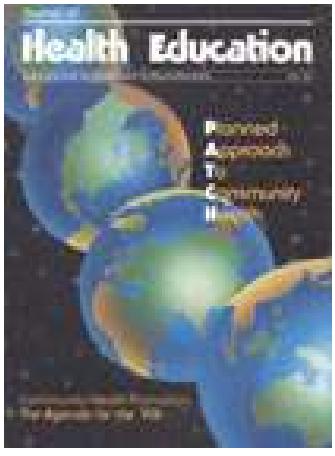

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PATCH: Its Origin, Basic Concepts, and Links to Contemporary Public Health Policy

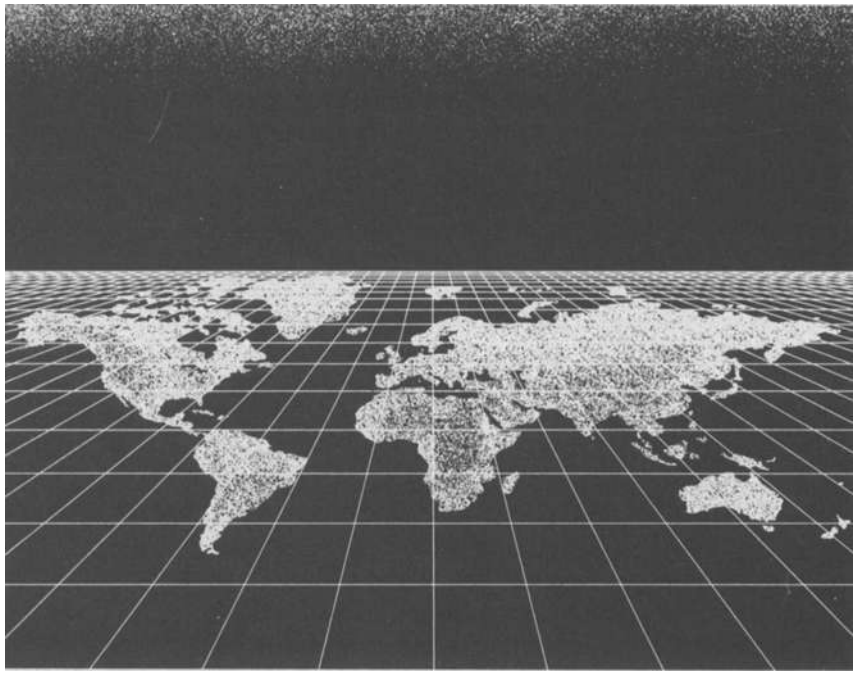
Marshall W. Kreuter

PATCH, the acronym for Planned Approach to Community Health, is a cooperative program of technical assistance managed and supported by the Centers for Disease Control (CDC). PATCH is designed to strengthen state and local health departments' capacities to plan, implement, and evaluate community-based health promotion activities targeted toward priority health problems.

The PATCH concept emerged in 1983 primarily as a CDC response to the shift in federal policy regarding categorical grants to states. One of those categorical grant programs was the Health Education-Risk Reduction (HERR) Grants Program.

In 1979, the HERR program was created under the authority of Public Law 94-317, The Health Information and Health Promotion Act of 1976. Through this program, a modest amount of resources helped local, state, and federal health agencies take an organized, planned approach to community-based interventions. Agencies were urged to make maximum use of existing resources and to monitor and evaluate progress.

This unprecedented federal effort was designed to provide five years of economic support for state health agencies to establish (1) a focal point for health education (staff and organizational infrastructure) to carry out and manage state-level risk reduction programs, and (2) a program of local grants program, managed by the state health education focal point, to support tobacco and alcohol abuse prevention and education programs for youth (HERR funds required applicants to demonstrate that their programs placed primary emphasis on tobacco and alcohol abuse among youth. Also, some portion of program activity had to be directed toward minority populations).



The local intervention grants required grantees to submit proposals that:

* documented state or territorial and local health needs;
* revealed detailed plans for the inclusion or development of a health promotion, disease prevention network;
* included evidence of either the existence or development of a statewide mechanism to provide and maintain a data base for monitoring prevalence of selected risk factors;
* demonstrated that the proposed intervention was part of an "organized approach" within the target community.
* secured program evaluation assistance from appropriate university programs.

At the midpoint in the five-year HERR program, federal policy shifted. The economic philosophy of President Reagan's administration held that states should assume greater responsibility for the manner in which federal resources were to be spent. The Administration accordingly determined that categorical grants to states, managed by federal agencies, should be combined into more generic "blocks" under the management control of the states. As a result, the HERR grants program was consolidated into the "Prevention Block" with seven other categorical grant pro-

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grams: emergency medical services, health incentive grants, hypertension control, rodent control, community and school-based fluoridation, home health services, and rape prevention and services (Brandt, 1981).

For the first year of the new block grants, the formula for determining the level of money available for the entire block was the sum of the previous year's allocation for each of the programs within the block, less 25 percent.

Even though the block grant approach evoked the principle of local control and reduced the federal prevention expenditure, the blow it dealt to the HERR program was especially severe. The key concept in the HERR program was to strengthen the health education capacity at the state and local levels. The federal policy decision to create block grants immediately eliminated the CDC support function, and shifted the management function of the program from the federal level to the state. In most instances, this shift occurred before the state focal point was fully in place, thus weakening the attempt to strengthen the federal, state, and local level health education infrastructure.

So, halfway through the HERR program, health education units in each state and territory had to compete for resources from a pool that already had been reduced by 25 percent. In the aftermath of the block grant policy, a few HERR programs continued to prosper, most continued amid severe economic cuts, and a few were discontinued (Kreuter, Christensen, & DiVincenzo, 1982).

Despite these difficulties, experiences from the first two years of the HERR program convinced staff in CDC's Center for Health Promotion and Education that the capacity-building and community intervention principles of the HERR program should remain a priority in their overall prevention mission. As a result, two key components of the HERR program became institutionalized at CDC: (1) the monitoring and assessment dimension of the program was formally developed into what is known now as the Behavioral Risk Factor Surveillance System (BRFSS), and (2) PATCH.

Basic Concept: Diffuse Effective Strategies

From its inception, the primary goal of PATCH to create a practical mechanism through which effective community health education action could be targeted to address local-level health priorities. A secondary goal was to offer a practical, skills-based program of technical assistance wherein health education leaders in state health agencies would work with their local level counterparts to establish community health education programs. (Kreuter, 1984; Nelson, Kreuter, Watkins, & Stoddard, 1987).

During the formative stages of PATCH, knowledge of what constituted effective community-based health education interventions was by no means complete and, of course, remains in a continuous state of development. However, as investigators directing community-based cardiovascular disease intervention programs began to describe results of their work in the literature, it became evident that there was a consistent pattern across successful interventions (Farquhar, Fortmann, Wood, & Haskell, 1983; Carlaw, R.W., Mittlemark, M., Bracht, N., & Lupker, R. (1984); Puska, P., Nissinen, J., Tuomilehto, J., & Salonen, T., 1985). Those interventions included:

* a strong core of representative local support and participation in the process;
* the collection and analysis of local data and health issues;
* setting objectives and standards to denote progress and success;
* the design and implementation of multiple intervention strategies to meet objectives including strategic application of behavioral sciences, community mobilization, health education, and mass media;
* continuous monitoring of problems and intervention strategies to evaluate progress and detect the need for change;
* securing support of a public health infrastructure (system) either nationally, within the target community, or both.

While providing clear details on research methods and initial results, the literature reporting the findings from community intervention studies provided only superficial descriptions of the intervention's methods and strategies. State and local level health education specialists encouraged their CDC counterparts to develop a means by which details of intervention innovations could be shared with them.

These community intervention elements described above, organized within the context of the PRECEDE model (Green, Kreuter, Deeds, & Partridge, 1980; Green, & Kreuter, 1991), became essential components of the PATCH program.

Basic Concept: Local Ownership

The most effective center of gravity for health promotion is the community. Governments can and should exercise their responsibilities for formulating policies, providing leadership, and allocating funding in support of prevention programs. Individuals can govern their own behaviors and control the determinants of their own health up to a point, but the decisions for social change affecting the more complicated lifestyle issues can be made best collectively, as close as possible to the homes and workplaces of those affected. Relevant and appropriate programs are more likely to result in such a context, since those for whom the program is intended will be engaged in all phases of the program. Accordingly, PATCH has been influenced greatly by the literature on community organization and community development (Minkler, 1980; Green, 1986; Bracht, & Tsouros, 1990) and the *Model Standards: A Guide for Community Preventive Services* (1985).

The principle of community participation also embodies the often used, but rarely defined, concept of empowerment. Cuoto (1990) describes empowerment as a process wherein information, skills and resources are transferred to "improve the decision making power of individuals and groups... empowerment begins with the realization that a condition, problem, or

need is not theirs only, but that of others as well" (pp. 145-146).

Ironically, the element of the PATCH process that usually is identified as the most demanding for all parties turns out to be the primary source of local empowerment: gathering and analysis of local area data to facilitate program planning and evaluation. On average, communities spend about a year collecting and analyzing data. This energy appears to be well spent, however. With information to document the magnitude and extent of their health problems and to set measurable health priorities for health promotion and disease prevention, communities have additional leverage to strengthen their requests for resources.

In 1987, 25 PATCH projects were underway in 12 states. A survey of those 25 projects revealed that a total of $564,000 had been secured by localities for program support beyond the resources invested in PATCH by CDC or the states. For every dollar invested in PATCH in 1987, the community generated an additional $9 for program implementation (J. Belloni and C.F. Nelson, personal communication).

Basic Concept: Vertical and Horizontal Networks

Although PATCH is applied at the local level, the total process is designed to operate within an interdependent system that connects local, state, and federal public health agencies. This process addresses a priority concern voiced by public health leaders: the need to strengthen the infrastructure and system of public health (National Academy of Sciences, 1988; Roper, 1990). The arrangement also makes PATCH unique among other community intervention efforts.

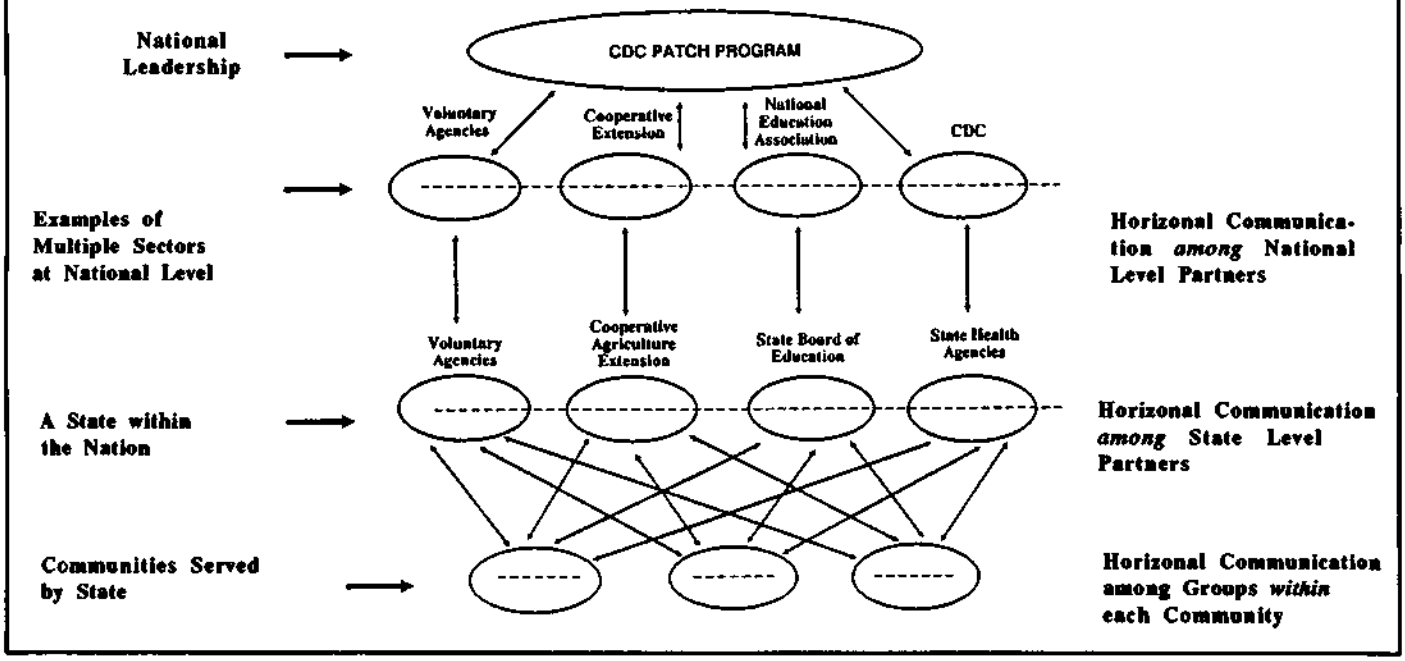
As has been mentioned previously, PATCH was envisioned as a means to strengthen existing communication channels among state health agencies, their local counterparts, and CDC. These agencies, which share a common mission, constitute the vertical chain of public health. The effectiveness of PATCH largely depends on the chain's functional capacity.

The PATCH program also requires horizontal collaboration and partnerships at each of the three vertical levels. For example, at the national level, CDC has gained support for PATCH by engaging cooperative efforts of national voluntary agencies, foundations, other agencies within the Public Health Service, and other federal agencies, including the Department of Transportation and the Cooperative Extension Service of the Department of Agriculture (Figure 1).

Similarly, state health agencies have leveraged support of public, private, and voluntary sector organizations to support PATCH. In the spirit of community participation, PATCH programs at the local level are required to bring together representatives of the community not only to maximize the probability that existing health-related resources will be put to use, but also to ensure that the interests, wants, and needs of the community are fairly represented throughout the process.

Positioning PATCH within the context of a functional vertical and horizontal system builds in the opportunity to provide technical assistance and training, so essential for effective execution of complicated community intervention programs. As a part of an established infrastructure, this support can be sustained over time and thus provide continuity throughout the system.

Figure 1. PATCH: Mobilizing Vertical and Horizonal Communication and Support Among the National, Regional, and Community Levels



Although PATCH operates within the existing system of official public health agencies, its intention has been and continues to be the nurturing of prevention leadership wherever it might be found at any of the three levels. For a variety of reasons - political, economic, or financial - the local health agency may not always be the most appropriate and/or effective focal point for PATCH; primary care clinics, university groups, businesses, and other nongovernmental organizations may be in a better position to exercise leadership for a PATCH program. However, at a minimum, the local health agency should be engaged actively in the process; it should serve as facilitator to nurture and support the effort and as the key communication link both to sectors at the local level and to the state health agency and CDC.

PATCH and Contemporary Health Promotion/Disease Prevention Policy

PATCH citizens provide a democratic mechanism to become either equal or senior partners in determining the quality of life and health in their communities. This approach is consistent with contemporary public health policy. Healthy People 2000: National Health Promotion and Disease Prevention Objectives is a comprehensive report that outlines the national strategy for improving the nation's health in the decade from 1990 to 2000. The report calls upon communities to translate national objectives into state and local action. To facilitate that translation, Healthy Communities 2000: Model Standards provides a flexible planning tool to enable communities to share in various efforts necessary to attain these objectives; specifically, the document offers community implementation strategies for putting the objectives of Healthy People 2000 into practice (Health Communities 2000: Model Standards, 1991).

In discussing his vision for implementing these national health objectives, James O. Mason, M.D., Assistant Secretary for Health, U.S. Department of Health and Human Services, citing the importance of state and local participation, specifically calls attention to the role PATCH can play as a critical part of the nation's overall prevention strategy (Mason, 1990): "States and communities must make their own decisions, based on assessments of health needs and resources at their own levels. Using the national objectives as a template, they can select priorities, objectives, and implementation plans to guide their efforts. CDC's Planned Approach to Community Health (PATCH) program can be used to define and refine those priorities into community action and public health activities." (p.28)

Comment: The Future of PATCH

One of the lessons learned from implementing PATCH reinforces the "assessment" recommendations in the Institute of Medicine's *Future of Public Health* (1988), and has important implications for health policy makers: none of the communities participating in the program had any system or capacity to collect data routinely that is adequate for planning and evaluating health promotion programs. As a result, considerable time and effort go into gathering those data.

Because of limited resources for the overall PATCH effort, data collection is often carried out by persons who have little or no experience and only marginal interest in the process; further, resources spent on data collection cannot be used to implement the program. Communities need systems that can routinely and efficiently gather relevant data their prevention status. Such systems would not only facilitate but also would help to establish standard data bases, thus enabling collection of comparable small-area data across divergent populations.

Although PATCH continues to have broad intellectual support, its future will be dependent upon allocation of economic resources sufficient to support the management, developmental, and technical assistance aspects of the program. Economic support necessary to stimulate expansion has been problematic, largely because government funding tends to target categorical problems, such as HIV/AIDS, heart disease, unintentional and intentional injuries, and women's cancers. Within these and other problem categories, one can find varying levels of support for basic research, applied research and demonstration projects, and program implementation and diffusion.

With a focus on transfer of community intervention technology through states to localities, community PATCH applications do not start with an *a priori* health problem; they begin with community members trying to understand what their particular health problems are. Economic support is problematic in the absence of a discernable problem up front.

In some cases, PATCH planning leads to a priority problem for which resources are available; in others, where the indicated problem is not a priority of the government, the community may have to choose between shifting focus to a health issue for which there are available resources, or go without. This has been a long standing problem with PATCH - indeed, all community-based health promotion programs that require extensive technical assistance face this dilemma.

If public health commitment to strengthening community competence is to go beyond words, public health leaders must work with elected officials at all levels to find a mechanism that will allocate health promotion resources equitably without compromising the need to respond to categorical priorities.

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