The Healthy Lifestyle Center: A Case Study Illustrating the Opportunities and Challenges Confronting Local Health Departments in Preventing Chronic Disease

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The Healthy Lifestyle Center: A Case Study Illustrating the Opportunities and Challenges
Confronting Local Health Departments in Preventing Chronic Disease

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Acknowledgements

I would like to express my deepest gratitude to the following individuals who supported the writing of this manuscript:

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Raymond P. Ten Eyck, M.D., M.P.H., FACEP
Simulation Center Director, Department of Emergency Medicine
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Jeffrey A. Cooper, M.S., Assistant to the Health Commissioner
Public Health - Dayton & Montgomery County

I would also like to acknowledge these champions of health promotion and wellness:
Public Health – Healthy Lifestyle Center staff, Stephanie Nolan Leung and Brenda Alexander; contractor, Jameson Riner; volunteers, students and collaborators, Lindy, Yvette, Casey, Katie, Kelly, Kwaku, Maya, Mike, Jessica, and Christina; and last, but definitely not least, all the members of Public Health’s Healthy Lifestyle Center (with a special thank you to those who participated in the program from the start in February 2008). Working together, we made a positive contribution to the lives of others every single day!

Please see the Forward for additional comments.
Foreword

The First Surgeon General Report, *Smoking and Health*, was published in 1964. Forty-two years later, the Ohio Smoke-Free Workplace Act was passed. Marietta Langlois-Orlowski accentuated this point early in the evening, around 6:15 p.m., during my final Wright State University, MPH class lecture (Langlois-Orlowski, June 16, 2009). I have a vague recollection of John F. Kennedy’s assassination and the tumultuous year which followed, but I have absolutely no memory of the release of that Report. In 1964 school desegregation was commencing in the South, the U.S. military was becoming fully entrenched in Vietnam, the Beatles came to America, four year old Kathy Kemper moved from Lima, Ohio to the big city, Dayton, and almost half of all Americans, including my parents, my grandparents and the majority of their friends and colleagues, regularly and heavily used tobacco products. Smoking was widespread and customary in homes, offices, airplanes, cars, elevators, busses, schools, and even hospitals including maternity wards.

Leap forward to 1998. A World War II veteran and prolific pipe smoker had been diagnosed with Stage III lung cancer, and I was searching for “a cure” for this gentile man. Kathy Blossom, RN, BSN, and research nurse attended a dinner conference on lung cancer treatment which was sponsored by a multinational pharmaceutical conglomerate. The featured speaker, an internationally renowned cancer treatment Principal Investigator, spoke for more than an hour about “new treatments”. He closed his presentation by saying that over the last ten years, due to advances in chemotherapy and radiation therapy, life expectancy for advanced stage lung cancer patients had increased three months. Additional clinical trials needed to be undertaken. There was no mention of lung cancer causation (i.e., smoking), let alone prevention. I recall feeling a sense of hopelessness and despair and thinking that despite decades of research and billions of dollars invested, little demonstrable progress had been made in “the war” against cancer, yet the business of cancer treatment was “thriving” as evidenced by the complimentary four star meal and the upper-class audience dining with me at L’Auberge.

On a more positive note, that same night I was seated next to a well-respected local oncologist. During dinner we exchanged “pleasantries” and talked about our families, mutual acquaintances and our work. After the lecture, the physician made a point of reinforcing the investigator’s message; advising me that there was little that could be done to help my friend other than palliative care. Surprisingly, he then shifted the dialogue 180 degrees by saying that he felt that my work in cancer prevention research was critical and that I was “going to make a difference”. This compliment was “out of character” for this austere physician and very unexpected, but welcomed. I left the restaurant wondering if I had heard him correctly and trying to comprehend why someone who had spent most of his life treating cancer patients with drugs would be so audacious as to suggest that prevention was “the cure”. I truly believed it, but I had rarely heard that doctrine uttered by a physician let alone an oncologist.

As I’ve grown older, more observant and a bit wiser, I’ve found a profound truth in this physician’s words. Dr. Steven G. Aldana (2005) summarizes it this way, “Preventing common chronic diseases and premature death later in life requires that you take action now, even though you have no symptoms of chronic disease” (p. 35). As a registered nurse I have seen that most Americans don’t understand this concept or the reality of poor health until they are at “heaven’s gate” or “deaths door,” and despite the tissue carnage, they truly believe that they will be
“rescued” by physicians, technology and treatment. Dr. Aldana (2005) refers to this as the “‘fix me up, doc’ attitude; eat whatever you want, exercise only if you really want to, and, if you do have heart problems, just have the doctor fix you up” (p. 44). This concept is engrained in American society and culture, but not altogether grounded in reality. According to Aldana (2005) “the effectiveness of medical care in the United States is better than anywhere else in the world” (p. 44). So, if medical care is needed, the U.S. is the place to be. If you need treatment for heart disease, transplants, bypass surgery, angioplasty, pacemakers, automated internal defibrillators and medication are all plentiful and by and large accessible to all residents. This is fabulous news if you are among the 50% of the population with cardiovascular disease who survive their first heart attack (Aldana, 2005). If not, you will not need any of it. This “gold star”, six figure “fix me up, doc” option is also available for cancer patients where five-year relative survival rates have somewhat improved for many types of cancer (breast and leukemia) but not for others. The long term survival rates for lung and bronchial cancer have remained steady since 1977 at 13.4% (National Cancer Institute/Surveillance Epidemiology and End Results, n.d.).

I find some comfort in these data since my friend who had lung cancer decided to stop his chemotherapy and radiation treatment and take an extended trip before he died (i.e., he chose to make the most out of the time he had remaining), but despair in knowing how much money has been spent on unproductive research (which could have been allocated to prevention efforts).

The United States currently spends more than two trillion dollars annually on health care with three-fourths of that spending being directly attributable to costs of unhealthy lifestyles (Thorpe, 2005). Despite what the public perceives, that investment does not lead to “salvation” or miracle cures. Medicine cannot “heal” and the human body can be broken beyond repair by abuse. Millions of Americans suffer from early onset, debilitating chronic diseases many of which are entirely “preventable”. I see it every day. Everyone is subjected either directly or indirectly to the skyrocketing costs of health insurance and healthcare yet little has been done to control these expenses other than to throw more money at the problem and grumble. Although many factors have contributed to the current crisis, the most important is the concentration on caring for people after they have become sick. Few human and financial resources are allocated to prevention despite the indisputable evidence that daily lifestyle choices are the major determinant of human health, and individual/personal responsibility and accountability is largely overlooked.

A mountain of scientific research has exposed the adverse health effects of tobacco use. Armed with this knowledge, many Americans are finally choosing to live “smoke free”; however, it has taken almost 50 years for the Surgeon General’s message, smoking causes cancer and other types of disease, to be accepted by the American public and acted upon by federal, state and local government. As a result, hundreds of thousands of Americans have needlessly died as a direct result of tobacco use. Although the health benefits of being physically active have been extensively documented in the literature and are generally accepted in the United States, might the same “history” be repeated (Thompson et al., 2010). According to Robert Wood Johnson, Vice President, Dr. James Markes and other experts, obesity caused by physical inactivity and poor nutrition is the next great threat to the public’s health, yet despite this knowledge, “we are still getting fatter” (Neergaard, 2009). Authorities agree that something must be done to stem the epidemic, yet the mechanism for action is open to debate, and the
problem continues to literally grow more every day. Will obesity, like tobacco use, take decades to effectively address? Hopefully that will not be the case, but the data continues to indicate that this generation of children could be the first U.S. in history to live less healthful and shorter lives than their parents and that the outlook for the baby boomers is not much better (Neergaard, 2009; Belluck, P., 2005).

Disease prevention is difficult to quantify or qualify; therefore, demonstrating value is very arduous and challenging. Health promotion is not a profession for those who are not willing to tackle difficult issues or embrace change. We are truly a minority. Just speak with a Public Health employee who has been tasked with enforcing the 2006 Ohio tobacco legislation or who during these uncertain and difficult economic times is fighting to maintain federal and state funding for HIV/AIDS screening or childhood immunizations for the uninsured. The battles at times seem never ending. For fifteen years, I have been involved with promoting Smoke Free Ohio and other chronic disease prevention and early detection initiatives. The hours have been long, the recognition limited, and the road characteristically “difficult to travel”. That reality does not imply that the investment has not been worth the effort, but does suggest that personal and professional sacrifices have been made by public health leaders and will need to be made by future ones…like pursing an MPH degree while being a wife, mother and full time plus public health employee.

Luckily, I have been truly blessed with the unwavering love of my husband, children, and family and the steadfast support of friends and colleagues. Please trust me when I say that nothing I have achieved would have been possible without your guidance, patience, and support. Thank you from the bottom of my heart.

Now, forward we march to the next major public health challenge; addressing the obesity epidemic and improving the health of our families, friends, colleagues, communities and nation. I believe that the solution lies in making the healthy choice the easy choice, increasing physical activity levels and improving nutrition through a “small step” approach, and supporting one another as we strive to improve our health. Every day, whether we acknowledge it or not, we blaze a trail. The challenge lies in taking that first step and continuing to forge ahead while leaving tracks that are big enough for others, who chose, to follow.

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Abstract

Obesity is at epidemic levels in the United States, and is directly associated with decreased life expectancy, reduced quality of life, and increased health care costs. Public health system partners agree that reversing obesity trends will require a concerted effort led by government as well as business and civic organizations and that a multi-faceted approach will be needed to transform communities into places where the healthy choice becomes the easy choice for everyone. A foundational role for local health departments is to promote healthy behaviors. Public Health – Dayton & Montgomery County (PHDMC) has a history of providing community-based health education programs and preventive screening services, and is committed to reducing barriers to access, particularly for populations experiencing health disparities. Funding for these programs and initiatives emanate from a property tax levy, federal and state grants, and from foundations. This case study begins in February 2008, and explores PHDMC’s rationale for assuming operational control of a fitness center located in a highly underserved neighborhood in southwest Dayton, Ohio, eventually named The Healthy Lifestyle Center (HLC). The study outlines the HLC’s strengths and weaknesses, lessons learned during the first three years of business, and the decision-making process used to determine whether to continue the program after 2011. This in-depth case study illustrates the challenges as well as opportunities confronting local health department leaders as they endeavor to build chronic disease prevention capacity and implement evidence-based practices in today’s complex, rapidly changing political, social and economic climate.

Keywords: physical activity, evaluation, strategic planning, obesity, vulnerable populations, fitness services
The Wellness Connection (prior to 2002 known as the Dayton Area Heart and Cancer Association) was a 401c3 non-profit organization that had served the Dayton region in various capacities since 1947. In 2007 their board of trustees completed a strategic planning process that led to a major shift in focus designed to better serve the needs of the community. To successfully begin this transition, the Wellness Connection set a goal to raise the $1.5 million needed to become affiliated with the Wellness Community®, an international nonprofit organization focused on a patient active approach to cancer support and recovery (Cancer Support Community, 2012a, 2012b). This organizational evolution and the new mission required streamlining of some existing screening, health education and disease management...
programs and divesting expenses. To maintain goodwill with existing and potential donors, the Wellness Connection director identified community partners who might be willing to take over services that were no longer essential. These programs included a small, fully-equipped and professionally staffed fitness center with 50 dues paying members, many of whom had supported the not-for-profit for years.

In November 2007, Public Health – Dayton & Montgomery County (PHDMC) entered preliminary discussions with the Wellness Connection about taking over the fitness center. PHDMC is a non-profit, governmental agency of 380 employees (2007) that provides public health services mandated by Ohio Administrative Code (State of Ohio, n.d. - Administrative Code 3701) and other ancillary, community need-based services that prevent, promote and protect population health. PHDMC’s activities are overseen by a nine member board of health that employs a full-time health commissioner. The commissioner is responsible for major operational decisions such as the opportunity to acquire the Wellness Connection’s fitness center.

In 2007, PHDMC’s annual operating budget was approximately $40 million of which 46% derived from the Montgomery County Human Services Levy. A volunteer, multi-sectoral Human Services Levy Council (HSLC) consisting of community leaders oversees levy funds and is tasked with allocating revenues to organizations and agencies that provide services to the underprivileged and at-risk populations such as the disabled, elderly, children, the homeless, chemically dependent, among others. If PHDMC were to choose to acquire the Wellness Connection fitness center, funding would need to be procured through levy funds. An internal PHDMC analysis estimated that the facility would incur a net operating loss of approximately $165,000 per year during the first three years of operation with staff and rent being the major
contributors to negative cash flow. PHDMC proposed that the deficit spending would be offset by improved health leading to a reduction in healthcare costs.

The Wellness Connection fitness center occupied 2,800 square feet of the lower level/basement of the West Medical Plaza of Elizabeth Place (Figure 1); a former Franciscan hospital that had been fully renovated to house an assortment of mainly healthcare providers. PHDMC already had a presence in Elizabeth Place thorough its Center for Alcohol and Drug Services (CADAS) and Prenatal Health Clinic. The building complex was fully accessible to people with disabilities, was located on two Regional Transit Authority (RTA) bus routes, offered free parking, was a well-known landmark to area employees and residents and was highly visible from Interstate 75 as well as from U.S. Route 35 (Figure 2).

Figure 1. Image of Elizabeth Place n.d. (Retrieved from Elizabeth Place website http://www.elizabeth-place.com/ on March 2, 2008).
The ten acre, Elizabeth Place campus is located in southwest Dayton, Ohio in the Carillon neighborhood (pop. 818). According to the U.S. Census Bureau (2000), Non-Hispanic blacks constituted 90.2% of the population (as compared to 43.1% in the City of Dayton), 4.6% were non-Hispanic whites and 4.2% were two or more races. The median age of residents was 45.1 years as compared to Dayton’s 32.4 years. In regards to education levels of persons age 25+, 38.1% did not have high school diplomas (or a GED) and 38.1% had a high school diploma with no additional degrees. Median household income was $20,045 (whereas Dayton’s was $27,423), and 48% of the residents made less than $19,999 annually. Nearly half of Carillon residents had lived in their homes since 1970 and slightly less than 40% lived alone (U.S. Census Bureau, 2000). The census data, as well as anecdotal accounts by PHDMC staff and other community stakeholders, clearly supported this area as being underserved and at-risk for a variety of largely preventable health problems.
In December 2007, after completing a brief fact-finding period and consulting with PHDMC leadership and staff, health commissioner, James W. Gross, determined that the fitness center aligned well with PHDMC’s strategic directions and recommended that PHDMC should conditionally pursue this opportunity to enter the fitness business. In January 2008, the commissioner consulted with Montgomery County board of health, Human Service Levy Council members, and other community leaders and received positive feedback on the concept of opening a healthy lifestyle center. On Wednesday, February 6, 2008, the board of health heard a formal presentation on the project and unanimously approved funding. On Friday, February 20, 2008, an asset purchase agreement was signed and all the remaining Wellness Connection fitness center capital assets (valued at more than $40,000) were transferred to PHDMC for $1.00 (Figure 3).

Figure 3. Image of the main exercise floor of the Healthy Lifestyle Center (K. Blossom, April 2008).
On Monday, February 23, 2008, the fitness center became PHDMC’s Healthy Lifestyle Center (HLC), a conditionally funded ($500,000), three-year pilot program. Management would be provided by the PHDMC emergency preparedness educator who would transition to a new position at the HLC. The full time employee was a registered nurse who had prior experience managing a cancer prevention and screening outreach program for Premier Health Partners but who had no fitness center operation experience. This case study required the manager to analyze the current situation, identify issues and solutions, implement best practices, and evaluate and report outcomes. It is written from her perspective.

**Case Questions**

The strategic planning approach used by the new program manager was basic: where was the program now, where did the program need to be in three years, and what was the best way to get there? To initiate this process, the manager saw the need to answer to four foundational questions that form the basis of this case study:

1. What was the rationale/reasoning for PHDMC to acquire the Wellness Connection fitness center and open a healthy lifestyle center?

2. What were leadership’s expectations for the 3 year pilot? Specifically, where did the program need to be in 2010 to be considered successful and worthy of continued levy funding?

3. What were the current strengths and weaknesses of the Wellness Connection’s program? What should be continued and what needed to change as PHDMC developed a healthy lifestyle center?
4. What could be done to differentiate the new healthy lifestyle center from other fitness facilities? That is, where were the opportunities for creative programming and services?

A fifth case question was necessary to evaluate the outcomes that resulted from the first four:

5. To what positive individual or community outcomes did the healthy lifestyle center contribute?

**How Did We Get Here?**

The rationale for PHDMC’s decision to initiate this new program, the Healthy Lifestyle Center, was based on multiple factors including unhealthy lifestyles and Montgomery County health, the evolution of public health in Dayton and Montgomery County and the way that county leaders chose to link population health needs with available resources. Each of these is described in the following pages.

**Unhealthy Lifestyle and Montgomery County Health**

Physical inactivity, combined with poor nutrition and other factors had led to an obesity epidemic that was “threatening the health of our children, the productivity of our workers, the vitality of our communities, the affordability of our health care system and overall quality of life” (The Ohio Department of Health [ODH], March 2009, p. 7). The benefits of being physically active were extensively documented in the literature and were generally accepted in the United States (Thompson, Gordon, & Pescatello, 2010; Centers for Disease Control and Prevention [CDC], 2008). Despite this evidence, most American adults, adolescents and children reported levels of physical activity that fell well below national guidelines (CDC, 2008). This was also the situation in Montgomery County, Ohio (pop. 532,562) where less than half of adults got the recommended amount of exercise defined as 30+ minutes of moderate physical
activity, 5 or more days a week or 20+ minutes of vigorous activity, 3 or more days per week (PHDMC, 2011).

With the Healthy Lifestyle Center, there was a need to bridge knowledge with action so that every person in Montgomery County, regardless of race, ethnicity, gender, age or socioeconomic status, could adopt and maintain physical activity behaviors and make other informed healthy lifestyle choices. Local public health and medical experts agreed that reversing obesity trends would require a comprehensive and coordinated approach led by government as well as business and civic organizations and that policy as well as environmental change was needed to transform all communities into places that support healthy lifestyle choices (PHDMC, 2011).

The Evolution of Public Health in Montgomery County

The changing vision and leadership of PHDMC was integral in designing the outcomes that drove the planning process for the three year pilot of the Healthy Lifestyle Center. Public health has had a presence in Dayton since 1831 when the first board of health was appointed (Steele & Steele, 1896). In 1969, the Dayton and Montgomery County health departments merged and became the Combined Health District of Montgomery County (CHDMC). Following a traditional public health model, the county agency provided services that prevented the spread of disease, protected against health threats, and promoted healthy behaviors. In addition, staff worked with public health system partners to ensure that at-risk populations had access to health care and also informed and educated the community about health risks. The agency responded to the changing needs of the population while recognizing that individual health was dynamic and influenced by a variety of determinants of health, some of which were controllable and some which were not. Despite the well intentioned efforts of the health
department and community partners, population health had not measurably improved as evidenced by the high rates of obesity and preventable chronic diseases including cardiovascular disease, stroke, and diabetes (PHDMC, 2011).

The groundwork for the development of a revitalized Public Health promotion effort and the conception of programs to combat obesity and preventable chronic disease began in the spring of 2006 when Allene Mares, MPH, RN, left Public Health – Seattle & King County, Washington to become the health commissioner of the Combined Heath District of Montgomery County, Ohio. Although Mrs. Mares was with the health department for a short period, her legacy of progressive thinking prepared the agency for transformation. In March 2008, James W. Gross, the assistant health commissioner, a long time health district employee who worked closely with Mrs. Mares during her tenure, was promoted to health commissioner. This leadership transition represented a critical turning point for the health department. Mr. Gross was a long time resident of east Dayton and was a recent graduate of the Wright State University, Master of Public Health (MPH) program’s first class (2005). Among his many positive leadership attributes, the new commissioner had a profound understanding of the importance of strengthening public health infrastructure by convening stakeholders, forging new partnerships and building strategic alliances among groups and organizations from all sectors. As a lifetime distance runner, he also modeled and exuded a new enthusiasm for wellness and was committed to nurturing a culture of health not only within the agency but within Montgomery County. Promoting healthy behaviors became a health department priority.

Many aspects of the model initiated under commissioners’ Mares and Gross leadership are particularly pertinent to the Healthy Lifestyle Center story. For example, Mares changed the health department name from the Combined Health District of Montgomery County to Public
Health – Dayton & Montgomery County. This may seem a small thing, but in doing so, the new name incorporated the new National Association of County and City Health Officials (NACCHO) public health brand which tied it to the other national health organization. According to NACCHO, consistently using a visual symbol (i.e. a brand) over time helps to build awareness of the services provided by public health agencies across the U.S. (National Association of County and City Health Officials [NACCHO], 2013). As a Levy funded agency, it was important for the public to identify with the services the health department offered and to associate value with those programs.

Figure 4a: Image of the Combined Health District of Montgomery County logo.  
Figure 4b: Image of the new Public Health – Dayton & Montgomery County logo.

Mares espoused a new mission that better reflected the role of PHDMC in the community. Public Health workers and the community were told that “The mission of Public Health – Dayton & Montgomery County is to lead and innovate by working with our community to achieve the goals of public health: prevention, promotion, and protection” (Commissioner Mares PowerPoint presentation for WSU Center for Healthy Communities on June 20, 2007, Kettering Center, Dayton, OH).

The new leadership created a new vision statement (Figure 5) with subcomponents or “pillars” that reflect the National Public Health Performance Standards Program’s Ten Essential Public Health Services (CDC, 2010). The pillars provide a mechanism for leadership to easily display Public Health’s priorities to community stakeholders. All PHDMC programs were
expected to support at least one pillar or provide administrative support. The Healthy Lifestyle Center’s contribution was to “promote healthy behaviors” while also “reach(ing) out to vulnerable populations, linking or providing direct services” (Montgomery County Board of Health, 2007, Figure 5).

Our vision is to be an innovative leader in achieving the highest possible health and well-being for Dayton/Montgomery County residents and visitors. To that end, we provide vital, cost-effective and culturally proficient health services that protect and promote people’s health and support and create healthy environments and communities.

Through our services, we:
- Prevent the spread of disease
- Protect against health threats in air, food and water
- Promote healthy behaviors
- Reach out to vulnerable populations, linking or providing direct services
- Mobilize community action through partnerships
- Prepare for and respond to public health emergencies
- Serve as a public health information resource to physicians and others working in the interests of health

Figure 5. PHDMC’s vision statement, Montgomery County Board of Health, May 2, 2007. (Source: PowerPoint presentation to the Board of Health)

Perhaps the most ambitious leadership accomplishment was establishing PHDMC’s first Strategic Plan in 2009 (PHDMC, 2009b). This included five strategic directions (SDs), most pertinent to this case study is “Strategic Direction 1: Enhance and expand our chronic disease prevention measures to help reduce morbidity and mortality” (PHDMC, 2009b, p. 6). The Healthy Lifestyle Center was expected to play an important role in accomplishing the outcomes associated with this SD.

**Linking Population Health Needs with Available Resources**

Three agencies work together to identify community needs for at-risk populations, establish strategic direction, determine funding distribution, and ensure that services are provided cost-effectively to Montgomery County (Ohio) residents: the Montgomery County Commission,
the Family and Children First Council (FCFC), and the Human Services Levy Council (HSLC). PHDMC is a division of Montgomery County Government and is therefore under the leadership of the elected county commissioners; the Family and Children First Council is responsible for monitoring county needs and outcomes and the Human Services Levy Council provides almost 50% of PHDMC’s annual funding. The decision as to whether or not the Healthy Lifestyle Center would be funded after its three year pilot period would be made by the health commissioner, but as a good fiscal steward of taxpayer dollars, he would have to be able to justify its value to these three important stakeholders, each of which is described below.

**The Montgomery County Family and Children First Council.**

Ohio Revised Code, section 121.37, delineates the duties and responsibilities of the Ohio Family and Children First (OFCF) Cabinet Council that oversee the local Family and Children First Councils (FCFC) that exist in all 88 Ohio counties (State of Ohio, n.d. - Revised Code 121.37). The purpose of FCFCs is: “to streamline and coordinate existing governmental services for families seeking services for their children” (Montgomery County Family and Children First Council [FCFC], 2013a, p. 61). In Montgomery County, the OFCF is organizationally a department of the Board of County Commissioners. The Montgomery County FCFC has an annual budget of approximately $138 million, and has six Outcome Teams (Figure 6).
Since August 2007, Commissioner Gross has served as the co-chairperson of the Healthy People Outcome Team (HPOT). Prior to this leadership appointment, he served as a HPOT member. The HPOT is composed of community leaders and has multi-sectoral representation from healthcare, government, academia, schools, and philanthropic groups. The HPOT is tasked with promoting comprehensive wellness for all Montgomery County residents.

The HPOT identified obesity as a public health problem in 2007 and the team set a goal of establishing a county-wide childhood obesity prevention initiative (FCFC, 2013c). In 2008, the HPOT in collaboration with PHDMC and other partners including the Children’s Medical Center, CareSource, Wright State University/Center for Healthy Communities and the
Montgomery County Board of County Commissioners initiated a program entitled *GetUp Montgomery County* (GetUp). GetUp was (and remains) the foundational healthy lifestyle initiative in Montgomery County; however it has transitioned from what was largely a social marketing campaign to one that supports the implementation of policy, system and environmental change strategies through a sector based approach. GetUp is funded through the Human Services Levy with assistance from the CareSource Foundation (PHDMC, 2013b).

**The Human Services Levy Council.**

Montgomery County is one of only two counties in Ohio that use combined health and human services property tax levies to finance services/operations. This innovative, combined levy funding process began in 1983 and is a model framework that has created “a foundation of collaboration and shared decision-making” (FCFC, 2013b, p. 75). The majority of levy dollars are allocated to support the local cost of state-mandated agency services including PHDMC. OFCF staff support the volunteer driven Human Services Levy Council (HSLC) and work with funded agencies to “ensure accountability and effective communication on programs, practices and policy” (FCFC, 2013a, p. 58). Approximately 46% or $17.1 million of PHDMC’s annual budget comes from the Human Services Levy including 100% the funding for the Healthy Lifestyle Center pilot program (PHDMC, 2012).

**Where Do We Need to Be?**

An internal steering committee consisting of Commissioner Gross, the assistant to the health commissioner, Jeff Cooper, the director of the Division of Health Promotion, Fred Steed, and the preventive health education supervisor, Jennifer Boyd, was formed to advise and assist the program manager in her efforts to build the Healthy Lifestyle Center program. Weekly or then bi-weekly meetings were held from February through June 2008. During these sessions and
through subsequent dialogue with steering committee members and others, the new HLC program manager developed an understanding of key factors for success:

1. PHDMC needed to develop a more robust health promotion program specifically one which addressed adult obesity and the underlying unhealthy lifestyles. The HLC was an important new asset in meeting this strategic direction; however, GetUp Montgomery County was PHDMC’s foundational healthy lifestyle program. The HLC needed to support the GetUp program rather than compete with it.

2. Future PHDMC health promotion funding would be driven by demonstrating improvement in health behaviors. Consequently, the HLC had to develop and implement an outcome measurement plan that could build the case for program cost-effectiveness.

3. PHDMC had developed a community role as convener and collaborator, not a competitor. Hence, the HLC needed to differentiate itself from other fitness centers and emphasize its identity as a community asset. Duplication of services had to be avoided and service gaps identified and addressed. Whenever possible, center activities should link with other groups/organizations.

4. As outlined in the Healthy Lifestyle Center proposal accepted by the Montgomery County Board of Health, the HLC needed to provide fitness services to clients of the PHDMC Diabetes Education and Prevention Program (DEPP) and the Center for Alcohol and Drug Addiction Services (CADAS). Other internal relationships also needed to be explored and whenever possible, linkages established.
From the end of February through October 2008, the center continued to operate as it had under the Wellness Connection. The addition was the new program manager who had no experience managing a fitness center. Fortunately, she would team up with an experienced lead fitness instructor, Stephanie Leung, a University of Dayton graduate with a B.S. in exercise science and fitness management and Jameson Riner, a University of Dayton student pursuing a doctorate in physical therapy (graduated in April 2009).

Baseline SWOT Analysis

In April 2008, a strengths, weaknesses, opportunities and threats (SWOT) analysis was completed by the program manager and contractors to be shared with the HLC steering committee. “SWOT analysis is the most renowned tool for audit and analysis of the overall strategic position of the business and its environment” (Management Study Guide, 2008-2013, second paragraph). As such, the results had a major impact on program planning and future operations. The HLC SWOT analysis appears in Figure 7.
1. **Strengths (Internal: Keys to past and future successes of the program):**
   A. Tangible proof of PHDMC’s commitment to improve community health and address health disparities in an at-risk area by providing healthy lifestyle services.
   B. Addresses a community need.
   C. Good site location; (a) Easily accessible to Carillon and surrounding urban Dayton residents; (b) Elizabeth Place houses more than 60 businesses/organizations many of which serve at-risk clients; (c) within 1.5 miles of two community health centers; (d) within 1.0 mile of the Reibold building.
   D. Small exercise facility is amenable to more individualized member service/attention.
   E. Core group of 50 supportive and engaged members.
   F. Blood pressure monitoring system in place.
   G. Experienced staff with an interest in staying with the program.

2. **Weaknesses (Internal: Potential problem areas that impact growth):**
   A. Staffing vulnerabilities; The Program Manager was the only PHDMC staff person assigned to work at the Center and she was not a certified fitness instructor. The Center needs to hire a full time, PHDMC employee as a Lead Fitness Instructor.
   B. Wellness Connection services were focused on chronic disease management so many of the remaining members had pre-existing conditions like high blood pressure, diabetes, and heart disease.
   C. No standardized process for enrolling members.
   D. Monthly membership fees range from $0 to $35 and are not consistently applied.
   E. There are no marketing materials nor are any referral pathways/mechanisms in place to recruit new members.
   F. Unused facility space.
   G. Only fitness services are being provided. Member nutrition and other lifestyle related determinants of health are not being addressed.
   H. There is no process for performing baseline health assessments.

3. **Opportunities (External: Potential areas for growth):**
   A. An increased emphasis at the national, state, and local levels in reducing health care costs through chronic disease prevention (i.e. increased physical activity and improved nutrition).
   B. The potential for grants from local philanthropic as well as state and national groups.
   C. Forming relationships with new public health system partners and improved collaboration with external programs/partners.
   D. Establishing new linkages with existing PHDMC programs to strategically align resources and activities.
   E. Developing, implementing and sharing healthy lifestyle best practices.

4. **Threats (External: Outside factors to be corrected or limited):**
   A. Loss of existing members to other facilities.
   B. Elizabeth Place rent increases.
   C. Loss of fitness instructors due to employment uncertainty.
   D. The ability to prompt and sustain behavior change.
   E. Loss of funding from the Human Service Levy.

*Figure 7. SWOT analysis generated by the HLC program manager and staff and reviewed by PHDMC leadership in April 2008 (PHDMC internal document, K. Blossom & S. Leung).*

Note: The lettered format does not reflect prioritization.
The SWOT was used to select strategies for implementation and to formulate a business plan. The following items in Figure 7 are of particular interest since they are public health related and directly impact the four factors for success identified on pages 21 and 22. They will be further explained to build depth to this case study.

2.B. Wellness Connection services were focused on chronic disease management so many of the remaining members had pre-existing conditions like high blood pressure, diabetes, and heart disease. While the fitness center had at one time operated as a cardiac rehabilitation program, the Healthy Lifestyle Center concept generated by the health commissioner was to be centered in primary prevention (i.e. preventing disease development). The center needed to transition to this new model, but under a best case scenario, needed to do it without losing the patronage of existing members. The management challenge was how to “quickly”, but “seamlessly” make this transition so that a marketing plan focused on new member recruitment could be implemented.

After consulting with PHDMC leadership and staff, a Role Statement was drafted in 2008 and approved that espoused a mission transition from disease management to disease prevention. The role of the Healthy Lifestyle Center (HLC) became:

As a chronic disease prevention leader, innovator, and ambassador, we work collaboratively with others in the community to improve the health of individuals and families through evidence-based physical fitness, nutrition, and other healthy lifestyle management initiatives which have measurable outcomes. We endeavor to identify barriers to healthy living in those at highest risk for preventable chronic disease development and remove them. The Center focuses on promoting health to prevent a disease from occurring, and addressing a health problem before it becomes symptomatic.
Chronic disease rehabilitation is not within the scope of Public Health’s Healthy Lifestyle Center (PHDMC internal document, K. Blossom & S. Leung, 2008).

The role statement was an important accomplishment for the HLC because it was created through collaboration and consensus, was widely circulated throughout PHDMC, and was shared with community partners. People began to view the center as a place that promoted health, not treat chronic disease. Although the center continued to accept members with pre-existing conditions, rehabilitation services were accepted as being beyond the scope of HLC practice. The remaining members supported this role change which had a minimal impact on existing services. Staff would no longer monitor blood pressure during exercise, but would continue to perform pre- and post- exercise BP monitoring and recording. These metrics would be used as part of the member outcome measurement program that will be discussed in greater detail later in this case study. Unfortunately, the center did lose one member who due to a major stroke required one-on-one assistance to access the equipment. This service was no longer provided.

2.D. Monthly membership fees ranged from $0 to $35 and were not consistently applied. Unlike most area fitness centers, there was no contract involved with joining the Wellness Connection’s exercise program. This was identified as a strength because it removed cost and/or long-term obligation barriers found in similar facilities. Regrettably, the prior Wellness Connection process for determining and charging monthly membership fees was random. As a levy funded agency, PHDMC, prides itself on fiscal accountability, promoting equity, and removing barriers to access. As a 100% levy funded program the HLC was required to have standardized process for determining membership fees that was transparent and based on best practice. After discussion with the HLC internal steering committee, it was decided that the center would continue to charge fees on a month-to-month basis and that a sliding fee scale
based on one instituted by the Community Health Centers of Greater Dayton (CHCGD) would be implemented. Fee discounts would be offered to individuals living in households with combined gross income of less than 2.5 times the Federal Poverty Guidelines. The maximum fee would be $25. All members would be expected to pay at least $10. The program manager lobbied with leadership for this fee structure and insisted that services not be provided for free. Through her field experience as the community outreach, education and screening program manager at the Hipple Cancer Research Center, she knew that the $10 fee was generally not a barrier and in many cases served as an incentive to use the service since it gave the service value. This minimal charge model had proven effective in increasing mammography appointment show rates for the mobile mammography program that she managed and which provided services at the East Dayton Health Center.

This change in fee structure was vetted with some of the long-term members who supported it. Subsequently, they were given the option of applying for the discount by showing proof of income and many took advantage of this opportunity while others decided to pay the full monthly fee. Once this process was completed, the fee reduction paperwork was added to the introductory paperwork that all new members were expected to complete. A re-evaluation of fee structure was done each April, to correspond with “tax time”, because a completed Federal income tax return served as proof of adjusted gross income. The modification to the fee schedule negatively impacted the projected membership payment revenues, but the loss was negligible in the overall HLC budget.

**2.E. There are no marketing materials nor are any referral pathways/mechanisms in place to recruit new members.** The marketing plan developed by the program manager was basic: (1) Brand the Center as a Public Health - Dayton & Montgomery County healthy lifestyle
program; (2) leverage existing resources including word-of-mouth referrals from existing members; (3) create a one-page color flyer that can be printed and delivered by hand, posted on the HLC website, and/or distributed electronically; (4) associate with existing PHDMC programs; and (5) investigate opportunities to develop referral pathways with medical providers especially those serving at-risk populations. Each of these components will be discussed in greater detail.

As described earlier, leadership changed the health department name from the Combined Health District of Montgomery County to Public Health – Dayton & Montgomery County to reflect the NACCHO national brand. To promote the HLC as a PHDMC initiative, it made sense to change the name to Public Health’s Healthy Lifestyle Center (PHHLC). This name change became effective in May 2008 when a highly visible exterior sign was placed above the outside entrance of the West Medical Plaza of Elizabeth Place (Figure 8). From that point on, the center was referred to and marketed as the PHHLC.

Figure 8. Outside the West Medical Plaza entrance of Elizabeth Place (taken by Kathy Blossom, summer 2008).
About half of the members who transitioned in the fitness center changeover had lived in West Dayton for many years and were knowledgeable about the community and its culture. Since the PHHLC had a very small advertising budget (less than $1,000 a year), word-of-mouth was a valuable recruitment tool. To promote the Center, a one page flyer was created for distribution (see Appendix A). After receiving feedback from members and community partners, a second flyer was developed and distributed. It included a map of PHHLC’s location (see Appendix B).

**2.G. Only fitness services were being provided. Member nutrition and other lifestyle related determinants of health were not being addressed.** A weakness identified in the SWOT was unused facility. The center’s layout included four offices that were not needed by PHHLC staff. To make better use of the space, the program manager worked with the PHDMC facility manager to draft a plan to remove the walls and transition the area into an education room. The remodeling was completed in May 2008 (Figure 9).

*Figure 9. Image of the PHHLC education room (taken by Kathy Blossom, June 2008).*
PHHLC staff worked with students from Wright State University, Sinclair Community College and the University of Dayton to offer a variety of free wellness classes to members and others at-risk groups. All fitness and education programs at the center incorporated the use of the Transtheoretical Model of Behavior change (TTM) as developed by James O. Prochaska and colleagues (Prochaska & DiClemente, 1983; Prochaska, DiClemente, & Norcross, 1992; Prochaska & Velicer, 1997). It was critical that the center identify and help individuals who were receptive to making lifestyle changes. Consequently, emphasis was placed on identifying people in the contemplation, preparation, and action stages and tailoring interventions to eliminate barriers and address individual needs. Those in the maintenance phase were also included in the fitness and education programs because they often provided emotional support for those who were adopting new healthy behaviors. The PHHLC actually became its own close knit, small community, one which accepted everyone and supported lifestyle change among its members.

2.H. There is no process for performing baseline health assessments. Baseline results are an important tool in monitoring health improvement in clients and in evaluating health promotion interventions. In the fall of 2008, two nationally recognized fitness experts, Wayne L. Wescott, Ph.D. and Barry Franklin, Ph.D, visited the PHHLC and met with PHDMC staff and leadership. Both were resolute about the need for the Center to adopt a structured fitness outcome measurement program (Wescot, personal communication, Sept. 25, 2008; Franklin, personal communication, October 23, 2008). The development of a baseline fitness test battery with regular follow up subsequently became a center priority that led the program manager to develop three research questions: (1) What outcome measures cited in the literature are most commonly used to assess the effectiveness of a fitness intervention for a client age 16 or older;
(2) What outcomes measures are actually being used at community-based fitness centers in the Dayton area; and (3) What is the best combination of measures to use at the PHHLC?

The program manager began to answer these questions by reviewing two nationally accepted texts on the subject, Measurement and Evaluation in Human Performance (Morrow, Jackson, Disch, & Mood, 2005) and the American College of Sports Medicine’s (ACSM) Guidelines for Exercise Testing and Prescription (ACSM, 2006). She also researched nationally accepted guidelines and practices on pre-participation health screening and fitness testing (O’Donnell, 2005). After completing this review, she was able to identify and subsequently implement fitness centers best practices. This included: (1) requiring that services be provided by fitness instructors with certifications from nationally recognized fitness groups like the YMCA and the American College of Sports Medicine (this became a requirement for hiring new staff); (2) Risk stratifying clients prior to exercise by requiring clients to complete a Physical Assessment Readiness Questionnaire (PAR-Q) (Appendix C) (those with positive responses were required to get a physician’s release prior to exercise); and (3) Having an emergency plan in place that was regularly exercised (this included having an AED on site and requiring all staff to have CPR certification).

The program manager also worked with Stephanie Leung to develop an inventory of tests to include in the PHHLC’s outcome measurement program. This list was extensive, but since the tests were going to be implemented at a community-based fitness center, some options were easily eliminated because the center did not have access to the human, financial and/or materials resources to do them. An example would be measuring body fat through underwater submersion.
On January 16, 2009, the program manager, the health commissioner and the assistant to the health commissioner met with local fitness authorities, Dr. Lloyd L. Laubach, Ph.D., associate professor and former department chair, Department of Health and Sport Science, University of Dayton and PHDMC board of health member and Ms. Billie Sanders, chair, Department of Exercise, Nutrition, and Sport Sciences at Sinclair Community College. All meeting attendees agreed that a “comprehensive” baseline fitness testing and measurement process needed to be implemented. Multiple ideas were discussed and a decision reached that further research was needed. The challenge was to find “balance” between the ideal system for outcome collection and what is doable in a resource limited, community setting like Public Health’s Healthy Lifestyle Center. A follow up meeting with Dr. Laubach, Stephanie Leung, PHHLC’s lead fitness instructor, and the program manager was held to refine the test battery. A second draft was developed and forwarded to leadership for review. The matrix was finalized in March 2009. A plan and timetable for implementing the assessment process was presented to PHDMC leadership and the first assessment was completed in April 2009 by Ms. Leung.

For the next year, PHHLC staff would meet regularly and assess the strengths and weaknesses of the assessment process and changes were implemented. To track membership and assessments results, a database was created and populated with data. This helped to improve the program manager’s ability to track and report center outputs. Despite these efforts, showing measurable health improvement outcomes proved to be challenging throughout the 3 year pilot period. The reasons for this were multi-faceted, but simply stated there was a high drop-out rate among new members so longitudinal data was hard to come by in these new initiators.

3.D. Establishing new linkages with existing PHDMC programs to strategically align resources and activities. When the Healthy Lifestyle Center concept was presented to the
Montgomery County board of health, it was stated that the program would offer fitness services to the Center for Alcohol and Drug Addiction Services (CADAS) and the Diabetes Education and Prevention Program (DEPP). In May 2008, PHHLC staff began offering 60 minute, structured, group fitness services on Mondays, Wednesdays and Fridays to the inpatient CADAS adolescent program housed at Elizabeth Place. The service was provided by the lead fitness instructor between 1:00 and 3:00 p.m. when the center was closed. These classes were considered a reward for the inpatients and participation from 2 to 8 teens. In August 2008, the staff began offering fitness classes to clients enrolled in the PHDMC DEEP. The DEPP consisted of two phases; a sixteen week, introductory (meet once a week) education program and a “maintenance” program that followed successful completion of phase 1 classes. Neither program was evidence-based. DEPP program participants could attend free, optional low impact fitness classes that were held by the lead fitness instructor in the PHHLC education room two days a week following the normal DEPP classes. The center also implemented a reduced fee incentive program for the DEPP clients to become PHHLC members. In this way, they could access the full spectrum of PHHLC fitness services including blood pressure monitoring and access to the fitness equipment.

3.E. Developing, implementing and sharing healthy lifestyle best practices. One of the PHHLC’s greater achievements was developing a referral pathway between the Community Health Centers of Greater Dayton (CHCGD) and the PHHLC. The CHCGD is a nonprofit organization founded in 2007 through collaboration between two hospital systems and PHDMC. It was formed to improve access to high-quality, affordable primary health care in Dayton and operates from the Dr. Charles R. Drew Health Center, the Corwin Nixon Health Center, and the East Dayton Health Center.
Intertwining the worlds of doctors and fitness professionals into one model platform for assuring optimum health and fitness has long been a vision for healthy lifestyle proponents. Primary care providers fully comprehend the importance of physical activity in maintaining health but openly acknowledge that they have minimal training in the development of exercise plans and are often not aware of community resources. On the other hand, fitness instructors are engaged in marketing their services, but have not traditionally associated with health care providers. Although the two professions share a common interest, preventing disability and maximizing health, the link has not been made let alone formalized. The American College of Sports Medicine (ACSM) and American Medical Association’s (AMA) Exercise is Medicine® (EIM) campaign was designed to facilitate that process and membership was free.

On March 17, 2009, PHDMC became the first local public health agency in the United States to become a supporting member Exercise is Medicine® (EIM) (Exercise is Medicine® Global Initiative, 2008). There were two stages to the EIM project as implemented in Dayton. The first objective was to become the nation’s first local public health agency to meet the EIM guidelines for becoming a “supporting member”. In December 2008, the PHHLC program manager identified the EIM program on the ACSM website and during the next four months, drafted and disseminated a discussion document to brief PHDMC leadership as well as key stakeholders on the EIM program. Multiple meetings were held with stakeholders and the support was overwhelming. EIM’s guiding principles were adopted, action steps were taken, and supporting member status achieved through board of health approval.

The second objective was to operationalize EIM. This was accomplished by working with the CHCGD to develop and initiate a system for patients to be assessed and referred by physicians to the PHHLC where they received individualized fitness assessment and counseling
by certified fitness instructors. To facilitate referrals an exercise prescription pad was developed and distributed and CHCGD physicians and staff were briefed on the screening and referral process (Figure 10). Between June 2009 and November 2011, ninety-eight CHCGD clients received a low cost ($10), 90-minute baseline fitness assessment and individualized exercise counseling at the PHHLC.

Figure 10. Exercise is Medicine® prescription pad developed by PHHLC staff in 2009.

This EIM collaboration was an innovative way to reach underserved populations who could benefit most from increased physical activity. Developing this new partnership required flexible protocols to accommodate diverse groups, provider awareness of community-based exercise resources and outreach efforts supported by public health. Activities in the second half of 2011 focused on continued use of the prescription pads, holding regular meetings with CHCGD staff and providers to encourage exercise prescription, developing a mechanism for measuring and reporting patient outcomes and improving patient compliance.
PHHLC staff felt that the EIM pilot had potential to be replicated in other sites and should be shared with others. In 2011, staff submitted an application to the NACCHO describing the EIM pilot program with the CHCGD and it was awarded “promising practice” status. Having the PHHLC link with the CHCGD through EIM was a great example of supporting PHDMC’s mission of “leading and innovating by working with community partners to achieve the goals of public health”.

**Did the Center Accomplish its Goals?**

The PHHLC’s 3 year pilot phase was scheduled to end in January 2011. As part of her annual planning and review the program manager submitted a revised SWOT to PHDMC leadership in March 2010. She sensed a need to begin making her case for continued funding based on an external “threat”; the economic conditions in Montgomery County had deteriorated over the 24 month period. Unemployment was increasing, the housing market was in trouble and property values were dropping. She knew that a levy issue would be on the ballot in November 2010 and that the likelihood of reductions in PHDMC’s 2012 allocation was high. As a matter of fact, the question really wasn’t whether there would be cuts, but how much and who would be impacted. The timing really could not have been worse for the PHHLC.

The manager felt that center accomplishments warranted continued Human Services Levy funding in 2011, and she used the SWOT to frame her justification (Figure 10).
**Strengths** (Internal: Keys to past and future successes of the program):
- Tangible evidence of Public Health – Dayton & Montgomery County’s leadership role in improving community health through innovative health promotion/healthy lifestyle programs
- Meets a validated community need (physical inactivity)
- Fills unique market “niche”:
  - Site location
    - Easily accessible to Carillon and surrounding urban Dayton neighborhoods including the Job Center
    - Elizabeth Place campus houses more than 60 businesses/organizations many of which serve at-risk clients (i.e. highly concentrated, at-risk community)
    - On RTA bus route
    - Highly visible outdoor signage
    - Free parking
  - Innovative and leading program/establishes best practice model
  - Professional, individualized customer fitness services provided by certified fitness instructors
  - Sliding membership fee scale based on household income
  - Risk stratification
  - Biometrics (including blood pressure monitoring)
  - “Non competitive”/accepting environment
- Member satisfaction (as evidenced by survey and self report) is very high resulting in considerable word of mouth referral/marketing
- Exercise is Medicine™ and other relationships forged with external partners
- Staff/contractor diversity, expertise and commitment (including nurturing “a learning organization” culture and leading by example)
- College student internships, observation time and mentoring programs (UD, WSU and SCC)
- Facility safety record and ability to effectively respond and address unique/abnormal situations
- Ability to tailor fitness programs to individual needs

**Weaknesses** (Internal: Potential problem areas that impact growth):
- Data collection, tracking and reporting (includes short and long term follow up)
- Effectively quantifying/qualifying operating expenses through outcome measures based on health improvement
- Member retention rates
- Program relies heavily on developing and maintain personal relationships (staff/contractor support of client)
- Slow progress in shifting program focus from chronic disease management to disease prevention
- Effective linkages with other PHDMC programs (leading to new member referrals)
- Identifying and effectively addressing member “nutrition” issues
- High net cost per member encounter as compared to other community based fitness centers
- Inability to respond to requests from internal (PHDMC) and external partners for fitness and wellness programs.

**Opportunities** (External: Potential areas for growth):
- Increased focus at the national, state, and local levels on the cost effectiveness of “wellness” as opposed to disease treatment
- Increased/Improved collaboration with external partners with an interest in establishing effective, measurable “wellness” and health promotion programs
- Ability to create, operationalize and enhance healthy lifestyle best practices
- External grant funding
- To establish PHDMC as a health promotion/healthy lifestyle leader and innovator

**Threats** (External: Outside factors to be corrected or limited):
- Economics
  - Human Service Levy funding streams and potential PHDMC program budget cuts
  - Disposable income (i.e. ability to pay membership fees ranging from $10 to $25 a month)
  - Transportation costs (including Project Mobility and RTA)
  - Elizabeth Place bankruptcy and potential fees for visitor parking
- Competition for market share
- Loss of “trained” human resources attributable to temporary re-assignment of termination resulting in the need for a reduction of service/hours and loss of program momentum

*Figure 11.* SWOT Analysis completed by Kathy Blossom, Stephanie Leung, and Brenda Alexander and submitted to PHDMC leadership, March 2010.
Center staff worked diligently to develop and refine policies and procedures through research, expert opinion and literature, as well as member feedback, and a process of trial, error and improvement. Specific examples included increasing and adjusting hours of operation, employing a sliding fee membership schedule, developing and holding nutrition education and wellness classes, and most notably developing and implementing an outcome measurement program. In addition to these health promotion activities center staff were able support PHDMC’s vision by mobilizing community action through partnerships. During the first two years of operation, PHHLC staff worked with more than 20 different community-based organizations including the Carillon Neighborhood and Business Associations, the Life Enrichment Center, and East-End Community Services and researched ways to strengthen those

In summary, during its 25 months of operation, the PHHLC was able to differentiate itself from traditional fitness centers: (1) It was located in a highly underserved, urban area; (2) It addressed the needs of people who normally do not or could not access fitness equipment and services; (3) Membership fees were adjusted so that they were based on household income and were significantly less ($10 to $25 a month) than other fitness centers; (4) There were no written contracts/multiple month membership commitments required; (5) Clients were risk stratified (i.e. those with pre-existing medical conditions were identified and approval to begin an exercise program was obtained from the client’s physician); (6) Blood pressures were monitored pre- and post-exercise for those who were at increased risk for cardiovascular complications; (7) Members received regular, personalized fitness assessments based on their physical conditions and wellness goals; and (8) Services were provided by fitness instructors that had certifications from nationally recognized fitness groups like American College of Sports Medicine (American College of Sports Medicine [ACSM], 2013).
After thoughtful consideration, PHDMC leadership agreed to recommend continued funding for the program and the Montgomery County board of health approved the 2011 budget. Despite this positive news, PHDMC leadership had some reservations about the PHHLC program and its long term sustainability. The cost per encounter was high and new member retention particularly referrals from the Exercise is Medicine® initiative needed to improve, and demonstrating measurable improvement in individual health had proved to be challenging.

The program manager felt that some of these weaknesses could be addressed by making some minor process changes and streamlining the assessment process to make it less time consuming. In addition, implementing more rigorous screening for the EIM program had promise as did expanding the PHHLC outcome measurement program to other facilities like the Life Enrichment Center in East Dayton. The program manager was confident that the PHHLC was on the right track, but given the likelihood of budget cuts in 2012, she knew difficult funding decisions would have to be made by PHDMC leadership.

The question became, what could be done over the next six months to leverage program strengths and address weaknesses while moving aggressively forward with opportunities that could help to differentiate the program from other fitness centers. Reducing costs was a priority. The Elizabeth Place lease was approximately $40,000 a year. One possibility was to relocate to a new site where rent was low or possibility free. With assistance from the PHDMC supervisor of purchasing and facilities, a site in East Dayton was identified and in May, a move feasibility
study was commissioned. The results of the study were not shared with the program manager but the move was not approved.

In May, the PHHLC’s program manager sustained a serious back injury that required surgery and an extended leave of absence. Given the situation, the timing could not have been worse. The loss of a key staff member meant that all center staffing resources would have to focus on operations, not planning. Upon her return to the center in October, it was very apparent that the center was continuing to operate as it had in the past, but was that going to be enough? Although the center had been funded for 2011, 2012 was undecided.

Montgomery County is one of two counties in the state (the other being Cuyahoga County) that uses a consolidated levy to fund major human service needs: mental illness and substance abuse, mental retardation/developmental disabilities, children services and public health. There are strengths to this consolidated levy process; however, the downside is that during hard economic times, PHDMC competes for funding against organizations that are seeing increased need for basic services. The county spends approximately $104 million annually on these services and an additional $31 million on services for the frail elderly, the homeless, indigent ill, juvenile court, at-risk youth and other needs (Smith, 2010). Rather than having one levy and risking loss of all funding, the levies are broken into two parts. Each one runs for eight years with one expiring at the mid-point of the other. Levy A, a 7.21 mill property tax, was approved by voters in 2007 and generated approximately $75.6 million a year. Levy B expired at the end of 2010, with collection continuing through 2011. After performing a situational analysis, the Human Services Levy Council estimated $50 million additional dollars were needed to cover reductions in state funding and to meet an increasing need for social services. That would have equated to a need for a 5 mill increase which was not realistic given the existing
economic conditions. After thoughtful consideration, the council settled on a replacement levy/no millage increase. This decision meant that even if the levy passed, funding to services that were not mandated by the state, would have to be evaluated and cuts made. In November 2010, Issue 9, the replacement levy, passed.

Another way to reduce the PHHLC budget was to reduce payroll. In November 2010, the program manager, chose to apply for another position within the health department. In December, she was hired to work as the project manager for strategic planning and accreditation. This was a lateral move and was done as a last ditch effort to save personnel in case the center closed. The job shift made it possible for the PHHLC’s lead fitness instructor to assume a new position, PHHLC coordinator. It also allowed the contractor to be hired as a PHDMC fitness instructor. Staffing was reduced from 2.0 FTEs and a contractor to 2.0 FTEs and there were changes to position classifications/job descriptions that also contributed to a line item reduction in wages and benefits. Overall expenses decreased. 2011 would be a critical year for the PHHLC.

Decision to End the Program

Early in 2011, the health commissioner was notified by the Human Service Levy Council that budget cuts for 2012 and beyond were eminent and to plan for a worst case scenario of a 20% budget cut. Subsequently, PHDMC leadership began the difficult task of defining the process for determining how to address reductions. A Guideline for Managing Grant Funding Reductions had been finalized in May 2010 by the PHDMC Executive Team to address reductions in state and federal grants (Figure 12).
Guideline for Managing Grant Funding Reductions

Considerations for Program Continuation using General Funds

1. Program is mandated
2. Program is a core function / essential public health service
3. Program is consistent with PHDMC mission, vision and strategic direction
4. Program provides an unmet need as outlined in the Community Health Assessment
5. Program is not a duplication of services provided by other community partners
6. Program currently implements best practice, evidence-based public health interventions
7. Program interventions focus on primary and secondary prevention
8. Program is cost-effective and efficient
9. Program has clearly defined objectives and demonstrates measurable outcomes

**Figure 12.** Guideline for Managing Grant Funding Reductions developed by the PHDMC executive team.

In the spring of 2011, this model and evaluation process was expanded to create another set of standards, Guidelines for Managing Human Services Levy Funding which was applied to all non-grant funded programs (Figure 13).
Figure 13. Guideline for Managing HSL (Human Services Levy) Funding Reductions developed by the PHDMC executive team.

In June, 2011 all PHDMC programs underwent an extensive review process. Each aspect of program evaluation for Human Service Levy funding will be discussed separately as it pertains to Public Health’s Healthy Lifestyle Center.

1. Program is mandated. In the state of Ohio, health education is mandated: “(7) Provision of services for health education” (State of Ohio, n.d. - Administrative Code 3701-36-03). PHHLC staff educated members and taught skills as a part of daily operations. In addition, staff also offered an assortment of scheduled healthy lifestyle classes to community groups both on and off-site. However; it should be noted that health education services were also provided by other programs within the health department. Hence, the program is not “mandated” in code.
2. **Program is non-levy funded.** The PHHLC was 100% levy funded.

3. **Program is consistent with PHDMC mission, vision and strategic direction.** The mission of Public Health – Dayton & Montgomery County is to lead and innovate by working with community partners to achieve the goals of public health: prevention, promotion, and protection. The PHHLC supported the mission through the a-fore-mentioned innovations and by developing new linkages with community partners.

4. **Program is a core function/essential public health service.** Promoting healthy behaviors is a core function of public health.

5. **Program is designed to improve population health** (i.e. reduces diseases/conditions that have the greatest impact on Montgomery County citizens as outlined in the Montgomery County Community Health Assessment, 2010 (PHDMC, 2011). The PHHLC was a program that focused on addressing the needs of individuals and providing a high level of service. As such, the population impact was negligible.

6. **Program is not a duplication of services provided by other community partners** (i.e. PHDMC is the sole community provider). Views in regards to the PHDMC community “niche” were very diverse. Some felt that it served a unique community need and should be given additional time and funding to further improve and evolve. Others strongly felt that it was a duplication of services provided by others groups and that the program should be terminated and members referred to other fitness centers and facilities.

7. **Program currently implements best practice, evidence-based public health interventions.** The PHHLC was able to develop some innovative practices. Some of these became promising practices, but not model (i.e. showing measurable outcomes).
8. **Program interventions focus on primary and secondary prevention.** PHHLC activities focused on primary and secondary prevention; however, many clients had pre-existing conditions like obesity, high blood pressure, diabetes, and heart disease.

9. **Program is cost-effective and efficient.** The program was deemed to not be cost effective when compared to other fitness facilities.

10. **Program has clearly defined objectives and demonstrates measurable outcomes.** The PHHLC had goals and objectives that were “output” based. As previously stated, showing measurable behavioral outcomes was a challenge.

The Priorities for Transitioning/Abolishing Programs and/or Positions included:

1. **Programs that other community providers will accept (thereby saving Human Services Levy funds).** Other community agencies agreed to accept members from the PHHLC.

2. **Programs that are not cost-effective.** The PHHLC was deemed to not be cost effective when compared with other “traditional” fitness centers.

3. **Programs that do not show meaningful outcomes and cannot be readily changed to an evidence-based best practice model.** During the first three years of operation, the PHHLC was not able to show measurable outcomes.

4. **Programs that do not clearly align with the PHDMC mission, vision, strategic direction and priorities outlined in the “Montgomery County Community Health Assessment, 2010”**. The PHHLC aligned with PHDMC’s mission, vision, and strategic direction. Physical inactivity and reducing preventable chronic disease were all high priority areas identified in the Assessment (PHDMC, 2011).

After extensive and thoughtful deliberation, in August 2011 a decision about the future of Public Health’s Healthy Lifestyle Center was reached by PHDMC leadership. A
recommendation was made to and approved by the Montgomery County board of health for the center to be closed effective Friday, December 16, 2011. A facility closure plan was developed and implemented. Main components included: (1) individually notifying members of the closure and referring them to other fitness providers; (2) notifying other key stakeholders; (3) making a public announcement in the Dayton Daily News; (4) terminating the lease with Elizabeth Place; and (5) disposing of the equipment and other assets. This was only one of many county-wide cuts in health-related services to Montgomery County residents due to loss of county income (Morris, 2011).

Active members were notified of the closure by the PHHLC coordinator. When possible, the staff met individually with clients to encourage them to maintain their healthy lifestyles and to refer them to other community-based fitness centers in the County. Center stakeholders were notified by the assistant to the health commissioner and the PHHLC program manager through formal and well as informal channels (i.e. meetings, phone calls, emails.) On Saturday, December 3, 2011, the lead article of Section B in the Dayton Daily News focused on the PHHLC closure. 1st Casualties of Agency Cuts: Community Gym and 15 Jobs summarized the impact that state budget cuts and lower property values were to have on PHDMC’s ability to carry on services. This included the loss of 15 PHDMC employees. “This is just the start. The impact will be felt through all our different programs”, said Health Commissioner, James Gross (Smith, 2011, second paragraph).

On a positive note, some of the center’s exercise equipment was donated to not-for-profit community agencies including the Life Enrichment Center and East End Community Services which serve at-risk clients in East Dayton. Most notably, the PHHLC coordinator and fitness
instructor were retained as full time Public Health employees, relocated to offices in the Reibold Building in downtown Dayton, and reassigned to work on GetUp Montgomery County activities.

Recommendations and Lessons Learned

In the past, most healthy lifestyle interventions focused on education and skill-building which was the case at the PHHLC. Despite well intentioned efforts, by and large this approach did not yield measurable health improvements in member health outcomes during the four years of PHHLC operation. This lack of success can be largely attributed to public health’s greatest challenge, changing human behavior, and a flawed operating assumption that members would be receptive to being measured. There are no easy solutions to either of these dilemmas.

In addition to economics, the PHHLC was a casualty of a national prevention paradigm shift. The absence of positive outcomes and the high costs that are frequently associated with individual and small group interventions led to a new movement which focused on improving population health by addressing socioeconomic and other factors that make healthy lifestyle choices easier to make (Frieden, 2010). Federally funded initiatives like the Creating Healthy Communities Program (CHCP), Active Communities for Health, Innovation and Environmental Change (ACHIEVE), Communities Putting Prevention to Work (CPPW), Racial and Ethnic Approaches to Community Health (REACH) and the Community Transformation Grant (CTG) focus on reducing preventable chronic disease through population based intervention on the mid and lower levels of the Health Impact Pyramid (Figure 14). Additional information on these initiatives can be found on their eponymous CDC websites (http://www.cdc.gov/healthycommunitiesprogram/ and http://www.cdc.gov/communitytransformation/).
To access these grant funds, public health agencies throughout the country are in the process of transitioning health promotion programming from education and clinical intervention towards working with community partners to implement policy, systems and environmental (PSE) change strategies. This “transition” from one-on-one or small group service provision/programs to facilitating population and/or system change is a radical transformation for local health departments, not only in regards to how health promotion is practiced, but also in regards to the infrastructure needed to perform and evaluate the work.

Figure 14. Health Impact Pyramid (Frieden, 2010).

With this said, the question becomes is there a role for counseling and education and if the answer is “yes”, what is the best mix of strategies to improve population health in Montgomery County? The evidence-base suggests there is a role for these interventions, but that they must focus on at-risk populations and be targeted. A good example is CDC’s evidence-based National Diabetes Prevention Program (CDC, 2012) that PHDMC began offering in April
2013. If the PHHLC had been integrated into a multi-level strategy to improve population health would the decision to close have been different? In 2010, PHDMC received and began implementing a Creating Healthy Communities Program in East Dayton and in 2011 it received a Community Transformation Grant focused on Montgomery County. GetUp continues to operate but has transformed from what was largely a social marketing campaign in 2007 to a program that uses a sector based approach to help organizations to implement policy, systems and environmental change strategies. Unlike any of these programs, the PHHLC served as a visible, tangible base of operations for PHDMCs health promotion activities. It directly served an at-risk population, and the site location, hours, and fee structure were tailored to reduce barriers to participation. The fitness services provided were high quality and individualized to meet member needs and remove barriers to participation. The program directly served the community including individuals who vote for the Levy.

The PHHLC served as a multidisciplinary laboratory for developing and implementing education and skill building programs which helped contribute to the evidence base and public health practice. Through internships and practice placements, PHHLC staff mentored more than 20 college students from Wright State University (MPH, nursing, medicine), the University of Dayton (Exercise Science), and Sinclair Community College (nursing, exercise, nutrition and sport sciences). Many of these students are now practicing in the community and are advocates for Public Health and prevention.

The PHHLC was a unique program within PHDMC because it embraced and embodied the culture of a learning organization (Senge, Kleiner, & Roberts, 1994). It became a place where staff and students could expand their capacity to create results, where innovation was welcomed, and where system rather than silo thinking was nurtured. To her credit, the program
manager served as the designer for the learning organization. She created a common vision, she determined the policies, strategies and structures that translated ideas into business decisions and created effective learning processes that allowed for continuous improvement of policies, strategies and structures (Smith, 2001). The importance of establishing this learning environment cannot be understated. During her leave, staff was able to step in and up and operate the center. They were seen by PHDMC leadership as team players and as valuable assets not only to the PHHLC but to the agency. For this reason, when the PHHLC closed, staff was reassigned to work on other PHDMC health promotion programs. Given the reductions occurring within U.S. public health agencies throughout the U.S., the importance of maintaining institutional knowledge cannot be understated. Within PHDMC this challenge is compounded since many of the staff are eligible for or are close to retirement. Mentoring and coaching new employees while fostering team building will be critical to ensure that the agency is able to effectively provide essential services in the future.

In March 2012, the Exercise is Medicine® initiative with the Community Health Centers of Greater Dayton was named as a “Promising Practice” by the NACCHO. When the PHHLC closed in December 2011, a process was developed for the CHCGD to refer patients to other fitness facilities. This new process was never implemented. It is unfortunate that the EIM program no longer exists since it would be such an excellent fit with new models of primary healthcare like patient centered medical homes. The concept should be revisited.

The decisions that public health leaders, particularly health commissioners make on a daily basis can be very difficult and the ramifications very impactful. This was the case in 2010 and 2011 when the agency was faced with unprecedented budget reductions. Every effort was made to reduce capital and operating expenses without cutting positions. PHDMC leadership
should be recognized for their efforts to maintain services and reduce costs while minimizing the
toll on staff. While the closure of PHHLC was disheartening for PHDMC leadership and staff as
well as the members, the change in PHDMC’s priorities and shift of resources signifies the
beginning of a new public health approach to promoting healthy lifestyles and reducing
preventable chronic diseases in the larger community. Simply stated, the needs of the many
outweigh the needs of the few when population health improvement is the goal and maybe more
importantly, the expectation of the taxpayers that local health districts serve. Population health
improvement through innovation and the implementation of policy, systems and environmental
change strategies is public health’s future; however, it is important to not forget that evidence-
based programs that provide direct services also has a role.
References


http://www.mcohio.org/services/fecf/annual_progress_reports/docs/2012_FCFC_annual_report.pdf


http://www.mcohio.org/services/fecf/annual_progress_reports/docs/FCFC_08_ProgressReport_final.pdf


U.S. Census Data, 2000 Census of Population and Housing.

http://www.ci.dayton.oh.us/planning/Documents/2000%20CensusPDFs/Innerwest/SF3carillon.PDF
Public Health’s Healthy Lifestyle Center

One Elizabeth Place, West Medical Plaza, Lower Level, Dayton, OH 45417

Public Health's Healthy Lifestyle Center at Elizabeth Place offers fitness services and wellness classes to the community. Convenient and affordable, the Center provides a safe, supportive, and nurturing environment for adults to exercise. Unlike most fitness clubs, there are no contracts to sign. Memberships are based on a sliding fee scale ranging from $10 to $25 a month. Fees can be paid by cash or check. The Center is staffed by trained fitness instructors. Members have access to treadmills, exercise bikes, Nu-Step, rowing and elliptical machines, an upper bike ergometer, weight lifting equipment, Swiss balls and free weights. Clients are encouraged to participate in instructor led exercise classes. Locker rooms with showers are available for use by our members.

Hours of operation:
Monday: 8:00 a.m. to 1:00 p.m. and 3:00 p.m. to 6:30 p.m.
Tuesday: 8:00 a.m. to 1:00 p.m. and 3:00 p.m. to 6:30 p.m.
Wednesday: 8:00 a.m. to 1:00 p.m. and 3:00 p.m. to 6:30 p.m.
Thursday: 8:00 a.m. to 1:00 p.m. and 3:00 p.m. to 6:30 p.m.
Friday: 8:00 a.m. to 1:00 p.m.
Saturday and Sunday and all Federal holidays: Closed

Where are you located?
Public Health’s Healthy Lifestyle Center is located at One Elizabeth Place (the old St. Elizabeth’s Hospital/ Franciscan Medical Center) in the lower level of the West Medical Plaza. Visitor parking is free and is located outside the entrance. Elizabeth Place also has regular RTA bus service through bus #9.

Who can join?
Clients of the HLC must be at least 16 years of age. To ensure safety, each potential member will be asked to complete a Physical Activity Readiness Questionnaire (PAR-Q). Based on these results, our staff may ask for a physician’s written approval before you are able to exercise. In addition, members who use the fitness equipment and weights need to be able to function independently, without one-to-one assistance or direct supervision from Healthy Lifestyle Center staff. We do not provide personal training services at the Center, but will assist in developing a fitness program that is tailored to your individual needs. Visitors are welcome to tour the facility, but prior to starting your exercise program we you need to call 224-8915 to schedule a fitness assessment and an equipment orientation.
Appendix B: Public Health’s Healthy Lifestyle Center Map

Public Health’s
Healthy Lifestyle Center
One Elizabeth Place, West Medical Plaza, Lower Level, Dayton, OH 45417 224-8915

Where are you located?

From the South: I-75 North to exit 51 Edwin C. Moses Boulevard exit. Turn right at exit. Go past University of Dayton Arena. Turn left at Dayton Heart & Vascular Hospital at Albany Street. Go 1/10 mile and turn right on Elizabeth Place. Follow the signs to visitor parking.

From the North: I-75 South to exit 51 Edwin C. Moses Blvd. Exit. Turn left at exit. Go past University of Dayton Arena. Turn left at Dayton Heart & Vascular Hospital at Albany Street. Go 1/10 mile and turn right on Elizabeth Place. Follow the signs to visitor parking.

Other information: Visitor parking is free and is located outside the entrance (see map directly below). Follow the signs to Public Health’s Healthy Lifestyle Center. Elizabeth Place also has regular RTA bus service through bus #9.

Hours of operation:
Monday: 8:00 a.m. to 1:00 p.m. and 3:00 p.m. to 6:30 p.m.
Tuesday: 8:00 a.m. to 1:00 p.m. and 3:00 p.m. to 6:30 p.m.
Wednesday: 8:00 a.m. to 1:00 p.m. and 3:00 p.m. to 6:30 p.m.
Thursday: 8:00 a.m. to 1:00 p.m. and 3:00 p.m. to 6:30 p.m.
Friday: 8:00 a.m. to 1:00 p.m.
Saturday and Sunday: Closed
Public Health’s Healthy Lifestyle Center

New Member Materials Checklist

Paperwork to complete before baseline assessment and orientation:

☐ PHHLC Informational Flier (with hours of operation)
☐ Member Contact Information Sheet (Required)
☐ Member Demographic Sheet and Questionnaire (Required)
☐ Physical Activity Readiness Questionnaire and You, PAR-Q (Required)

☐ If no, no further action needed
☐ If yes:

☐ Physician’s Faxed Release or
☐ Physician’s Referral Form

☐ Confidentiality and Consent to Use of Information
☐ Public Health – Dayton & Montgomery County, Notice of Privacy Practices
☐ What to Expect: Your Healthy Lifestyle Fitness Assessment

Paperwork to complete during the baseline assessment and orientation:

☐ Informed Consent to Exercise (Required)
☐ Sliding Fee Discount Application (Required)
☐ Baseline Fitness Assessment Results (Required)
☐ Fitness Goals (Optional)
Public Health’s Healthy Lifestyle Center

Member Contact Information Sheet

Please print the following… Date of Form Completion: ________________

Name: ___________________________ Date of Birth: ________________

Gender: M  F

Home Phone: ______________________ Mobile Phone: ______________________

Home Address: ______________________

City: __________________ State: __________ Zip: ________________

Employer: __________________ Work Phone: ______________________

Work Address: ______________________

City: __________________ State: __________ Zip: ________________

Preferred Email: __________________ or Not Applicable

In case of an emergency situation, I grant my permission for you to contact:

First Emergency Contact Name: ______________________

Primary Phone: ________________ Secondary Phone: ______________________

Second Emergency Contact Name: ______________________

Primary Phone: ________________ Secondary Phone: ______________________

Family Physician Name: ______________________

Family Physician Office Phone: ______________________ Fax: ________________

Family Physician Address: ______________________

City: __________________ State: __________ Zip: ________________

Data Entered by: __________________ on: __________________

Last Updated: ________________
Public Health’s Healthy Lifestyle Center
Member Demographic Sheet & Questionnaire

1. Are you Hispanic or Latino?
   ___ Yes ___ No

2. Which one or more of the following would you say is your race? (Please check all that apply)
   ___ White
   ___ American Indian or Alaska Native
   ___ Black or African American
   ___ Other (specify) __________________________
   ___ Asian
   ___ Don’t know/Not sure
   ___ Native Hawaiian or Other Pacific Islander

3. Are you...?
   ___ Married
   ___ Separated
   ___ Divorced
   ___ Never married
   ___ Widowed

4. How did you first hear about Public Health’s Healthy Lifestyle Center? (Mark all that apply)
   ___ From a family member/friend/coworker
   ___ From a physician, nurse, or other medical professional
   ___ From the newspaper
   ___ From the TV
   ___ Building Tenant/Outdoor signage
   ___ Other (Please list): __________________________

5. What is the highest grade or year of school you have completed?
   ___ Never attended school or only attended kindergarten
   ___ Grades 1 through 8 (Elementary)
   ___ Grades 9 through 11 (Some high school)
   ___ Grade 12 or GED (High school graduate)
   ___ College 1 year to 3 years (Some college or technical school)
   ___ College 4 years or more (College graduate)

6. Are you currently...? (Please check all that apply)
   ___ Employed
   ___ Self-employed
   ___ Out of work for more than 1 year
   ___ Out of work for less than 1 year
   ___ A student
   ___ A homemaker
   ___ Retired
   ___ Unable to work

Version 1; page 1; March 29, 2010
Physical Activity Readiness Questionnaire (PAR-Q) and You

Regular physical activity is fun and healthy, and increasingly more people are starting to become more active every day. Being more active is very safe for most people. However, some people should check with their doctor before they start becoming much more physically active. If you are planning to become more physically active than you are now, start by answering the questions in the box below. If you are between the ages of 15 and 69, the PAR-Q will tell you if you should check with your doctor before you start. If you are over 69 years of age, and you are not used to being very active, check with your doctor. Common sense is your best guide when you answer these questions.

Please read the questions carefully and answer each one honestly:

Check YES or NO

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YES to one or more questions
Your doctor must be contacted by phone, fax, or in person BEFORE you start becoming much more physically active or before you have a fitness assessment.
-- You may be able to do any activity you want—as long as you start slowly and build up gradually. Or, you may need to restrict your activities to those which are safe for you. Talk with your doctor about the kinds of activities you wish to participate in and follow his/her advice.

No to all questions
If you answered NO honestly to all PAR-Q questions, you can be reasonably sure that you can:
-- Start becoming more physically active—begin slowly and build up gradually. This is the safest and easiest way to go.
-- Take part in a physical assessment—this is an excellent way to determine your basic fitness so that you can plan the best way for you to live actively.

Delay becoming much more physically active
-- If you are not feeling well because of a temporary illness such as a cold or a fever—wait until you feel better: or
-- If you are or may become pregnant—talk to your doctor before you start becoming more active.

Please note: If your health changes so that you then answer YES to any of the above questions, tell your fitness or health professional. Ask whether you should change your physical activity plan.

I have read, understood and completed this questionnaire. Any questions I had were answered to my full satisfaction.

Print Name: ___________________________ Date: ___________________________

Signature: ___________________________ Home phone: ___________________________

Signature of Parent/Guardian (if under 18 years of age): ___________________________

Doctor’s Name: ___________________________ Doctor’s Phone: ___________________________

Witness Name: ___________________________ Witness Signature: ___________________________
I have received and reviewed the Public Health-Dayton & Montgomery County Notice of Privacy Practices, which provides information about how we may use and disclose, protected health information about you. I understand I have the right to review the notice prior to signing this Consent. As provided in our notice, the terms of our notice may change. If we change our notice, you will receive a revised copy.

Upon signing this Consent, you acknowledge that you maintain the following rights:

➢ To request a restriction as to how my protected health information is disclosed;
➢ To revoke this consent;
➢ To review Public Health’s Notice of Privacy Practices.

I also consent to the use of any information, which is not personally identifiable with me for research, and statistical purposes so long as it does not identify my person or provide facts, which could lead to my identification.

Signature of Client: ____________________________________________

Name of Client: ________________________________________________

Date: __________________________

Witness Name: ________________________________________________

Witness Signature: _____________________________________________
Public Health’s Healthy Lifestyle Center
What to Expect: Your Fitness Assessment

A Fitness Instructor will spend about 90 minutes with you to get to know you and your fitness goals. By doing this, we will do our best to help you reach those goals. The following is a list of information we may gather during the assessment:

- General Medical History (as a follow up to positive PAR-Q responses and physician recommendations)
- Exercise History
- Client Exercise Goal Sheet
- Physical Assessment
  - Blood Pressure
  - Heart Rate
  - Height
  - Weight
  - Body Mass Index
  - Circumference Measurements
  - % Body Fat
  - Muscular Strength Test
  - Muscular Endurance Test
  - Cardiovascular Endurance Test
  - Flexibility Test

INSTRUCTIONS FOR YOUR FITNESS ASSESSMENT

1. Please arrive on time.
2. Please bring all paperwork including any notes from a physician if not already turned in to staff.
3. Please bring income verification in the form of one of the following: copies of your federal income tax return, copies of two recent checks/stubs, W-2, public assistance or social security check/stub or Letter of Award or “proof” of zero or limited income.
4. Wear comfortable clothes that are loose fitting and gym shoes.
5. Allow 90 minutes for the assessment with the fitness instructor.
6. Do not drink alcohol, eat a heavy meal, consume caffeine, or smoke 3 hours before the assessment.
7. If on any medication take as prescribed.

SOME ADDITIONAL RECOMMENDATIONS

1. Bring a water bottle.
2. Bring a towel.
3. Get plenty of sleep (6-8 hours) the night before the test.

We have locker rooms available for changing and/or storing your belongings. We also sell cold bottled water for 50 cents a bottle.
HEALTHY LIFESTYLE CENTER
Informed Consent to Exercise
Release and Waiver of Liability

PURPOSE AND EXPLANATION OF PROGRAM

In order to improve my physical exercise capacity, general health, and well-being, I hereby consent to participate in a physical fitness program at the Healthy Lifestyle Center, which will include self-directed physical exercise with staff guidance. I will be given instruction regarding the amount and kind of exercise I should do. Staff will provide input to direct my activities, monitor my performance, and otherwise evaluate my effort to be certain that I am exercising at the recommended level. The levels of exercise I perform will be based upon my cardio respiratory (heart and lungs) and muscular fitness. I understand that I may be required to undergo a graded exercise test as well as other fitness tests prior to the start of my exercise program in order to assess my present level of fitness. If I am taking prescribed medications, I will so inform the staff and further agree to so inform them promptly of any changes which my doctor or I have made with regard to use of these.

I have been informed that in the course of my participation in exercise, I will be asked to complete the activities unless such symptoms as fatigue, shortness of breath, chest discomfort, or similar occurrences appear. At that point, I hereby have been advised it is my complete right to stop exercise and that it is my obligation to inform the staff of my symptoms. I recognize and hereby state that I have been advised that I should immediately upon experiencing any such symptoms or if I so choose, reduce or stop exercise and inform the staff of my symptoms.

I understand that during the performance of exercise, staff will periodically monitor my performance and perhaps measure my pulse and blood pressure or make other observations for the purposes of monitoring my progress and/or condition. I also understand that the staff may reduce or stop my exercise program, when findings indicate that this should be done for my safety and benefit.

I also understand that during the performance of my exercise program, physical touching and positioning of my body may be necessary to assess my muscular and bodily reactions to specific exercises, as well as ensure that I am using proper technique and body alignment. I expressly consent to physical contact for these reasons.

POSSIBLE RISKS AND DISCOMFORTS

It is my understanding, and I have been informed, that there exists the possibility during exercise of adverse changes including, but not limited to, abnormal blood pressure, fainting, disorder of heart rhythm, and very rare instances of heart attack, stroke, or even death. I further understand and I have been informed that there exists the risk of bodily injury including, but not limited to, injuries to the muscles, ligaments, tendons, and joints of the body. Every effort, I have been told, will be made to minimize these occurrences by staff assessment of my condition, staff guidance during exercise, and my own careful control of exercise effort. I have also been informed that emergency personnel will be immediately contacted by phone should an emergency situation occur. I understand that there is a risk of injury, heart attack, stroke, or even death as a result of my exercise, but knowing those risks, it is my desire to participate as herein indicated.
Healthy Lifestyle Center

One Elizabeth Place
West Medical Plaza, Lower Level
Dayton, OH 45417
(937) 224-8915

It is the policy of the Healthy Lifestyle Center to provide fitness services and wellness education to clients based on their ability to pay. The standard monthly fee for members is $25 which is payable by cash or check within 10 days of the beginning of the month.

Fee discounts are offered to individuals living in households with combined gross income of less than 2.5 times the annual Federal Poverty Guidelines. The minimum membership fee is $10 a month.

If you prefer to not participate in the sliding fee scale program, please sign the following waiver and return this form to a staff member. If your financial situation changes, you may "re-apply" for a sliding fee discount.

If you are unable to make a membership payment, please contact the Healthy Lifestyle Center Program Administrator prior to the due date to discuss your need to modify your payment schedule. The Healthy Lifestyle Center reserves the right to terminate membership for failure to pay.

Waiver:
I choose not to provide the following information at this time. I am waive my right to any discount to which I may otherwise be entitled.

---

Member Name (Please Print)       Signature of Member       Date

SLIDING FEE DISCOUNT APPLICATION

For us to determine the percentage for which you qualify, please complete the following information and return it to the Program Administrator.

A. Number of people supported by the household below (Please list): ________________

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<th>First Name</th>
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<th>Relationship</th>
<th>Member?</th>
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<td>Y</td>
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Public Health’s Healthy Lifestyle Center

Baseline Fitness Assessment Results:

Client Name: __________________________ Fitness Instructor: ______________________

DOB: __________________ Date of Assessment: __________________

Time of Assessment: __________________

I. Standard Measurements:

- Resting Blood Pressure (left side unless indicated):  
  Resting Heart Rate:  
  1st. __________ 2nd. __________

- Weight: _____ lbs. ÷ 2.2 = _____ Kg

- Height: ______ cm ÷ 100 = _____ m

- Body Mass Index = weight (kg) ÷ height (m)^2: __________

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<tr>
<th>Underweight</th>
<th>Normal</th>
<th>Overweight</th>
<th>Obese</th>
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Circumference Measurements: (nearest quarter inch)  __ Client declined  __ Unable to measure

Abdomen (Belly Button): ______ in

Hips: ______ in

Waist: ______ in

Very Low  Low  High  Very High

Body Composition: (optional) ______ % Body Fat  ______ Percentile

Skinfold sites:  __ client declined  __ unable to get measurements

Female:
  Triceps: ______  Suprailiac: ______  Thigh: ______  SUM: ______

Male:
  Chest: ______  Abdomen: ______  Thigh: ______  SUM: ______

Data Entered by: ______________ on: ____________________
Appendix D: List of Tier 1 Core Public Health Competencies Met

<table>
<thead>
<tr>
<th>Domain #1: Analytic/Assessment</th>
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<tbody>
<tr>
<td>Identify the health status of populations and their related determinants of health and illness (e.g., factors contributing to health promotion and disease prevention, the quality, availability and use of health services)</td>
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<tr>
<td>Describe the characteristics of a population-based health problem (e.g., equity, social determinants, environment)</td>
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<tr>
<td>Identify sources of public health data and information</td>
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<td>Describe the public health applications of quantitative and qualitative data</td>
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<tr>
<td>Collect quantitative and qualitative community data (e.g., risks and benefits to the community, health and resource needs)</td>
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<tr>
<td>Use information technology to collect, store, and retrieve data</td>
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<tr>
<td>Describe how data are used to address scientific, political, ethical, and social public health issues</td>
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<tr>
<th>Domain #2: Policy Development and Program Planning</th>
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<tr>
<td>Gather information relevant to specific public health policy issues</td>
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<tr>
<td>Describe how policy options can influence public health programs</td>
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<tr>
<td>Gather information that will inform policy decisions (e.g., health, fiscal, administrative, legal, ethical, social, political)</td>
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<tr>
<td>Describe the public health laws and regulations governing public health programs</td>
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<tr>
<td>Participate in program planning processes</td>
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<tr>
<td>Incorporate policies and procedures into program plans and structures</td>
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<tr>
<td>Apply strategies for continuous quality improvement</td>
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<tr>
<th>Domain #3: Communication</th>
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<tbody>
<tr>
<td>Communicate in writing and orally, in person, and through electronic means, with linguistic and cultural proficiency</td>
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<tr>
<td>Solicit community-based input from individuals and organizations</td>
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<tr>
<td>Apply communication and group dynamic strategies (e.g., principled negotiation, conflict resolution, active listening, risk communication) in interactions with individuals and groups</td>
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<tr>
<th>Domain #4: Cultural Competency</th>
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<tbody>
<tr>
<td>Incorporate strategies for interacting with persons from diverse backgrounds (e.g., cultural, socioeconomic, educational, racial, gender, age, ethnic, sexual orientation, professional, religious affiliation, mental and physical capabilities)</td>
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<tr>
<td>Recognize the role of cultural, social, and behavioral factors in the accessibility, availability, acceptability and delivery of public health services</td>
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<tr>
<td>Respond to diverse needs that are the result of cultural differences</td>
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<tr>
<td>Describe the dynamic forces that contribute to cultural diversity</td>
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<td>Describe the need for a diverse public health workforce</td>
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<th>Domain #5: Community Dimensions of Practice</th>
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<tbody>
<tr>
<td>Recognize community linkages and relationships among multiple factors (or determinants) affecting health (e.g., The Socio-Ecological Model)</td>
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<td>Demonstrate the capacity to work in community-based participatory research efforts</td>
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<td>Identify stakeholders</td>
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<tr>
<td>Collaborate with community partners to promote the health of the population</td>
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<tr>
<td>Maintain partnerships with key stakeholders</td>
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<tr>
<td>Use group processes to advance community involvement</td>
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<tr>
<td>Describe the role of governmental and non-governmental organizations in the delivery of community health services</td>
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<tr>
<td>Identify community assets and resources</td>
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<tr>
<td>Gather input from the community to inform the development of public health policy and programs</td>
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<tr>
<td>Inform the public about policies, programs, and resources</td>
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<tr>
<th>Domain #6: Public Health Sciences</th>
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<tbody>
<tr>
<td>Relate public health science skills to the Core Public Health Functions and Ten Essential Services of Public Health</td>
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<tr>
<td>Partner with other public health professionals in building the scientific base of public health</td>
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