventions.

Small Business Wellness Grants

On June 23, 2011, the CDC announced a competitive bidding process for one contractor that qualifies as a small business to provide health promotion programs to a network of small- and medium-sized employers through its Comprehensive Health Programs to Address Physical Activity, Nutrition, and Tobacco Use in the Workplace.[10] Proposals were due August 8, 2011. On September 30, 2011, Viridian Health Management was announced as the winner of a $7,769,250 contract to be the health promotion provider. Viridian will be responsible for recruiting 70 to 100 small, mid-sized, and large employers who are based in seven geographic regions and do not have health promotion programs already in place but have demonstrated leadership commitment to developing programs. Viridian will help these employers create comprehensive health promotion programs to promote physical activity, proper nutrition, and tobacco cessation. Programs will focus on engaging employees and creating physical, cultural, and policy environments that promote health over a 2-year period. RTI was selected to receive a contract for approximately $1 million to measure the impact of these programs on knowledge, behavior change, and absenteeism and to draw out lessons that can be applied to helping other employers develop programs.[11] This program emerged indirectly from section 10408 of the Affordable Care Act, which authorized appropriations of $200 million for the period of 2011 to 2015 but did not also appropriate these funds within the provisions.[12]

I have very mixed reactions to this grant opportunity, and I wonder if it makes the best use of nearly $10 million in an environment of scarce resources. It is positive because it will

help 70 to 100 employers develop health promotion programs for the first time. It is also positive that the creative minds at RTI will focus their time on drawing out lessons to help other employers implement programs. However, I was disappointed with the design of this grant opportunity for several reasons. First, it does not follow the intent of section 10408 of the Affordable Care Act, which specified that grants should be provided to employers with 100 or fewer employees. Section 10408 limited grants to businesses with 100 or fewer employees because of the challenges that small businesses have in developing health promotion programs. These challenges include not having a human resources department that can coordinate development of a program, not having the volume purchasing power to negotiate discount pricing, and not being able to capture any of the medical cost savings that occur when medical use is reduced as a result of improved health because they are not self-insured. The original legislation did not address the first two of these limitations, and the CDC was astute in the way they structured this opportunity to provide a national support network to be created by Viridian. However, I am puzzled why they decided to allow medium and large employers to be included in the network. Medium and large employers do not suffer from the limitations of small employers. Second, the task presented to Viridian, a small health promotion provider based in Phoenix, Arizona, to recruit 70 to 100 employers in seven regions of the country and to help them develop comprehensive health promotion programs in 2 years is formidable. I wonder if it would have made more sense to engage a large health promotion provider with staff based in multiple areas of the nation, a trade association that has existing contacts with many businesses, or a group like WELCOA (formerly known as Wellness Councils of America) or the National Network of Wellness Councils that has already created a national network of small employers to help them develop health promotion programs. Another approach would be to work with a local business council that could have focused on a more limited geographic area. Alternatively, it might have been possible to combine this with the CTGs described earlier and allow the grantee to use these funds to support local businesses. Ideally, it would make sense to test the relative success of several of these outreach approaches on a pilot basis and then focus future efforts on the most successful approach. I do want to acknowledge the difficult situation presented to the CDC in developing this program. Through the special efforts of several members of Congress, the CDC received an unexpected $10 million from the Prevention Fund for this program in early 2011. In a period of a few months, they had to hire staff to coordinate this effort, develop an approach to address the limitations of small business, create a mechanism to award grants, and actually disburse the grants before the $10 million evaporated at the September 30, 2011, end of the fiscal year. They had to do this in a low profile way so that deficit hawks would not see this as another cash rich program and try to cut it.

Conclusions and Continued Funding

These three programs represent the federal government's first major forays into stimulating health promotion efforts in diverse segments of the nation through grant programs. Despite the limitations cited above, these programs will have a positive impact of infusing cash into the health promotion field and enhancing the health of the populations they reach. Given the plans to evaluate the programs in a structured way, we are also likely to learn much about what works best in multiple settings. However, the lasting impact of these programs on the nation as a whole will depend on the extent to which they change the way we engage Medicaid recipients in health promotion programs, build our communities to make the healthy choice the easiest choice, and provide comprehensive health promotion programs to employees in all small business settings. Making progress in all of these areas will require more than one round of grant funding. In a normal budget environment, programs like these would be given time to be refined. In today's environment of budget deficits and partisan efforts to repeal the Affordable Care Act, the future of these programs is less certain. So what are the fiscal futures of these programs? My best guesses are below.

Medicaid Wellness. The first-year funding for this program has already been distributed. My best guess is that the 5-year funding for these programs is safe. The federal Medicaid program has significant internal control over its funds, and the potential cost savings to state and federal Medicaid programs are very obvious.

Community Transformation Grants. The first-year funding for this program has already been distributed. My best guess is that the 5-year funding for the 35 communities that received implementation grants is safe, but the future opportunity for the 26 additional communities that received capacity-building grants to apply for implementation grant funding may be at risk. Funding the 35 communities for the full 5 years would cost $377,411,250. Adding the $6,936,052 cost of the 1-year funding of the 26 capacity-building grants and the $60 million cost of the evaluation brings the total cost of this program to $444,347,302, about half of the $900 million originally announced for this program. Funding for this program comes from the Prevention Fund, which has authorized and appropriated funding of $15 billion for fiscal years 2010 to 2019, with $750 million in 2011 and the annual amount increasing until it reaches $2 billion in 2015.

This funding is currently intact but is under attack from several sources. President Obama offered to reduce the Fund by $3.5 billion in October,[13] as part of the deficit reduction discussions, and the Democrat members of the Super Committee were rumored to be offering to cut $8 billion from the Fund in early November.[14] Ironically, the failure of the Super Committee to come up with additional deficit cuts may provide some protection to the Fund and limit its cuts to the 7.8% required in all nondefense discretionary funding through the "sequestration" process.[15]

Small Business Wellness Grants. The CDC announcement of this program did not mention any extended funding, and the funding for the program as described has already been distributed; therefore, the existing program should be safe from any budget cuts. Furthermore, the Senate Labor, Health and Human Services, Education, and Related

Agencies Appropriations Committee, requested funding for an additional $10 million in 2012 on September 21, 2011,[16] with funding coming from the Prevention Fund. This is a positive sign, but given the funding cuts expected from the Prevention Fund, reaching the $200 million level suggested in the Affordable Care Act for the 2011 to 2015 period will be very challenging.

Funding for All Health Promotion Programs. Future federal funding for most, if not all, health promotion programs is likely to come from the Prevention Fund. Therefore, the best way to ensure funding for health promotion efforts is to advocate that Congress preserve the Prevention Fund and maintain the balance specified in the Affordable Care Act. The best way to advocate for individual health promotion programs, like the CTGs or the small business wellness grants is probably to build support for them within the broader public health community. If the public health community is able to speak with one voice on this issue, we are more likely to secure Congressional support.

Of course, the Prevention Fund and all of these federal health promotion programs would evaporate if the Affordable Care Act were repealed. A full review of the prospects of repeal would require at least one more editorial, but my best guess is that it will not be repealed. My abbreviated reasoning is below.

The first challenge to the Affordable Care Act will be surviving a ruling by the Supreme Court on whether or not the act violates the constitution.[17] The Supreme Court agreed to hear this case on November 14, 2011. Oral arguments are expected to be presented in March of 2012, and a ruling is expected in late June of 2012. My guess is that it will be ruled constitutional. My guess is based on the fact that three appellate courts staffed by conservative judges who were appointed by Republican presidents have already upheld its constitutionality.

The second challenge will be overcoming attempts by Congress to repeal it, with the 2012 Presidential, House, and Senate elections playing a crucial role. Most Republicans, including all of the candidates running for president, want to repeal the act. Most Democrats want to preserve it. To overturn the act, three things must happen: (1) The president must sign the repeal bill or a two-thirds majority of the House of Representatives and the Senate must vote to repeal it to overturn a presidential veto. Any Republican president would sign the repeal bill. President Obama would veto it. (2) A repeal bill must pass the House of Representatives. My guess is that the majority status of the House of Representatives will follow the presidency (i.e., if President Obama is reelected president, the Democrats will retake the majority in the House). If any Republican wins the presidency, the Republicans will retain the majority. A Republican majority will repeal the act. The Republicans would need only a simple majority if a Republican wins the presidency and a two-thirds majority if President Obama wins. A Democrat majority will not repeal the act. (3) A repeal bill must pass the Senate, probably with a 60% majority to overcome a filibuster. The Democrats are likely to lose majority control of the Senate to the Republicans, regardless of the outcome of the presidential elections, because 23 of the 33 Senate seats up for reelection in 2012 are held by Democrats. That means the Democrats need to win 20 of 33 Senate elections to hold the majority with 50 seats if Obama is reelected (the Senate majority goes to the party of the President if 50 seats are held by each party) and 21 of 33 elections to hold the majority if a Republican president is elected. The Republicans need to win only 13 or 14 of 33 elections seats to take a simple 50- or 51-seat majority, and it is likely that they will win that many seats. However, Republicans would need to win 23 of 33 seats to win the 60-seat majority that could overcome the filibuster of a Democrat minority and 29 of 33 seats to win the 66% majority required to overcome a Presidential veto—and neither of those is likely to happen. The other option open to the Republicans, or whomever controls the Senate, is to change the rules of the Senate to eliminate the ability of the minorty to filibuster. That rule change can be made on the first day of the Senate. The Democrats decided not to make that change for the current Congress, but I would NOT be surprised to see the Republicans make that change, especially if a Republican is elected President. If the President is a Republican, and the Republicans change the Senate rules, the Affordable Care Act WILL probably be repealed.

Ironically, the factor providing the Affordable Care Act the greatest protection may be the February 11, 2011 judgment of the non-partisan Congressional Budget Office that repealing the Act would increase the federal debt by $210 billion over the next 10 years[18] and Rules in the House of Representatives that require increases in the federal debt to be offset by other spending cuts.[19] Given the recent failure of the Super Committee to find $1.2 trillion in savings over 10 years to prevent forced cuts to the military and domestics discretionary programs, finding these additional savings is not likely.

All of this brings to light the fact that restoring the health of our population requires all health promotion professionals to become very involved in the political process. It is truly bizarre that we must fight elected officials to be successful in achieving this goal, but we need to push that to the background and focus on what will motivate members of Congress to support these efforts going forward. With that in mind we should focus on two key themes: (1) Health promotion programs improve the health and quality of life for the people they engage. (2) Improving people's health through lifestyle is probably the only way to allow employers (including the federal government) to add jobs and remain financially sustainable, and to prevent Medicaid and Medicare from bankrupting state and federal governments.[20]

Michael P. O'Donnell, MBA, MPH, PhD
Editor in Chief
American Journal of Health Promotion

References

1. Partnership for Solutions, Chronic conditions: making the case for ongoing care. September 2004 update. Available at: http://www.rwjf.org/files/research/Chronic%20Conditions%20Chartbook%209-2004.ppt. Accessed November 4, 2011.
2. Congressional Budget Office, Congress of the United States. CBO's 2011 long-term budget outlook, pages 38–39. Available at: http://www.cbo.gov/ftpdocs/122xx/doc12212/06-21-Long-Term_Budget_Outlook.pdf. Accessed November 4, 2011.
3. National Association of State Budget Officers, State expenditure report fiscal year 2009. Available at: http://nasbo.org/LinkClick.aspx?fileticket=w7RqO74llEw%3d&tabid=79. Accessed November 4, 2011.
4. Ohio Department of Insurance Communications. Press release—June 24, 2011. Guest column: president's healthcare plan is bad for Ohio and our state insurance market. Available at: http://www.insurance.ohio.gov/Newsroom/Pages/06242011HealthcarePlan.aspx. Accessed November 2, 2011.
5. Grants.gov. Public prevention health fund: community transformation grant: Available at: http://www.grants.gov/search/search.do?mode=VIEW&oppId=93873. Accessed November 4, 2011.
6. HealthCare.gov. The Community Transformation Grants Program. Available at: http://www.healthcare.gov/news/factsheets/2011/09/community09272011a.html. Accessed November 21, 2011.
7. County of Los Angeles, Chief Executive Office. 2011–2012 budget. Available at: http://ceo.lacounty.gov/budget11-12.htm. Accessed November 4, 2011.
8. Cox J. Duval County health-care grant application stirs unexpected controversy. Mayport Mirror. Available at: http://mayportmirror.jacksonville.com/news/florida/2011-07-01/story/duval-county-health-care-grant-application-stirs-unexpected. Published July 1, 2011. Accessed November 4, 2011.
9. RTI International to evaluate program designed to transform community health, RTI International. Available at: http://www.rti.org/newsroom/news.cfm?nav=713&objectid=6B77690E-5056-B100-31FB3C347E25BEFD. Published November 8, 2011. Accessed November 4, 2011.
10. Comprehensive health programs to address physical activity, nutrition, and tobacco use in the workplace, FedBizOpps.gov. Available at: https://www.fbo.gov/index?s=opportunity&mode=form&id=c1189e59011374608aa0eb7c6087c71d&tab=core&_cview=1. Accessed November 4, 2011.
11. Comprehensive workplace health programs to address physical activity, nutrition, and tobacco use in the workplace. Centers for Disease Control and Prevention. Available at: http://www.cdc.gov/workplacehealthpromotion/nhwp/index.html. Accessed November 4, 2011.
12. O'Donnell MP. Federal grants to small employers for comprehensive wellness programs: passed as part of health care reform. *Am J Health Promot.* 2010;25:iv–v.
13. Serafini MW, Carey MA. Health programs risk sharp cuts if Super Committee deadlocks. National Journal. Published October 17, 2011. Available at: http://www.nationaljournal.com/healthcare/health-programs-risk-sharp-cuts-if-super-committee-deadlocks-20111017. Accessed November 4, 2011.
14. Hamburg R. November 10, 2011 wellness and prevention. Health Reform Digest, Trust for America's Health.
15. Serafini MW, Carey MA. Health programs facing cutbacks after super committee's failure. *Kaiser Health News.* November 21, 2010. Available at: http://www.kaiserhealthnews.org/Stories/2011/October/16/Health-Programs-Face-Sharp-Automatic-Cuts-If-Super-Committee-Deadlocks.aspx. Accessed November 29, 2011.
16. Prevention and Public Health Fund detailed activities by agency. Trust for America's Health. Available at: http://healthyamericans.org/health-issues/wp-content/uploads/2011/09/Prevention-and-Public-Health-Fund-Chart-FY2010-12.pdf. Accessed November 4, 2011.
17. Slack M. The White House Blog. Supreme Court announces it will hear challenges to the Affordable Care Act. Published November 14, 2011. Available at: http://www.whitehouse.gov/blog/2011/11/14/supreme-court-announces-it-will-hear-challenges-affordable-care-act. Accessed November 14, 2011.
18. Letter to Congressman John Boehner from Douglas W. Elmendorf, Director of the Congressional Budget Office, February 18, 2011. Available at: http://www.cbo.gov/ftpdocs/120xx/doc12069/hr2.pdf. Accessed November 29, 2011.
19. H. RES. 5 Adopting Rules for the One Hundred Twelfth Congress. January 5, 2011. Available at: http://rules.house.gov/Media/file/PDF_112_1/112th-Rules_xml.pdf. Accessed November 29, 2011.
20. O'Donnell MP. Can We Reduce Our Federal Deficit and Create Jobs by Making the Healthy Choice the Easiest Choice? *Am J Health Promot.* 2011;26(2):iv–xii. Available at: http://ajhpcontents.org/doi/full/10.4278/ajhp.26.2.iv. Accessed November 30, 2011.

AMERICAN JOURNAL *of*

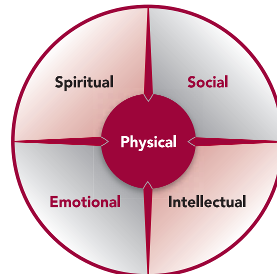
Health Promotion

The Wisdom of Practice and the Rigor of Research

Definition of Health Promotion

"Health Promotion is the art and science of helping people discover the synergies between their core passions and optimal health, enhancing their motivation to strive for optimal health, and supporting them in changing their lifestyle to move toward a state of optimal health. Optimal health is a dynamic balance of physical, emotional, social, spiritual, and intellectual health. Lifestyle change can be facilitated through a combination of learning experiences that enhance awareness, increase motivation, and build skills and, most important, through the creation of opportunities that open access to environments that make positive health practices the easiest choice."

(O'Donnell, *American Journal of Health Promotion,* 2009, 24,1,iv)



DIMENSIONS OF OPTIMAL HEALTH

Online subscriptions now available

ERICAN JOURNAL *of*
Health Promotion

Volume 25, Number 4
March/April 2011

THE SCIENCE OF HEALTH PROMOTION
REFLECTIONS ON THE 25TH ANNIVERSARY OF PUBLISHING THE AMERICAN JOURNAL OF HEALTH PROMOTION
Michael P. O'Donnell — iv — Editor's Notes: Reflections on the 25th Anniversary of Publishing the *American Journal of Health Promotion*: People, Scientific Progress, and Missteps
Judd Allen, David R. Anderson, Bill Baun, Steven N. Blair, Larry S. Chapman, Allan Best, Michael Eriksen, Jonathan Fielding, Gil Omenn, Dean Ornish, Kenneth R. Pelletier — ei — Reflections on Developments in Health Promotion in the Past Quarter Century From Founding Members of the *American Journal of Health Promotion* Editorial Board
Barry A. Franklin — eix — Systems Thinking and Health Promotion
Ron Z. Goetzel — exi — Health Implications of Low Cardiorespiratory Fitness, Too Little Exercise, and Too Much Sitting Time: Changing Paradigms and Perceptions
Lawrence W. Green — exvi — Reflections on 25 Years of Health Promotion—Where Have We Been and Where Are We Going?
Melissa Grim, Brian Hortz, Rick Petosa — exix — What Has Changed Most Dramatically Since the Inauguration of the *American Journal of Health Promotion*?
Ellinor K. Olander, Frank F. Eves — 227 — Impact Evaluation of a Pilot Web-Based Intervention to Increase Physical Activity
Mariane M. Fahlman, Nancy McNevin, Debra Boardley, Amy Morgan, Robert Topp — 231 — Effectiveness and Cost of Two Stair-Climbing Interventions—Less Is More
Sheree M. Schrager, Carolyn F. Wong, George Weiss, Michele D. Kipke — 237 — Effects of Resistance Training on Functional Ability in Elderly Individuals
Laura Rosen, David Zucker, David Brody, Dan Engelhard, Marina Meir, Orly Manor — 244 — Human Immunodeficiency Virus Testing and Risk Behaviors Among Men Who Have Sex With Men in Los Angeles County
Christine E. Cronk, Raymond G. Hoffman, Mary J. Mueller, Virginia Zerpa-Uriona, Mahua Dasgupta, Francisco Enriquez — 248 — Enabling Hygienic Behavior Among Preschoolers: Improving Environmental Conditions Through a Multifaceted Intervention
Ana D. Goode, Elisabeth A. H. Winkler, Sheleigh P. Lawler, Marina M. Reeves, Neville Owen, Elizabeth G. Eakin — el — Effects of a Culturally Tailored Intervention on Changes in Body Mass Index and Health-Related Quality of Life of Latino Children and Their Parents
Lee-Ann M. Wilson, Billie Giles-Corti, Nicola W. Burton, Katrina Giskes, Michele Haynes, Gavin Turrell — 257 — A Telephone-Delivered Physical Activity and Dietary Intervention for Type 2 Diabetes and Hypertension: Does Intervention Dose Influence Outcomes?
Noe C. Crespo, James F. Sallis, Terry L. Conway, Brian E. Saelens, Lawrence D. Frank — e12 — The Association Between Objectively Measured Neighborhood Features and Walking in Middle-Aged Adults
Laura C. Williams, Brian T. Day — 264 — Worksite Physical Activity Policies and Environments in Relation to Employee Physical Activity
272 — Medical Cost Savings for Web-Based Wellness Program Participants From Employers Engaged in Health Promotion Activities
281 — DataBase: Research and Evaluation Results
287 — Abstracts
The Art of Health Promotion
Mark Nordtvedt, Larry S. Chapman — TAHP-1 — Health Promotion in Faith-Based Institutions and Communities

"The *American Journal of Health Promotion* provides a forum for that rare commodity — ***practical and intellectual exchange between researchers and practitioners***."

Kenneth E. Warner, PhD
Dean and Avedis Donabedian Distinguished University Professor of Public Health
School of Public Health, University of Michigan

"The contents of the *American Journal of Health Promotion* are timely, relevant, and most important, ***written and reviewed by the most respected researchers in our field***."

David R. Anderson, PhD, LP
Senior Vice President & Chief Health Officer, StayWell Health Management

Subscribe today...

ANNUAL SUBSCRIPTION RATES: (Effective 1-1-12 through 12-31-12)

	INDIVIDUAL	INSTITUTION			
	Print + Online	Print Only*	Tier 1 Print + Online	Tier 2 Print + Online	Tier 3 Print + Online
U.S.	$139	$184	$359	$459	$559
Canada and Mexico	$148	$193	$368	$468	$568
Other Countries	$157	$202	$377	$477	$577

Call 800-783-9913 (U.S. only) or 731-645-4496

*Print-only subscriptions are based on location. For multi-site institutions, each site must have its own subscription.

Tier 1 — Most Employers and Corporations except Health Organizations, Libraries and Schools

Tier 2 — Health Organizations including Hospitals, Clinics, Health Promotion Providers, Insurance Companies and Voluntary Health Agencies

Tier 3 — Libraries, Colleges and Universities

Check out our new online format:

http://www.HealthPromotionJournal.com/online.htm

Editor in Chief
Michael P. O'Donnell, PhD, MBA, MPH

Associate Editors in Chief
Margaret Schneider, PhD
Jennie Jacobs Kronenfeld, PhD
Shirley A. Musich, PhD
Kerry J. Redican, MPH, PhD, CHES

SECTION EDITORS

Interventions

Fitness
Barry A. Franklin, PhD
Medical Self-Care
Lucy N. Marion, PhD, RN
Nutrition
Karen Glanz, PhD, MPH
Smoking Control
Michael P. Eriksen, ScD
Weight Control
Kelly D. Brownell, PhD
Stress Management
Cary Cooper, CBE
Mind-Body Health
Kenneth R. Pelletier, PhD, MD (hc)
Social Health
Kenneth R. McLeroy, PhD
Spiritual Health
Larry S. Chapman, MPH

Strategies

Behavior Change
James F. Prochaska, PhD
Culture Change
Daniel Stokols, PhD
Population Health
David R. Anderson, PhD, LP

Applications

Underserved Populations
Antronette K. (Toni) Yancey, MD, MPH
Health Promoting Community Design
Bradley J. Cardinal, PhD
The Art of Health Promotion
Larry S. Chapman, MPH

Research

Database
Leslie Spenser, PhD
Financial Analysis
Ron Z. Goetzel, PhD
Measurement Issues
Shawna L. Mercer, MSc, PhD