

SEPHLI Year 11 Leadership Project  
Final Report



Coordinating Public Policy Efforts for  
the Chronic Disease and Injury Section  
of the NC Division of Public Health

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## **Coordinating Public Policy Efforts for the Chronic Disease and Injury Section of the NC Division of Public Health**

### **Abstract**

The purpose of this project is to coordinate policy efforts for the North Carolina Chronic Disease and Injury Section (CDI). Policy and environmental change are recognized in public health as major catalysts in the promotion of behavior modification. Increasing emphasis has been placed on pursuing evidence based policy efforts by the Centers for Disease Control and Prevention (CDC), the National Institutes of Health (NIH), and other public health funding organizations. Chronic disease and injury public health programs in North Carolina would greatly benefit from a more organized, coordinated policy infrastructure to help programs become more effective and efficient in reaching their health outcome goals.

CDI recently published a Program Integration Blueprint that guides efforts for public health programs to be better coordinated across disease specific categories. Using the Blueprint's new framework, this project will inventory existing public health policy efforts across the Section, create a community of practice focused on policy for participants to share policy knowledge and opportunities, and create a unified policy platform for the Section. Recommendations will be made for future policy efforts for the CDI Section and the North Carolina Division of Public Health as a whole.

### **Introduction / Background**

Chronic diseases and injuries are responsible for approximately two-thirds of all deaths in North Carolina, or about 50,000 deaths each year<sup>1</sup>. Cancer, heart disease, stroke, chronic lung disease and unintentional injuries make up the top five causes of death in the state. Many of the deaths are considered preventable and involve risky behaviors or lifestyles. Among the leading causes of preventable death are tobacco use, unhealthy diet/physical inactivity, alcohol and drug abuse, and motor vehicle crashes<sup>2</sup>.

The enormity of the burden of chronic disease and injury mortality and morbidity in the state cannot be addressed through individual behavior change alone. Policy and environmental change at the community level are needed to support North Carolinians to make healthy choices. Often the control of needed change falls outside of the domain of public health. For example, transportation may be the appropriate purview regarding the construction of new sidewalks, or school districts may be the best avenue to pursue advocating for improved diabetes training for school nurses. Coordination of public health advocacy efforts between state government and partners inside and outside of the health sector is needed for successful policy change.

The North Carolina Chronic Disease and Injury Section is made up of eight chronic disease and health promotion programs and branches:

- Comprehensive cancer control,
- Breast and cervical cancer control,
- Asthma prevention and control,

- Heart disease and stroke prevention and control,
- Diabetes prevention and control,
- Injury and violence prevention and control,
- Physical activity and nutrition, and
- Tobacco prevention and control.

The Section also includes the Office of Healthy Carolinians, a statewide community-based health promotion initiative, and the State Center for Health Statistics, the North Carolina's resource for health-related data collection, research, production of reports, and collection of health statistics. The rich diversity of the focus of the Section's programs and branches offer a breadth of experience and approaches to public health (Appendix I).

Many of the branches in the CDI Section are sophisticated in their understanding of policy and environmental change due to well-developed training programs and encouragement from federal funders, such as the Centers for Disease Control and Prevention (CDC) and the National Institutes of Health (NIH). While some section entities include policy and environmental change as a central part of their programmatic efforts, other section programs are not as advanced in their skills of developing or implementing a policy agenda.

The CDC study *Policy and Environmental Change: New Directions for Public Health*, performed in 2001 and updated by the Directors of Health Promotion and Education in 2006, analyzed the critical success factors and unique issues and barriers facing health departments in effectively affecting policy change at the state level. More than fifty percent of the states polled in the study cited that critical success factors for policy change included collaboration, community support, supportive decision makers, and a strong data/science base<sup>3</sup>. The update of the study found that, while the value of policy and environmental change is accepted and growing in the field, more training in the skill set is necessary across chronic disease programs<sup>4</sup>.

North Carolina has been a leader and innovator in chronic disease programming for decades. The state has achieved the highest level of categorical funding from CDC for all of its chronic disease programs and has close ties to National Association of Chronic Disease Directors (NACDD) through regular staff participation in national conferences and trainings and the state Chronic Disease Director serving as the President of the NACDD Board of Directors. The Section has a history of sharing and disseminating its successful models with the help of CDC, NACDD, and other national partners.

In 2005, the CDI Section started to pursue program integration as a strategy to improve effectiveness and efficiency within the Section. Institutional history, federal and state funding patterns, and differences in approaches to specific disease programs led to the ten entities of the Section often acting in isolation from one another. North Carolina followed the advice of national leaders in public health who encouraged states to attempt to integrate the work of their chronic disease programs across traditional boundaries to more efficiently use staff, funds, and surveillance and intervention efforts<sup>5</sup>.

In order to pursue program integration in a deliberate and organized fashion the section focused on the development and implementation of a formal plan, the North Carolina Integration

Blueprint. The Blueprint serves as a tool to establish priorities for the section, maximize resources, enhance credibility, avoid duplication and ultimately impact health outcomes. The overarching goal for the North Carolina Chronic Disease and Injury Integration Blueprint is to create a new organizational culture, where collaboration and integration are defined as a normative priority process and expectation. North Carolina has established three key goals for the Blueprint and program integration:

1. Develop infrastructure and build best management practices to support integration efforts.
2. Prioritize and implement integrated programs and processes using evidence-based science and best practice models.
3. Continuously evaluate integration outputs and health outcomes.

The priority areas of policy, epidemiology and surveillance, healthcare systems, and community based health promotion were identified as the first areas to pilot program integration efforts, based on specific criteria<sup>6</sup>.

The principles of the Blueprint and the recommendations of the CDC's policy change literature led the Section to support efforts to coordinate policy efforts by creating a Section-wide Policy Community of Practice<sup>7\*</sup> (CoP).

### **Objectives, Methodology, and Results**

The overall goal of this project was to establish a robust policy platform for the Chronic Disease and Injury Section and create a sustainable learning community to disseminate best practices for chronic disease policy and advocacy. The objectives included:

- **Analyze policy staffing across the Section and recruit members for a community of practice focused on policy for participants to share policy knowledge and opportunities**

Names of staff dedicated to policy and advocacy were collected by polling branch and program leads for each entity. A date was established for the first CoP meeting and invitations were sent to each potential member. A roster of the CoP is attached (Appendix II). A needs assessment tool is being developed to determine needed skill building training. A long term curriculum will be created based on the needs assessment. CoP members will be matched with other members based for mentoring opportunities.

The first meeting of the CoP was held in May of 2008. The group meets monthly and has enjoyed a high level of attendance at meetings and participation.

- **Inventory existing public health policy efforts across the Section and develop goals and objectives for the community of practice to achieve**

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\*Community of Practice is defined in literature as, "A group of people who share a concern or a passion for something they do and learn how to do it better as they interact regularly".

The community of practice met and identified areas of policy and advocacy that they were interested on working on together. SMART (Specific, Measurable, Achievable, Realistic and Time Framed) objectives and goals were drafted along with a corresponding strategic map (Appendix III). The goals and objectives are listed below:

**Team Mission:** To maximize the effectiveness of the Chronic Disease and Injury (CDI) Section for development, advocacy and the successful adoption of evidence-based and promising practices policies at the state and local level to prevent and reduce chronic disease in NC.

**Goal #1: Develop Section policy platform**

**Focus Area 1:** Develop an coordinated, prioritized Chronic Disease and Injury (CDI) Section evidence-based policy agenda

Objective 1a: By January 2009, develop policy prioritization criteria using evidence-based policy development tools

Objective 1b By July 2009, conduct at least 2 meetings to review and provide input to each Branch's 2020 policy objectives

Objective 1c: By September 2009, collect Section policy priorities from all branches and programs

Objective 1d: By September 2009, CoP, Section Management Team, and Chronic Disease Director use policy prioritization criteria to rank policies

Objective 1e: By October 2009, publish Section policy agenda and share with Office of State Health Director and NC Department of Health and Human Services

Objective 1f: By November 2009, disseminate policy platform to grassroots partners and influential stakeholders

Objective 1g: By November 2009, develop and implement social marketing and media campaigns that support policy priorities

Output	Process measure(s) (include data source & monitor)	Outcome objective (include data source & monitor)	Critical Assumptions (if any)
Criteria protocol Policy agenda Social marketing/ media campaign	The Policy CoP will monitor criteria protocol satisfaction via integration survey, policy adoption by partners via written documentation, and media campaign via	By November 2009, a percent of influential partners and grassroots partners will provide advocacy for the CDI Section policy agenda as evidenced by	

	reach reports	legislative summaries	
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**Focus Area 2:** Create a policy tracking tool of Section and Branch policy priorities

Objective 2a: By March 2009, conduct a needs assessment of necessary tracking tool components with Section leadership

Objective 2b: By March 2009, collect recommendations based on needs assessment from Section leadership

Objective 2c: By April 2009, develop and implement policy tracking tool

Output	Process measure(s) (include data source & monitor)	Outcome objective (include data source & monitor)	Critical Assumptions (if any)
Needs assessment tool  Policy tracking tool	The Policy CoP will monitor needs assessment and tool development via meeting minutes and tool satisfaction via integration survey	By April 2009, the Section will use the policy tracking tool for all relevant legislation	The Section will create and maintain an intranet

**Focus Area 3:** Create a policy calendar of critical policy events and deadlines

Objective 3a: By March 2009, conduct a needs assessment of necessary calendar events with Division and Section leadership

Objective 3b: By March 2009, collect recommendations based on needs assessment from Section leadership

Objective 3c: By April 2009, develop perpetual policy calendar with critical timelines

Output	Process measure(s) (include data source & monitor)	Outcome objective (include data source & monitor)	Critical Assumptions (if any)
Needs assessment tool  Perpetual policy calendar	The Policy CoP will monitor needs assessment and tool development via meeting minutes and tool utilization via Section Management Team	By April 2009, all Section Branches and Programs will use the perpetual policy calendar	

**Goal #2: Increase capacity for policy development**

**Focus Area 4:** Establish sustainable Section policy training program

Objective 4a: By May 2009, create an assessment tool of policy training needs

Objective 4b: By August 2009, survey Section policy staff using training assessment tool

Objective 4c: By October 2009, analyze results of assessment to identify gaps and resources

Objective 4d: By January 2010, create training program curriculum, including webinars, site visits, and seminars

Objective 4e: By February 2010, implement policy training program

Output	Process measure(s) (include data source & monitor)	Outcome objective (include data source & monitor)	Critical Assumptions (if any)
Needs assessment tool Survey results report Training curriculum	The Policy CoP will monitor needs assessment and tool development via meeting minutes and tool utilization via Section Management Team	By February 2011 all Section policy staff will be trained using Section policy curriculum	Sufficient personnel to create training curriculum  Funding for webinars and guest speakers for seminars

**Focus Area 5:** Develop and support program staff with experience and skills in policy development

Objective 5a: By August 2009, review position descriptions and current qualifications for policy positions in the Section

Objective 5b: By November 2009, draft model job descriptions for policy positions that list core duties and competencies (including core public health competencies and essential public health services)

Objective 5c: By February 2010, disseminate model job descriptions to CoP, Section Management Team, and others in Section

Objective 5d: By May 2010, disseminate at least one interview/resume protocol that provides questions and measures to assess core competencies critical to policy positions

Output	Process measure(s)	Outcome objective	Critical Assumptions
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	(include data source & monitor)	(include data source & monitor)	(if any)
Draft model job descriptions  Interview protocol	The Policy CoP will monitor progress on developing an interview protocol and job descriptions through review of subcommittee reports and meeting minutes. When both are completed, the CoP will annually track the number of positions hired using the protocol by management voice or e-mail confirmation	By May 2010, a percent of Section positions will match the model job descriptions as monitored by a database which will be developed by the Policy CoP and stored on the intranet  By May 2010, all policy positions will be hired using the interview protocol	Section Management Team is willing to disclose this information and allow for standards to be used

**Goal #3: Enhance relationships with internal and external policy partners**

**Focus Area 6:** Coordinate Section managed Task Forces and partner organizations

Objective 6a: By February 2009, create a descriptive inventory of all Section managed Task Forces and partner organizations

Objective 6b: By March 2009, determine shared policy goals and opportunities

Objective 6c: By January 2010, establish quarterly meetings of lead staff of Section managed Task Forces and partner organizations

Objective 6d: By February 2010, disseminate Section policy platform to Task Forces and partner organizations for review and implementation

Output	Process measure(s) (include data source & monitor)	Outcome objective (include data source & monitor)	Critical Assumptions (if any)
Task Force and partner organization inventory	The Policy CoP will monitor partner satisfaction via survey	By February 2010 all Task Force and partner organization will demonstrate advocacy support of policy agenda via survey results	Task Force and partner organization members support Section priorities

**Focus Area 7:** Coordinate and improve partner organizations policy efforts

Objective 7a: By September 2009, recruit influential internal and external public health stakeholders as CDI Section policy champions

Objective 7b: By January 2010, create a descriptive inventory of all partner organizations and develop consensus documents on policy priorities

Objective 7c: By February 2010, disseminate Section policy platform to partner organizations for review and implementation

Objective 7d: By February 2010, under the supervision of Division Leadership, meet with legislative bill drafting and agree on language for Section priorities

Objective 7e: By March 2010, assign roles and continue execution of media awareness strategies for policy platform

Objective 7f: By April 2010, implement of newspaper editorial board strategies for legislative priorities

Objective 7g: By April 2010, develop and disseminate technical assistance plans to partners to support policy platform, especially the NC Alliance for Health

Output	Process measure(s) (include data source & monitor)	Outcome objective (include data source & monitor)	Critical Assumptions (if any)
Partner inventory  List of assigned roles for media awareness campaigns  List of editorial board strategies  Technical assistance plans for partners	The Policy CoP will annually review and update partner inventory and revise roles as needed	By April 2010, have the endorsement of a majority of newspaper editorial boards for policy priorities  By September 2009, have at least two priorities supported by influential professional organizations/trade associations  By September 2009, have at least two policy priorities supported by most chronic disease	Section policy priorities meet the priority criteria and are supported by partner organizations

		advocacy groups	
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- **Create a unified, prioritized policy platform for the Section that includes issues from each Section entity.**

In June 2008, each program and branch was asked to submit their fiscal and substantive policy priorities. A list was compiled of the substantive priorities and presented to the Section Management Team, which is made up of the heads of all program and branch managers. The list was narrowed based on the voting of the Section Management Team and the interest of the Chronic Disease Director and forwarded to the Office of the State Health Director (Appendix IV). The State Health Director and her management chose priorities from the CDI Section and the other three DPH Sections, Oral Health, Epidemiology, and Women and Children's Health. The CDI priorities included in the Health Director's final list were:

- Make all NC workplaces and public places smoke free
- Increase cigarette tax by \$1.00 as has been recommended by NCIOM and other tobacco products by a comparable amount. Index both to the national average (currently \$1.18 for cigarettes).
- Increase the administrative fee for driver's license restoration to \$125: \$50 to the General Fund; \$50 to Forensic Tests for Alcohol Program and \$25 to the county.

CDI staff are currently working with Department of Health and Human Services attorneys to draft legislation bill language and find legislative sponsors for the issues. Priorities that were not successful in making the list were referred to more appropriate partner organizations and government organizations to be pursued.

Fiscal priorities of the Section were condensed into one list and narrowed by the Section Management Team and the Chronic Disease Director (Appendix V). Requests for additional funds were presented and forwarded to the DPH budget office to fund:

- Childhood obesity prevention demonstration projects
- Comprehensive worksite wellness programs
- Tobacco quitline
- Screening additional low income women for breast and cervical cancer
- Public awareness campaigns about the signs and symptoms of strokes and heart attacks
- Falls prevention awareness and education initiatives
- Child maltreatment surveillance system
- Healthy Carolinians community-based health promotion partnerships

### **Results and Next Steps**

The Section Policy CoP has regular, monthly meetings and has regular attendance from Section staff. Most meetings have representation from each branch and program in the Section. Members of the CoP volunteer their time to work on projects and deliverables between our monthly meetings. Currently the group is focused on creating:

- A legislative calendar to illustrate policy milestones that need to be met during the year, whether the General Assembly is meeting for a short or long session,

- Criteria for the CoP and Section Management Team to use in ranking policy priorities for the Section,
- A web-based tool to post CoP meeting minutes, common documents, and information on policy issues, and
- A legislative tracking chart (to be posted on the web-based tool) to record the progress of Section policy priorities through the legislative process.

The Section has had consistent, enthusiastic participation in the group and the CoP has developed useful tools to support existing policy efforts and encourage new policy work amongst branches and programs that previously were not engaged in the policy arena. The Section CoP will continue to meet on a monthly basis and function as a sustainable tool for policy coordination and development.

Katie Clarke Adamson, Director of Health Partnerships and Policy for the YMCA of America, acted as an advisor when developing the CoP. Ms. Adamson suggested ways to recruit members, to show vision and openness when first meeting, and to encourage creativity when determining policy goals. To assure wide participation, Ms. Adamson recommended creating and distributing a fact sheet that highlighted the success of policy efforts in the Section as a way to remind staff of the value of policy and environmental change in public health (Appendix VI). She then suggested contacting high level managers to interview them on the role of their staff related to policy to determine who might be the best people to initially include in the CoP. Ms. Adamson's advice was invaluable when approaching programs that had little experience with policy. She suggested showing the links between community-based policy change and broader statewide or Federal policies. A fact sheet was developed showing the evolution of policy change from the grassroots level to the Federal level and the local impact of policy change that begins at the highest levels of government. All of the techniques and suggestions offered by Ms. Adamson helped make the CoP an energetic, knowledgeable group.

## **Conclusion**

Progress towards program integration has been mixed in the Section. The Section Policy CoP has been one of the few successful components of the process thus far because of thoughtful planning and implementation of the CoP. CoP members were specifically recruited from all of the Section programs, strong goals and objectives were established early in the process, and members were given justification for the efforts of the group. CoP members' supervisors were invited to attend the meetings and were given updates on the group's work through the Section Management Team's weekly meetings. The accomplishments of the CoP are heralded as inspiration to continue program integration work in the other three program integration priority areas, evaluation and surveillance, healthcare systems, and community-based health promotion.

The value of the CoP extends beyond its contribution to program integration. For the last 15 years in public health, policy and environmental change have been increasingly emphasized as the best way to affect population-based behavior change. Collaboration and partnerships are essential for government agencies to fulfill their goals because of the legal limitations of government agencies related to public policy advocacy. Coordination of efforts also strengthens messages for policymakers and leads to quicker, accurate policy changes. The Section Policy

CoP is a sustainable community for staff to share ideas and learn from one another, collaborate on joint policy issues that might benefit multiple programs, and create consistent policy messages for external and internal partners on the priorities of the Section. Long-term, the existence Section Policy CoP will result in an increase in successful policy change related to chronic disease and injury prevention in North Carolina and better health outcomes for all North Carolinians.

### **Leadership Development**

Participation in the Southeast Public Health Leadership Institute (SEPHLI) molded the approach to creating a Section Policy CoP. Skills and advice gleaned from trainers, assigned readings, presentations, mentors, and fellow colleagues caused the CoP creation process to be intentional and thoughtful. Numerous aspects of the process were affected by SEPHLI, including the need for community partnering, diverse partner engagement, clear meeting structure, emphasizing the value of staff, leading with integrity, character, and confidence, and articulating a strong vision.

### ***Community Partnering***

The *Community Partnering Presentation*, by SEPHLI Year 10 Scholars Jean McNeil, DVM and Bob Weedon, DVM, MPH of New Hanover County, NC, emphasized that a successful collaborative project begins by having a well defined mission statement. The impetus to build the Section Policy CoP grew out of the Section's Program Integration Blueprint, which included a clear mission statement. The Section Policy CoP took that mission and expanded it to specifically focus on policy related issues.

Within the presentation, community partnering is defined as, "Building a coalition to draw upon the full range of potential human and material resources to improve the community." It is illustrated as a way to leverage resources and multiply manpower and reach new audiences<sup>8</sup>. This model was used when establishing the membership of the CoP. The most diverse staff available were recruited to represent all of the programs and branches in the Section and a wide range of policy knowledge.

As we developed the goals and objectives for the CoP, it was clear that local (county, city, or community-based) policy change was very important to our Section. Focusing solely on state or federal level policy changes would not capture a large portion of the policy work that is preformed in the Section. The CoP agreed that local policy change, supported by strong coalitions, often act as the catalyst for broader change at the state and federal level and that high level policy changes typically need to be implemented at the local level through strong coalitions.

### ***Diverse Partner Engagement***

The mentorship of Katie Clarke Adamson, Director of Health Partnerships and Policy for the YMCA, reinforced the need to have diverse stakeholders involved in the Policy CoP. Ms. Adamson has worked in policy the state and Federal levels of government for private, non-profit, and government agencies. Her experience representing broad range of constituencies and interfacing with both small and large entities proved invaluable when she described the need to engage partners from all arenas in developing policy platforms. She described how having

community members as a part of your coalition offers policymakers first person stories of the impact of specific public health issues. Often personal accounts from constituents are the most effective way to the impact of public health outcomes to legislators and other influential members of society. Ms. Adamson emphasized that successful Federal policy efforts frequently start with compelling narratives from local constituents and state policy is shaped by modeling Federal legislation.

The Federal process is so complex that the more vocal support you can garner for your policy issues, the better are your chances at success. It is essential to have a large, diverse group of advocates from influential organizations. Once your coalition is gathered, it is vital that all policy promotion efforts around your issue are coordinated. Due to the uncertainty of funding in the current economy, public health needs coordination of all relevant players, including pharmaceutical firms, non-profits, voluntary health organizations, universities, private foundations, and government agencies around distinct, clear policy goals.

### ***Meeting Structure***

The Policy CoP would not have had such initial success in its first meetings without incorporating the lessons of Danny Martin, PhD. Dr. Martin's suggested in his lecture, *Relationship as the Heart of Public Health: Developing Systems Thinking and Partnerships* starting every meeting with a description question for each person to answer during their introduction to instill a higher level of connectiveness between participants. This method encouraged participants to invest in the process of building the CoP and facilitated bonding with their teammates.

Dr. Martin recommended addressing meeting agendas using 3 rules:

- 1) Make sure ground rules are established
- 2) Modeled behavior starts with self-modeling
- 3) Often people that speak too much do not feel like they are being heard

Each of these suggestions was especially relevant to the Policy CoP. Ground rules for participation in meetings were instituted the first meeting and leader of the meeting was especially conscious of following the roles and regulations that were agreed upon. Members of the CoP are established staff of the Section and some are known for dominating meeting time. The CoP ground rules were clear that all participants needed to keep their comments within the allotted agenda time and the group regularly reinforced that complete attention should be given to anyone speaking. The leader of the CoP assures speakers that their contributions are being heard by summarizing points of interest from all participants' comments intermittently throughout meetings. Having a consistent, thoughtful meeting structure has led to productive meetings and respect for CoP members and leadership.

### ***Integrity/ Value of Personnel (your best asset are your people)***

The Policy CoP was faced with the challenge of convincing already busy staff to commit to spending more time in meetings per month and performing additional work. It is important that everyone involved in the CoP feels that their time is being well spent and that they are being valued as contributors when they participate. The article, *Do You Have The Will To Lead* by Polly Labarre highlighted that leadership is not simply about competence, but 'authenticity' as well. Effectively leading the CoP requires skills and character. Without both, members will not

be inspired to continue working on the CoP and will not be invested in the mission of the group.

The lessons of SEPHLI and the Labarre article taught the leader of the CoP to strive to approach situations in a 'people first' manner and appreciate the leadership of others who truly value their employees as their most important asset. The best leaders strike the balance of operating in the "four dimensions: vision, reality, ethics, and courage". The values of courage, compassion, and hope should lead life inside and outside the office.

The SEPHLI experience and all of its teachings created a wonderful opportunity for the Chronic Disease and Injury Section to thoughtfully approach the development of their policy infrastructure. The gift of establishing the strong, effective Policy CoP will remain a legacy to the breadth of the SEPHLI program.

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<sup>1</sup> North Carolina Department of Health and Human Services, Division of Public Health, State Center for Health Statistics. North Carolina Vital Statistics Volume 11: Leading Causes of Death 2006.

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<sup>2</sup> North Carolina Department of Health and Human Services, Division of Public Health, State Center for Health Statistics. Health Profile of North Carolinians: 2007 Update- May 2007.

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<sup>4</sup> Directors of Health Promotion and Education. Policy and Environmental Change: A Second Look at Public Health Agency Involvement: January 2006.

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<sup>5</sup> Slonim AB, Callaghan C, Daily L, Leonard BA, Wheeler FC, Gollmar CW, Young WF. Recommendations for integration of chronic disease programs: are your programs linked? *Prev Chronic Dis*: 2007 Apr.

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<sup>6</sup> North Carolina Department of Health and Human Services, Division of Public Health, Chronic Disease and Injury Section. NC Chronic Disease and Injury Section Integration Blueprint: 2007- 2012: February 2008.

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<sup>7</sup> Wenger, Etienne. *Communities of Practice: A Brief Introduction*. 2004.

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<sup>8</sup> McNeil, J and Bob Weedon, Conference Call and Powerpoint Presentation, Community Partnering: July 17, 2008.