chronic disease notes & reports

National Center for Chronic Disease Prevention and Health Promotion

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Tracing the Roots of CDC's National Center for Chronic Disease Prevention and Health Promotion

Although we are celebrating the 10th anniversary of the National Center for Chronic Disease Prevention and Health Promotion during 1998, the roots of the center actually extend into a time few NCCDPHP employees can recall.

The year was 1949 when President Harry S. Truman established the Presidential Commission on Chronic Illness. In the Commission's report, published in 1956, the then Surgeon General Leonard Scheele, MD, stated, "The great obstacle to prevention is the development of methods for complete application of the knowledge and measures we now possess. These difficulties of application affect both research and practice. What is now known is not being fully applied." These three lines became a call for dramatic changes in the infrastructure of the nation's public health system to address the need for chronic disease prevention, health promotion, and the development of strategies to help people adopt healthier lifestyles.

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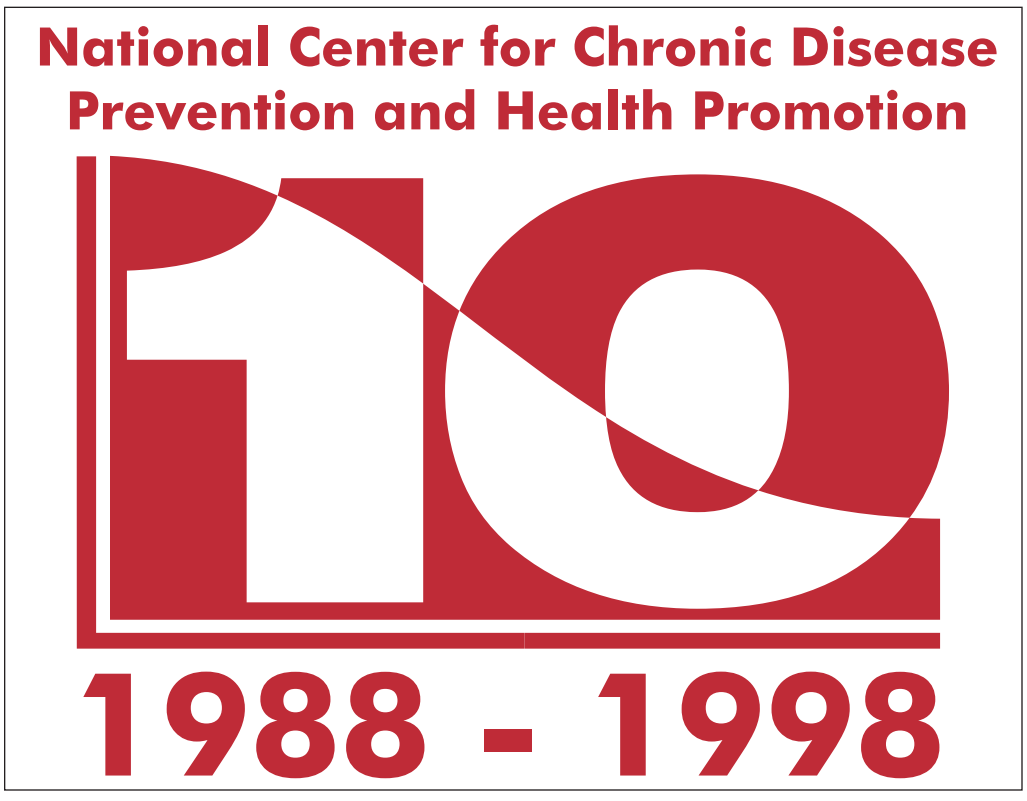

Special Focus:
NCCDPHP's 10th Anniversary

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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

CDC CENTERS FOR DISEASE CONTROL AND PREVENTION

Commentary Commentary Commentary

Looking Back Offers Perspectives for Meeting Challenges That Lie Ahead

James S. Marks, MD, MPH
Director
National Center for Chronic Disease Prevention and Health Promotion

As I reflect on the 10-year history of the National Center for Chronic Disease Prevention and Health Promotion, I am quickly taken back to a time of great change for public health and for CDC. In the mid-1980s, I was the Chronic Disease Coordinator for CDC, working with Jeffrey P. Koplan, MD, MPH, (who has just returned to CDC as its director), then the Assistant Director for Public Health Practice. The new center within CDC that Dr. Koplan and I, along with many others, were working so hard to create was both the realization of a dream and a necessary reaction to the public health realities of the time.

Since 1946, the year CDC was created, chronic diseases have been the leading causes of death in the United States. The falling death rates from infectious diseases that resulted from a combination of dramatic improvements in sanitation and widespread use of antibiotics and immunizations had moved cardiovascular disease and cancer to the top of the list of the reasons Americans were dying. When CDC was established as the Communicable Disease Center in 1946, these facts were recognized, and indeed the intent was to set up various "Centers of Excellence" within the Public Health Service, including a chronic disease center. But 40 years later, in 1986, a center that focused on chronic disease still had not been created.

Perhaps a part of the reason for the delay in establishing such a center was that even though in 1946 we knew that chronic diseases accounted for most deaths, our interventions were very limited. For example, in the 1940s the relationship between lung cancer and tobacco was not proven. Indeed, the landmark 1964 Surgeon General's report on smoking and health did not come to any conclusions about tobacco use and cardiovascular disease, only about lung and laryngeal cancers. However, it was after the formation of CDC that research during the next few decades lead to the identification and confirmation of significant risk factors for chronic diseases.

In the 1950s, the administration of Dwight D. Eisenhower had a dramatic but quite unexpected impact on the way we view chronic diseases. The President suffered two heart attacks while in office. His physician, cardiologist Dr. Paul D. White, not only talked frankly for perhaps the first time about the President's health to the American people, but also was among the first to realize the relationship between physical activity and cardiovascular disease. He had the President up and around when most heart patients were advised to rest, and his patient did well. The visible embodiment of Dr. White's view of the value and importance of physical activity led to more research and acceptance of physical activity initially for recovery from, and then for prevention of, cardiovascular disease.

In the 1960s and 1970s came striking evidence that controlling hypertension and cholesterol could reduce the risk of cardiovascular disease, along with increasingly strong evidence of the importance of nutrition in reducing the risk of premature death. Additionally, these years saw the growing realization that cancer screening interventions such as mammograms could save many lives and that eye screening could prevent blindness among persons with diabetes.

In the late 1970s, CDC convened an outside group of experts to examine the burgeoning issues in public health and to advise the agency on how it should respond to these issues. Among the recommendations of the group, headed by the then Commissioner of Health for Utah, James O. Mason, MD, DrPH, was that CDC should greatly expand its mission and its purview. The result was the sweeping CDC reorganization of 1981 that added the "s" to Center for Disease Control and created new centers such as the Center for Health Promotion and Education and the Center for Environmental Health.

In the 1980s, the important implications of prevention research strongly supported creating a chronic disease center. Such reports as *Closing the Gap: The Burden of Unnecessary Illness* produced by the Carter Center with William H. Foege, MD, MPH, as the lead, and *Positioning for Prevention* from CDC's Chronic Disease Planning Group provided the support and documentation needed to move forward. In a letter

Science/Medicine

The Atlanta Journal ☐ THE ATLANTA CONSTITUTION ★★★★ TUESDAY, DECEMBER 13, 1988

CDC Turns Spotlight On Chronic Diseases

By Nita King

The Centers for Disease Control, best known for its work in combating infectious disease, is shifting some of its focus — and its tactics — in an effort to deal more effectively with the diseases that cause three-fourths of the country's 2.1 million deaths a year.

In recent months, the Atlanta-based CDC has consolidated dozens of programs that had been spread throughout the agency into a single Center for Chronic Disease Prevention and Health Promotion.

The new center, the seventh at the agency's headquarters on Clifton Road, will coordinate $145 million-a-year worth of federally sponsored public health efforts aimed at heart disease and other diseases that are inherited or result from a person's lifestyle or environment.

CDC officials acknowledge that the new approach marks a departure from the agency's traditional mission of tracking and preventing infectious and communicable diseases, such as AIDS and influenza.

AIDS and other infectious diseases account for fewer than 100,000 deaths a year in the United States, but

Chronic Disease: The Leading Killers

Deaths per 100,000 population

Heart Disease

Stroke

Cancer

Lung, Respiratory Disease

Chronic Liver Disease

Diabetes

Source: National Center for Health Statistics

CINDY JONES/STAFF

CDC Worker prepares sample for examination on an electron microscope

A newspaper article from December 1988 acknowledged the formation of the National Center for Chronic Disease Prevention and Health Promotion and illustrated the burden of chronic diseases.

accompanying *Closing the Gap: The Burden of Unnecessary Illness,* Edward N. Brandt, Jr., MD, PhD then Assistant Secretary for Health wrote, "Far too many people suffer pain, loss of function, and premature loss of life from preventable causes. The gap can be closed."

The formation of the Center for Chronic Disease Prevention and Health Promotion in October 1988* proved the realization of an important dream for many in public health, and we can point with pride to the many accomplishments of this relatively new player in public health.

But where are we now, and what does the future hold? Never before has humankind had in its own hands so much potential to control its health. We now know more than we ever have about how to prevent premature death and illness. But there is a serious imbalance. We are falling further behind in ensuring that the means to sustain health is provided to all sectors of our population.

I have no doubt that this is where the future of CDC and public health will be written. And as members of the "babyboom" generation fast approach the age when chronic diseases begin to increase rapidly in incidence and seriousness, we are faced with an urgency unlike any that we have faced before. There are but few years to make sure that the millions of members of this generation and their families are as healthy as possible. Nevertheless, our biggest challenge is, as always, also our most exciting opportunity.

Public health at all levels needs to have strong programs aimed at delaying and preventing the onset and complications of chronic diseases and conditions. Still we are late in making these a priority. Many people see these conditions as inevitable, not urgent. This sense of inevitability also makes it seem like these conditions are nondiscriminatory, falling relatively equally on all of us. Yet nothing could be further from the truth. Part of our work lies in letting people know how they can lead healthier, longer, more satisfying lives. Even modest lifestyle changes, such as moderate exercise, better nutrition, and stopping tobacco use, can reduce the prevalence of cardiovascular disease, cancer, and diabetes.

Those of us at all levels of public health must engage all of our society—our institutions, grass-roots community groups, businesses, and private voluntary organizations—in keeping people healthy. This major challenge affects us all, and only by pulling together the resources from each of these sectors will we succeed in reducing the burden of chronic diseases.

*"National" was officially added to the title of CDC's centers and institutes in June 1991 to reflect more fully their scope.

Chronic Illness
NEWS LETTER

PREVENTION · CARE · REHABILITATION
AN INTEGRATED COMMUNITY PROGRAM

Issued monthly by the COMMISSION ON CHRONIC ILLNESS — an independent national agency to study the problems of chronic disease, illness and disability. First Issue, July, 1950

THE COMMISSION ON CHRONIC ILLNESS—

WHAT IT IS

For the first time a single national agency is charged with the responsibility of studying the problems of integrated community action in the field of chronic illness.

An independent agency, the Commission on Chronic Illness, is an organization of 39 persons nationally prominent in medicine, industry, education, government and business.

The Commission was founded by the American Medical Association, American Public Health Association, American Hospital Association and American Public Welfare Association.

It is supported financially by the American Medical Association, National Tuberculosis Association, American Cancer Society, American Heart Association, the National Society for Crippled Children and Adults, the New York Foundation, and the National Foundation for Infantile Paralysis.

WHAT IT DOES

The job of the Commission is to act as a national clearing house to bring together the many separate organizations and programs dealing with chronic illness, disease and disability.

It is now gathering information regarding many activities now under way in various parts of the country through community social agencies, State and county medical societies, State commissions, health departments and hospitals.

The Commission will explore the need for, and carry out further administrative research in the field of chronic illness. It plans a national campaign to acquaint the public with the positive aspects of chronic illness. Finally, as a result of the information gathered and the cooperative work of all the agencies concerned, there should result a set of programs for continued, concentrated action by local, state and national agencies.

STATES URGED TO FORM PLANNING GROUPS

At its second annual meeting in Chicago, May 8 the Commission on Chronic Illness recommended that each state, city and major community take steps to establish planning groups to study the many problems relating to prevention, treatment and care of chronic illness. State medical societies are urged to form Committees on Chronic Illness to work with the state-wide planning agency.

Dr. Morton L. Levin, Staff Director, reported that a model community survey plan has been developed for use by communities studying their local needs, services and facilities. The plan will be tested in several communities this summer before it is presented for use by communities throughout the country. Plans have been drawn up for a definitive study of prevalence and medical needs in an urban and a rural area, Dr. Levin said, and the Commission is now endeavoring to secure funds for this study.

To carry out its education-research program the Commission will need $89,975 next year and the group voted to appoint a special sub-committee on finance to secure additional financial support.

It was decided that a broad base of financial support was desirable because of the wide scope of the Commission's work and that the principle contributions should come from many widely representative organizations and private individuals.

Members of the executive committee for the coming year will be: Leonard W. Mayo, New York, re-elected Chairman; Dr. Andrew C. Ivy, Chicago, vice-chairman; J. Douglas Colman, re-elected secretary-treasurer; Thomas Parran, M. D., Pittsburgh; and Mrs. R. L. Ireland, Cleveland.

Objectives—Commission on Chronic Illness

- Modify Society's attitude that chronic illness is hopeless.
- Define the problems arising from such illness in all age groups.
- Coordinate separate programs for specific disease with a general program designed to meet the needs of all the chronically ill.
- Clarify the relationships of all groups working the field.
- Stimulate in every locality a well-rounded plan for the prevention and control of chronic disease and the care and rehabilitation of the chronically ill.

The Presidential Commission on Chronic Illness, formed in 1949, marked the start of the modern era in chronic disease prevention and health promotion. In July 1950, the Commission published the first known newsletter, the Chronic Illness News Letter, that dealt with chronic diseases.

NCCDPHP's Roots

▸ *Continued from page 1*

Surgeon General's Report Rallies Prevention Efforts

The next major call to action was the first Surgeon General's Report on smoking and health in 1964. The report stated, "Cigarette smoking is a health hazard of sufficient importance in the United States to warrant appropriate remedial action." What constituted "remedial action" was left unspecified, but this landmark document highlighted the potential to prevent and control the devastating effects of two chronic diseases—specifically lung and laryngeal cancers—through a single, nonclinical, behavioral-based intervention: abstaining from smoking cigarettes.

By 1970, CDC had acknowledged the agency's broader mission and the dire need to address the tremendous challenges posed by chronic disease by changing its name from the Communicable Disease Center to the Center for Disease Control. This broader mission for CDC was further substantiated in November 1971 when CDC Director David J. Sencer, MD, MPH, announced the transfer of the National Clearinghouse on Smoking and Health to CDC. In 1974, a key report by the Canadian Minister of Health and Welfare provided an important precursor to efforts in chronic disease prevention at CDC, and the ultimate development of a center at CDC to address these issues.

In 1979, *Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention* established the U.S. direction for health promotion and chronic disease prevention. The most significant finding of the report was that substantial improvements in health were most likely to be achieved through disease prevention and health promotion rather than through increased medical care services and health expenditures. The report further recommended five priority areas: smoking, high blood pressure, alcohol consumption, nutrition, and physical activity.

CHPE Blazed Trails

A very tangible CDC response to the report was the creation of the Center for Health Promotion and Education (CHPE), one aspect of the sweeping 1981 reorganization that changed the Center for Disease Control to the Centers for Disease Control. CHPE initially consisted of the Division of Nutrition, the Division of Health Education, and the Division of Reproductive Health, all inherited from other CDC programs.

A statement from CHPE's 1981 Annual Report reflected the new center's mission: "Areas of involvement are reproductive health, including family planning; nutrition; smoking; alcohol; physical fitness; stress; violence; accidents; and other risk factors of public health significance."

The new center was first headed by Horace (Hod) Ogden, who had been Director of the Bureau of Health Education, which during the 1970s was in many ways the forerunner of CHPE. His successor, Dennis D. Tolsma, MPH, became CHPE's Director in 1983.

Under his leadership, CHPE's scope grew to include greater infant and maternal health initiatives, the widely used PATCH (Planned Approach to Community Health) methodology, violence epidemiology,* the Behavioral Risk Factor Surveillance System, which responded to a need for collecting state-specific data, plus other key surveillance programs (see related story, p. 13), and a collection of bibliographic resources that evolved into the Health Promotion and Education Database. In 1986, during Mr. Tolsma's tenure, the Office on Smoking and Health was folded into CHPE. The next year CHPE received supplemental funding to develop an AIDS education program for school-aged children, which soon developed into a formal adolescent and school health program.

*In 1986, CDC transfered violence-related programs to the Division of Injury Epidemiology and Control within the Center for Environmental Health.

1984 Proved Key Year

In 1984, two significant events led to the creation of a chronic disease-focused center within CDC: the first cooperative agreements for developing continuous surveillance systems to measure risk factors for chronic disease and a report issued from the Carter Center Health Policy Project, *Closing the Gap: The Burden of Unnecessary Illness,* that sought to focus national health policy on the burden of unnecessary illness. Both events centered on closing the gap between the current burden of chronic diseases and the application of knowledge and technology at hand to lessen the burden. By 1986, the Chronic Disease Planning Group, established within CDC, submitted an assessment and plan for chronic disease activities, which included major risk factors for initial focus, recommendations for programs, and potential options of how CDC could be organized to address those needs.

Defining Chronic Diseases

For the next three years, CDC's internal Chronic Disease Advisory Committee planned for the creation of a chronic disease center. The first challenge was to define the scope of CDC's involvement in preventing chronic diseases—an area that encompasses a wide variety of diseases and conditions that were difficult to crisply delineate.

The committee began by broadly defining chronic diseases as those illnesses that are prolonged, do not resolve spontaneously, and are rarely cured completely. The committee used two principal criteria to determine which of the many diseases that fit this definition should be targeted by CDC: the illnesses should be preventable and should pose a significant burden in mortality, morbidity, and cost.

In May 1988, CDC Director James O. Mason, MD, DrPH, issued a memorandum to CDC executive staff indicating he would be establishing a center that would focus on chronic diseases. The proposed organizational structure comprised these CDC components: the Center for Health Promotion and Education; the Division of Chronic Disease Control from the Center for Environmental Health and Injury Control; the Division of Diabetes Control and the Preventive Health and Health Services Block Grant from the Center for Prevention Services. The new center was to be composed of the Office of the Director, Office of Surveillance and Analysis, Division of Adolescent and School Health, Division of Chronic Disease Control and Community Intervention, Division of Diabetes Translation, Division of Nutrition, Division of Reproductive Health, and the Office on Smoking and Health.

NCCDPHP Created in 1988

In October 1988, then Secretary of Health and Human Services Otis R. Bowen, MD, announced the creation of the Center for Chronic Disease Prevention and Health Promotion.* In an interview with *The Washington Post* on November 14, 1988 ("CDC Setting Up Chronic Disease Center, Focus Shifting From Infections, Formerly the Culprit in Most Deaths"), Jeffrey P. Koplan, MD, MPH, the center's newly appointed director said, "The new Center for Chronic Disease Prevention and Health Promotion, which the Department of Health and Human Services approved last month, symbolizes a shift in the CDC's focus from infections, which caused most deaths early in this century, to chronic disorders, which cause 70 percent of deaths today."

Dr. Koplan emphasized that one of the center's major roles would be collecting more complete statistics on major chronic conditions such as arthritis and diabetes, but he stressed that the center's programs would go beyond case counting to devising and testing strategies for improving disease detection and changing behavior to reduce risk. "It's the ultimate in prevention if you can influence a child's lifestyle choices early on," he said.

Interventions Yield Results

The affects of prevention campaigns often take years, even decades, to yield measurable consequences. NCCDPHP has persistently tracked trends and conducted interventions since its inception.

For instance, "In 1988, we knew little about the extent to which young people engaged in risky health behaviors, but now we have national data on these issues in 38 states and 17 major cities," said James S. Marks, MD, MPH, who succeeded Dr. Koplan as NCCDPHP's Director in 1995. Moreover, CDC recently confirmed that for the first time in 20 years, fewer young people are having sex and that those who do are more likely to use condoms.

In 1990, only 26 states received CDC resources for diabetes prevention and care. Now all 50 states do. Participants in a diabetes care program in the Michigan Upper Peninsula experienced reductions of 45 percent in the hospitalization rate, 31 percent in lower extremity amputations, and 27 percent in death rates compared with these rates for nonparticipants. This program has since been adopted statewide.

Consider, too, that 10 years ago only 29 percent of women took advantage of

*"National" was officially added to the title of CDC's centers and institutes in June 1991 to reflect more fully their scope.

mammography screening in spite of research showing its benefits in reducing breast cancer deaths among women over 40 years of age. From 1991, the start of CDC's National Breast and Cervical Cancer Early Detection Program, through 1994, the last year national trends were reported, mammography screening rates increased from 55 percent to 61 percent.

Growth in Resources

"In the years since NCCDPHP's formation, our programs, staff, and budget have grown dramatically," said Virginia S. Bales, MPH, Deputy Director, NCCDPHP. The fiscal year 1989 budget was $122 million, and the center had 343 employees. In fiscal year 1992, the Division of Cancer Prevention and Control was proposed and approved, and by fiscal year 1993, the center's budget had grown to $321 million.

In the mid-1990s, as the center further refined its organization, Dr. Marks oversaw the creation of the Division of Adult and Community Health and the Division of Nutrition and Physical Activity. In 1996, the Division of Oral Health was added, and by fiscal year 1998, NCCDPHP's budget resources totaled more than $500 million and 800 employees.

Communicating about Chronic Diseases

Today, chronic diseases are among the most prevalent, costly, and preventable of all health problems. Almost every American family is in some way adversely affected by chronic diseases —through the deaths of loved ones; through family members living with long-term illness, disability, and diminished quality of life; and in many cases, through the enormous financial burden wrought by these diseases. In the United States, chronic diseases account for two thirds of the $1 trillion spent annually on health care and for 70 percent of all deaths, and they are the leading causes of disability among persons older than 15 years of age.

A statement from *Medicine and Health Perspectives* (Faulkner and Gray's *Medicine and Health* 1996:50 (47); Dec. 9, 1996) perhaps best distills this issue: "The cost and prevalence of chronic illness in the United States in the 1990s are emerging as problems that threaten to overwhelm a health care system that was designed primarily to meet the often very different needs of acute-care patients."

The good news is that research over the last 20–30 years has shown us the importance of not using tobacco, of being physically active and maintaining a healthy weight, of lowering blood pressure and cholesterol, of good diabetes control, and of the importance of early diagnosis and treatment for many conditions.

Unfortunately, bad news is not hard to find when looking at whether these research findings are being widely applied by Americans. Findings from just two monitors of our health risks, the Behavior Risk Factor Surveillance System and the Youth Risk Behavior Surveillance System, provide us some sobering numbers. In 1997, 36.4 percent of high school students had smoked cigarettes during the past 30 days, 70.7 percent had not eaten 5 or more servings of fruits and vegetables in the day preceding the survey, and 72.6 percent had not attended physical education class daily. The most recent data for adults show that almost 30 percent get no leisure-time physical activity, 22.4 percent of adults smoke, and screening for colorectal cancer lags far behind hoped-for percentages.

What Makes a Good Message?

These numbers have many in public health asking, "Are Americans getting the message about behaviors that put them at risk of chronic diseases?" And these numbers have lead many who work in health communications to ask, "What makes a good message?"

Perhaps all of these numbers and data make our challenge of reducing the burden of chronic diseases in the United States today appear hopeless. Granted the task is daunting, but it is far from hopeless. As we reflect on the past, and look to the future of chronic disease prevention and health promotion efforts, perhaps no greater challenge exists than that of designing health messages that will cut through the clutter of messages we all receive every day.

What formative research in health communications and focus group after focus group may well be saying to us most clearly in 1998 is that messages must be finely targeted and consider the unique perspective of the target audience on some very complex issues. How we address issues such as perceptions of death, illness, fate, and the role that food plays in a particular culture can very well make or break a health communications campaign.

As the Division of Diabetes Translation worked to develop messages about controlling diabetes targeted to Hispanics, focus group research showed very clearly that the cultural perception of fate, or luck, has a very strong influence on how members of this particular ethnic group view illness. If an audience thinks that getting a disease such as diabetes is just plain bad luck, and there is nothing to be done about it, health messages targeted to that audience had better address that cultural viewpoint.

When the Division of Cancer Prevention and Control developed prevention messages about skin cancer, their focus group research showed that their target audience viewed tanned skin as something to be desired; consequently, this viewpoint had to play a large role in the design of messages meant to change behavior.

Marketing Is Not Advertising

As Alan R. Andreasen, PhD, professor of marketing at the School of Business, Georgetown University, wrote in *Marketing Social Change: Changing Behavior to Promote Health, Social Development, and the Environment* (1995), the concepts of what he has called social marketing have enormous potential for affecting major social problems. But, he cautions, social marketing is not social advertising. Dr. Andreasen states that although we ask those trying to influence behavior to "think like a marketer," simply using advertising and advertising techniques are not sufficient. "Social marketing recognizes that influencing behaviors—especially behavior change—cannot come about simply by promoting the benefits of some new course of action. Careful attention must be paid to the nature of the behavior to be promoted (the Product), the ways in which it will be delivered (the Place), and the costs that consumers perceive they will have to pay to undertake it (the Price)."

Dr. Andreasen also points out that consumers do not act on decisions such as changing health behaviors immediately. Instead, he says, they move toward action in stages. Thus, as good as our campaign may be, we probably won't see our target population move from risky behavior to healthy behavior overnight.

The challenges to designing messages that will be received and acted on are not just those of communicating to the external world. As Heather Tosteson, PhD, a health communicator with NCCDPHP said during a meeting of the CDC Communicators Roundtable, the approach of communications staff and scientific staff may be very different. "Good messages require a position of advocacy, empathy, and creativity . . . criteria that don't necessarily jibe well with the values of scientific neutrality, objectivity, and an emphasis on method over content," she said.

And, as she pointed out, we at CDC have to let go of assuming everyone thinks the way we think. "To communicate well, we have to be curious about how people think, how variously they put two and two together . . . . A good message, one that really clicks, works inside the audience's meaning system, inside what is credible

and persuasive reasoning to them. That little click of recognition, which is the hallmark of a good message, means that someone can see themselves in what we're saying."

Marketers talk about the four P's of marketing: product, place, price, and promotion. Often what we are marketing is a product whose benefit may be years down the road, and whose price seems quite high. Jerry Garcia of the Grateful Dead may have put it most succinctly in an interview with *Rolling Stone* magazine a few years before his death. He said he wanted to quit smoking and said, "It'll be a major score if I can do it. It's harder than quitting drugs."

We often hear that everyone knows what behaviors they should be changing to avoid chronic diseases, so why do we keep reminding people. As James S. Marks, MD, MPH, Director, NCCDPHP, often says, "Everybody has heard of Coke, but Coca-Cola still advertises!"

Chronic Disease Conferences Address Major Health Problems

In 1986, the first National Conference on Chronic Disease Prevention and Control in Atlanta marked another milestone in the recognition of chronic diseases as the major causes of death and disability in the United States and the expansion of CDC's activities to combat this growing threat. Cosponsored by CDC and the Association of State and Territorial Health Officials, the conference provided a forum for more than 400 attendees to exchange information on chronic disease activities, techniques for specific disease interventions, and current scientific bases for preventing and controlling chronic diseases.

Participating public health officials offered suggestions for improved surveillance, applied research, and training on chronic disease prevention and control as well as ideas on organizing and marketing chronic disease intervention programs. Attendees called for establishing a coalition of public health agencies and interested private and nonprofit organizations and a national agenda to combat chronic diseases.

Expanding on the Foundation

Subsequent conferences have built on the foundation established by the first conference. (See chart, p. 10.) The second conference, attended by more than 600 participants, focused on partnerships and the importance of creative collaboration in reaching underserved communities. At the closing session, then CDC Director James O. Mason, MD, DrPH, spoke of the 60,000 excess deaths among minority groups in the United States, 70 percent of which are attributed to four chronic diseases (cancer, cardiovascular disease, diabetes, and cirrhosis). Dr. Mason pointed out that death, illness, and disability from chronic diseases among white Americans are also beyond what is acceptable and noted that "Public health moves forward by defining what is unacceptable."

The third through the eleventh conferences moved from identifying strategies and partners to implementing interventions and preparing for future challenges of chronic disease prevention and control. For example, during the seventh national conference, chronic disease prevention and control was discussed in the context of health insurance coverage.

At the tenth national conference in 1996, as CDC was celebrating its 50th anniversary, Jeffrey P. Koplan, MD, MPH, NCCDPHP's first Director, pointed out that many recommendations that emerged from the first national conference have withstood the test of time. He also noted that, over the past 10 years, "We've added a year to our life span, and death rates are down."

At the same conference, however, the continuing devastating impact of chronic diseases was evident. NCCDPHP Director James S. Marks, MD, MPH, reported that

"the cost of chronic illness has increased to more than 60 percent of the $1 trillion spent on medical care in the United States."

Then CDC Director David Satcher, MD, PhD, added perspective by comparing the widely publicized Ebola outbreak in Zaire, which killed approximately 245 people, with the impact of chronic diseases in America. "During the same 6 weeks in the United States, more than 30,000 deaths related to tobacco use, 20,000 related to diet and physical inactivity, and 8,000 related to alcohol use occurred."

Promoting Prevention in the 21st Century

The National Conferences on Chronic Disease Prevention and Control are continuing to bring awareness and structure to the mission of conquering chronic diseases. Although participation has increased to more than 800 participants, and the themes have changed to reflect current health care issues, the basic forum has remained the same. To take advantage of technological advances, conferences now include Internet training and multimedia presentations for public health outreach and education. At the twelfth national conference, prevention opportunities for the 21st century were discussed. The thirteenth conference, which will be held in Atlanta on December 8–10, 1998, will have as its theme "Prevention: Translating Research into Public Health Practice. "

Public health leaders have recognized the establishment of the national conference as an important stride in helping federal, state, and local health agencies meet the tremendous public health demands imposed by chronic diseases. These conferences are a vital part of NCCDPHP's and CDC's partnerships with the Association of State and Territorial Chronic Disease Program Directors and others to work toward the vision of "Healthy People in a Healthy World."

National Chronic Disease Conferences: 1986–1998

Dates	Themes	Locations
Sept. 9–11, 1986	*Identifying Effective Strategies*	Atlanta, GA
Sept. 16–18, 1987	*Working Together—Players and Priorities*	San Antonio, TX
Oct. 19–21, 1988	*Putting Science into Practice*	Denver, CO
Sept. 20–22, 1989	*Implementing Effective Strategies*	San Diego, CA
Oct. 17–19, 1990	*From 1990 to 2000*	Detroit, MI
Oct. 22–24, 1991	*Making Prevention a Reality*	Washington, DC
Oct. 21–23, 1992	*Prevention: Can It Be Marketed, Managed, and Make a Difference?*	Salt Lake City, UT
Nov. 17–19, 1993	*The Role of Chronic Disease Prevention and Control in a Changing Health Environment*	Kansas City, MO
Dec. 7–9, 1994	*Chronic Disease Prevention and Control and the New Public Health*	Washington, DC
Dec. 6–8, 1995	*Ten Years of Progress—A New Decade of Opportunity*	Atlanta, GA
Dec. 3–5, 1996	*Creating Linkages and Partnerships for Healthier Communities*	Phoenix, AZ
Dec. 3–5, 1997	*Prevention Opportunities for the 21st Century*	Washington, DC
Dec. 8–10, 1998	*Translating Research into Public Health Practice*	Atlanta, GA

NCCDPHP Acts to Expand New Programs

Since its creation in 1988, the range of programs and activities conducted within the National Center for Chronic Disease Prevention and Health Promotion has dramatically expanded.

Ten years ago, the center did not have major programs that addressed cancer prevention and control or physical activity, but now these are full-fledged priorities. The Diabetes Control Program has become national; half a dozen Surgeon General's reports on the effects of tobacco on health have been published; the Youth Risk Behavior Surveillance System was developed to report on health risk behaviors practiced by young people. There are many more examples of important areas that had "breakout" years during this first decade.

Now, other prime areas, such as cardiovascular disease, oral health, epilepsy, and arthritis are breaking new ground.

Cardiovascular Disease

For fiscal year 1998, Congress appropriated $8.1 million for the prevention of cardiovascular disease (CVD), the leading cause of death for all Americans between the ages of 45 and 75 years. With these funds, NCCDPHP will begin to build a comprehensive, integrated national program—first in Kentucky, Mississippi, South Carolina, Georgia, Alabama, Missouri, New York, and North Carolina—to target CVD and its risk factors, said Gary C. Hogelin, MBA, Director, Division of Adult and Community Health. The grants will be used to build states' capacity in science, surveillance, communications, training, and partnerships.

The action plans for the eight pilot states will address priority populations, particularly African Americans, Native Americans, and Hispanics, Mr. Hogelin told *cdnr.* Another priority area, because of its historically high burden of CVD, is Appalachia. In addition, the link between diabetes and risk for CVD will be closely examined.

From this initial effort, NCCDPHP will develop a national model that emphasizes policy and environmental measures to prevent CVD. For example, Mr. Hogelin said, "Are children in public schools being served 'heart-healthy' menus? Are there no-smoking policies in worksites? Are there sidewalks to encourage physical activity?"

Secondary prevention efforts such as monitoring people already diagnosed with CVD are also planned. Within each state, the proportion of adults taking daily aspirin or the proportion of the population with a history of CVD taking ACE inhibitors will be measured.

Oral Health

With the naming of William R. Maas, DDS, MPH, as director in July 1998, the Division of Oral Health (DOH) is poised to play an increasingly important public health role . New findings about the links between oral health and CVD, cancer, and even reproductive outcomes suggest that improving the nation's oral health will also lessen the burden from other chronic diseases.

In 1998, 30,000 Americans will be diagnosed with oral and pharyngeal cancer, and 8,000 will die. Nearly two thirds of oral cancers in the United States result from smoking tobacco, particularly when combined with heavy alcohol drinking. Increasing public and professional awareness about the risk factors for oral cancer and encouraging health care providers to look for oral cancer during examinations are keys to its prevention and early detection.

In August 1998, DOH released *Preventing and Controlling Oral and Pharyngeal Cancer: Recommendations from a National Strategic Planning Conference,* the result of a 5-year effort by public and private organizations to develop a plan for preventing and controlling oral and pharyngeal cancer.

DOH is also expanding its efforts in other areas. "We intend to increase collaboration throughout NCCDPHP to improve oral health and to encourage the inclusion of the dental care community in addressing other chronic diseases," Dr. Maas

told *cdnr*. "We need to ensure that our programs are built around existing efforts to prevent and control chronic diseases. For example, destructive periodontal disease, not responsive to treatment, is the first irreversible health consequence of smoking for some tobacco users. Having their dentists call this situation to their attention may increase the salience of messages about stopping smoking."

"We also hope to identify interventions that aid early detection of diabetes and its oral health effects, to reduce not only oral health complications but also other burdens," he added.

Epilepsy

For several years, NCCDPHP has nurtured a relationship with voluntary, professional, and service organizations devoted to meeting the health and emotional needs of persons with epilepsy and their families. In early 1998, the center began developing a comprehensive communications plan to decrease stigma associated with epilepsy and particularly to increase self-efficacy among adolescents with epilepsy. Teenagers were identified as a target population because of safety issues related to driving and employment and stigma issues that affect their social and emotional development. Work is under way to help adolescents with epilepsy make informed decisions about what details of their condition to share and with whom.

"We're excited about this opportunity to meet the needs of a group that has had few resources to turn to. We expect that many of the lessons we learn will be useful in developing programs for other chronic conditions that are not widespread but still pose tremendous difficulties for the people who live with them," said Patricia Price, DO, epilepsy coordinator with the Division of Adult and Community Health.

Treatment issues are also getting attention. CDC is working with the Agency for Health Care Policy and Research to develop a report to determine if there are credible criteria for deciding on effective, optimal care for people with epilepsy.

Arthritis

To target the leading cause of disability among Americans, NCCDPHP has begun innovative efforts to better characterize arthritis, identify modifiable risk factors, and develop intervention strategies through prevention research and surveillance.

The first public and private partnership to address arthritis will be jointly unveiled in November 1998 by CDC and the National Arthritis Foundation. Together with 21 other interested organizations, CDC and the Arthritis Foundation are developing a comprehensive, systematic public health approach to arthritis through the National Arthritis Action Plan. NCCDPHP's involvement with developing this plan highlights three key facts: the rapidly increasing numbers of cases of arthritis, the high degree of impact arthritis has on individuals and society, and the gap between available treatment programs and services and what is being used by people with arthritis. The development of the plan also emphasizes that public health officials see a need to address conditions that affect quality of life as well as those with high mortality.

Hip and knee osteoarthritis are the leading causes of arthritis disability and the primary reasons for expensive joint replacement. NCCDPHP, in collaboration with the University of North Carolina at Chapel Hill and the National Institutes of Health, is assessing risk factors for hip and knee osteoarthritis among 3,600 study participants in Johnston County, North Carolina.

To develop and evaluate promising prevention strategies, NCCDPHP supports prevention centers at universities. The Prevention Center at the University of Washington in Seattle is comparing the effectiveness of different interventions for arthritis. Also, NCCDPHP has worked with states to develop an optional arthritis module for the Behavioral Risk Factor Surveillance System. This module will allow states to develop their own estimate of the prevalence of joint problems in different populations and to monitor trends.

Surveillance Systems Provide Information About Behaviors

Out of the need to know about the personal health choices Americans make daily, CDC researchers have developed a number of surveillance systems that provide data about the general population and about specific subgroups such as children, young people, and pregnant women. On a state-by-state and a national basis, the data tell us about tobacco use, physical activity, diet and nutrition, alcohol and drug use, violence, sexual behavior, and use of preventive services. Such information helps health workers set priorities, design interventions, and evaluate the effectiveness of health promotion efforts.

Behavioral Risk Factor Surveillance System

The Behavioral Risk Factor Surveillance System, established in 1984, is notable for its wide use and comprehensiveness; it is the primary source of state-based information on adult risk behaviors. The system is active in all 50 states, the District of Columbia, and three U.S. territories.

After 15 years of operation, the BRFSS is the largest continuous telephone health survey in the world. Full national participation means that the system tracks national health behaviors and also provides a database that is state-specific. Such data are essential to direct public health monies to risk-reduction programs that will deliver the greatest benefit. Because of the system's longevity, the BRFSS is able to provide high-quality data on health trends.

The BRFSS monitors health behaviors and knowledge on the following topics:

- tobacco use
- physical inactivity
- poor diet
- alcohol use
- violence
- risky sexual behaviors
- lack of preventive services (e.g., screening, immunization)

Of its many strengths, perhaps the most powerful is its flexibility. Because the questionnaire is frequently updated, the BRFSS is able to address emerging health issues. States select from a number of optional modules and may add questions on topics of special interest, such as bike helmet use. This flexibility allows states to use the system to measure the effect of a behavioral intervention; for instance, did a campaign cause an increase in the number of bike riders wearing helmets? Standardized methodology allows data to be compared state-to-state and state-to-nation. The fact that data collection is continuous and long-term allows trends in health behaviors to be identified and monitored.

CDC's multiple roles as a partner with states in the BRFSS go beyond providing technical assistance. States participate in constructing the core questionnaire. The data are collected monthly by states; the agency processes the data and returns analyses to the states. CDC compiles the results and publishes them annually. The agency also provides funding for data collection.

Pregnancy Risk Assessment Monitoring System

The Pregnancy Risk Assessment Monitoring System (PRAMS) is part of CDC's initiative to reduce infant mortality and low birthweight. This ongoing, state-specific, population-based surveillance system was designed to identify and monitor selected maternal behaviors and experiences before, during, and after pregnancy among a stratified sample of mothers who have recently given birth to live infants.

PRAMS was established to supplement vital records data by providing state-specific data on maternal behaviors and

experience to be used for planning and assessing perinatal health programs. Because PRAMS uses standardized methods for data collection, it allows data to be compared among states.

By collecting population-based data about pregnancy and early infancy, researchers hope to better understand how behaviors, attitudes, and experiences during and immediately after pregnancy affect infant health. Like the BRFSS, PRAMS uses a questionnaire that consists of a core component and a state-specific component. Each state develops its own state-specific portion that addresses its particular data needs. Questionnaire topics include the following:

- attitudes and feelings about pregnancy
- barriers to, and content of, prenatal care
- nutrition and folic acid awareness.
- pregnancy-related violence
- psychosocial support and stress
- use of alcohol and tobacco before and during pregnancy
- economic status of the mother
- early infant development, health care, health status, sleep position, and exposure to passive smoke
- HIV prevention
- health insurance coverage

PRAMS data are population-based; therefore, PRAMS findings can be generalized to an entire state's population of women whose pregnancies resulted in a live birth. However, because not all pregnancies end in a live birth, PRAMS data are not generalizable to all pregnant women. PRAMS operates through cooperative agreements between CDC and 16 participating states that have been awarded competitive grants. PRAMS surveillance currently covers about 35 percent of all U.S. births.

PRAMS states have used their data to obtain new funds for programs, make changes in health programs, and develop or modify policy. PRAMS data enhance states' understanding of maternal behaviors and experiences and their relationship to adverse pregnancy outcomes.

Youth Risk Behavior Surveillance System

Until this decade, little was known about the prevalence of behaviors practiced by young people that put their health at risk. The Youth Risk Behavior Surveillance System (YRBSS) now provides vital information on risk behaviors among young people. This information enables public health professionals to more effectively target and improve health programs. Developed by CDC in collaboration with federal, state, and private-sector partners, this voluntary surveillance system includes a national school-based survey conducted by CDC and surveys conducted by state and local education agencies.

Among young people aged 5–24 years, injuries are responsible for 73 percent of all deaths. Among adults, chronic diseases—such as cardiovascular disease, cancer, and diabetes—are the nation's leading killers. Convincing young people to adopt healthy behaviors, such as eating low-fat, high fruit, and vegetable diets; getting regular physical activity; and refraining from tobacco use, could prevent many of these deaths. The YRBSS monitors the top health risk behaviors among young people in these categories:

- tobacco use
- unhealthy dietary behaviors
- inadequate physical activity
- alcohol and other drug use
- sexual behaviors that may result in HIV infection, other sexually transmitted diseases, and unintended pregnancies
- behaviors that may result in intentional injuries (violence and suicide) and unintentional injuries (motor vehicle crashes)

With technical assistance from CDC, state and local department of education

staff conduct a youth risk behavior survey every two years. Staff can add or delete questions in the core questionnaire to better meet the interests and needs of the individual state or local school district. School-based surveys were last conducted in 1997 among students in grades 9 through 12 in 39 states, 16 large cities, and four territories.

In addition to assisting states, CDC conducts national surveys every two years to produce data representative of students in grades 9 through 12 in both public and private schools in the 50 states and the District of Columbia.

Pregnancy Nutrition Surveillance System

Maternal health behaviors are critical to pregnancy outcome and to the well-being of mothers and infants. The leading causes of low birthweight, infant morbidity, and infant mortality are closely associated with behavioral choices, in particular nutritional practices. Few national data are continuously collected on the health choices of pregnant women. The CDC Pregnancy Nutrition Surveillance System (PNSS) has monitored behavioral and nutritional risk factors among low-income pregnant women enrolled in public health programs in participating states since 1979.

The PNSS collects data on the following indices of nutritional status.

- quality of maternal diet
- prepregnancy weight
- weight gain during pregnancy
- anemia
- infant-feeding method
- alcohol use
- tobacco use
- time of entry to prenatal care

Pediatric Nutrition Surveillance System

The CDC Pediatric Nutrition Surveillance System (PedNSS) monitors selected health indicators of low-income U.S. children who participate in federally funded maternal and child health and nutrition programs. The system describes trends and patterns of key indicators of nutritional status so that the information can be used for program planning, targeting, and evaluation, and for developing appropriate health and nutrition interventions. Information from the PedNSS is also used to monitor progress toward the year 2000 national health objectives.

Child growth is a key indicator of nutritional status because it is affected by both dietary intake and illness. Since 1973, CDC has worked with states to monitor the nutritional status of low-income children participating in federally funded maternal and child health and nutrition programs. By 1997, PedNSS had expanded to include 44 states, the District of Columbia, and five tribal governments.

CDC's PedNSS monitors the following indicators of health and nutrition among low-income children.

- low birthweight
- short stature
- underweight
- overweight
- anemia
- infant-feeding practices

For more information about the BRFSS, contact National Center for Chronic Disease Prevention and Health Promotion, CDC, MS K–30, 4770 Buford Highway, NE, Atlanta, GA 30341-3717; 770/488-5292; E-mail ccdinfo@cdc.gov.

For more information about PRAMS, contact National Center for Chronic Disease Prevention and Health Promotion, CDC, MS K–22, 4770 Buford Highway, NE, Atlanta, GA 30341-3717; 770/488-5227; E-mail ccdinfo@cdc.gov.

For more information about YRBSS, contact National Center for Chronic Disease Prevention and Health Promotion, CDC, MS K–32, 4770 Buford Highway, NE, Atlanta, GA 30341-3717; 770/488-3168; E-mail ccdinfo@cdc.gov.

For more information about PNSS and PedNSS, contact National Center for Chronic Disease Prevention and Health Promotion, CDC, MS K–25, 4770 Buford Highway, NE, Atlanta, GA 30341-3717; 770/488-5702; E-mail LDC2@cdc.gov.

An Array of Information at NCCDPHP's Web Site

The spring/summer 1994 issue of *cdnr* focused on the various information technologies being used at CDC, including databases, software, the CDC Voice/FAX Information service, and other products. Just a year later, that issue seemed as outdated as a typewriter, for it preceded the great gold rush of the 1990s: the Internet. This electronic tidal wave of information has deeply affected how we communicate and to whom we communicate.

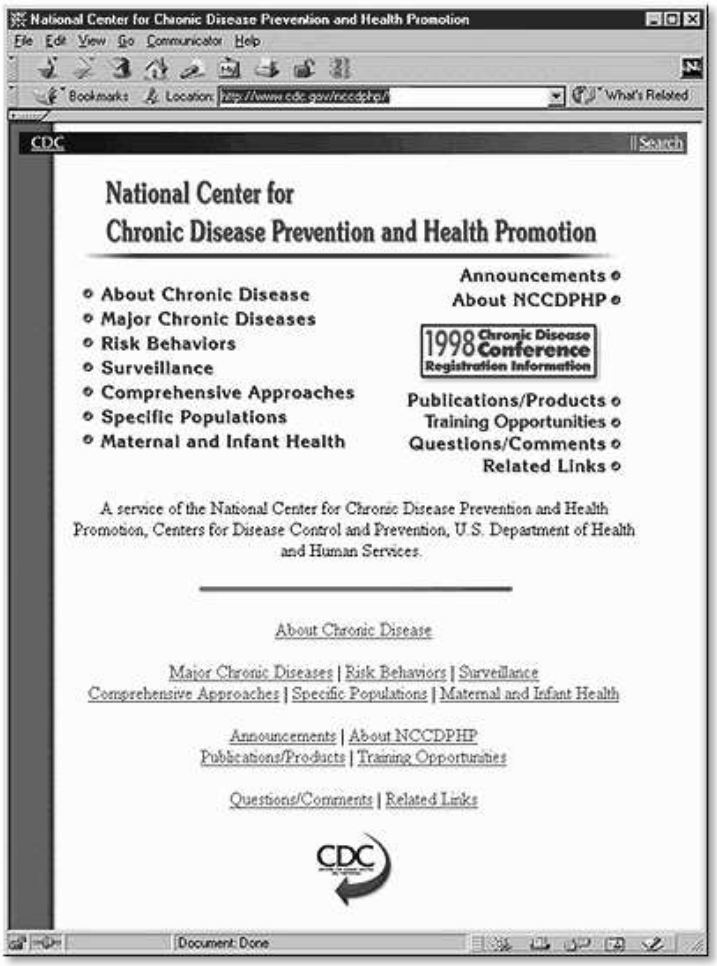
Anyone who can access the Internet can find at the NCCDPHP Web site surveillance data about risk behaviors for adults and young people or download myriad reports including *Tobacco Use Among U.S. Racial/Ethnic Minority Groups: A Report of the Surgeon General* (1998); the *1995 Assisted Reproductive Technology Success Rates National Summary and Fertility Clinic Reports; Chronic Diseases and Their Risk Factors: The Nation's Leading Causes of Death* (1998); or *Physical Activity and Health: A Report of the Surgeon General* (1996). Briefing documents that summarize a number of NCCDPHP's programs, factsheets about activities and diseases; and a host of charts, graphs, and tables are also available.

Even health promotion campaigns such as *Ready, Set, It's Everywhere You Go: CDC's Guide to Promoting Moderate Physical Activity* and *Choose Your Cover—Protect the Skin You're In* or the *Use and Handling of Toothbrushes in Schools and Institutions* are now available at desktops all over the globe.

Persons interested in attending the 13th National Conference on Chronic Disease Prevention and Control can find program summaries and registration information. And even this newsletter, which you are holding in your hands as you read it at your desk, is available as a PDF file on our Web site.

Today, NCCDPHP's Web site contains more than 1,647 pages and some 474 documents that are posted in their entirety as PDF files. "When you consider that the original NCCDPHP Web site consisted of a mere 26 pages just 3 years ago, this exponential growth reveals the impact of the Internet on how we communicate with our constituents," said Michael Greenwell, Communications Coordinator, NCCDPHP.

The Internet address for NCCDPHP's Web site is http://www.cdc.gov/nccdphp.



The NCCDPHP Web site serves as a portal for information about the center's various programs and activities as well as a repository for many of the center's publications and its surveillance data.

Awards Underscore Decade's Achievements

As we celebrate 10 years of public service in preventing and controlling chronic diseases, we can also celebrate our key accomplishments, many of which have been recognized by awards at the department and agency levels and some of national or international distinction.

DHHS Recognition

The Department of Health and Human Services annually presents 50 Secretary's Awards for Distinguished Service to deserving individuals or groups that actively promote the department's goals.

In May 1998, NCCDPHP's Office on Smoking and Health was recognized for outstanding scientific and public health leadership on the 1997 proposed tobacco settlement, and Frank Vinicor, MD, Director, Division of Diabetes Translation, was honored for visionary leadership in the prevention and control of diabetes. The team that developed *Physical Activity and Health: A Report of the Surgeon General,* the first-ever Surgeon General's report on this subject, received a 1997 DHHS Secretary's Award. In addition, two members of the Office on Smoking and Health—Michael Eriksen, ScD and Gary Giovino, PhD—received a DHHS award for their efforts as part of the Tobacco Initiative Group that developed initiatives to protect the nation's youths from cigarette smoking. Since 1988, six other NCCDPHP employees have received departmental awards.

Public Health Service Awards

Until 1995, the Assistant Secretary for Health annually presented Public Health Service awards to agency employees. NCCDPHP staff received three such awards in 1995: members of the *Youth and Elders Against Tobacco Use* campaign team received a Special Recognition Award; staff from the Division of Cancer Prevention and Control were honored for shaping the National Program of Cancer Registries; and the grants application working group in the Office of the Director received the Special Recognition Award for Productivity. In 1993, the Comprehensive School Health Education Group received this award for developing a comprehensive school-based HIV prevention program. In 1989, the Office on Smoking and Health received the Special Recognition Award for producing the landmark Surgeon General's report, *The Health Consequences of Smoking: Nicotine Addiction*. Since 1988, 30 NCCDPHP employees were recognized by PHS awards for superior service, special accomplishments, or volunteer service.

CDC Awards

During the past 10 years, NCCDPHP employees have earned 110 CDC honor awards in categories ranging from research to administrative support, and from program operations to volunteer service. CDC's highest honor award, the William C. Watson, Jr., Medal of Excellence, was presented to two NCCDPHP executives: Virginia S. Bales, MPH, in 1993 and Gordon Robbins, MPH, in 1996. Highlights of other agency awards presented to NCCDPHP employees include these:

- 1998 Award for Collaborative Success *Secretarial Initiative: Reduce Tobacco Use Among Teens and Preteens*
- 1996 Award for Program Operations—*Managed Care Team*
- 1995 Award for Program Operations—*Cancer Surveillance Section*
- 1995 Award for Research: Operational—*The Preterm Delivery Research Group*
- 1993 Award for Research: Epidemiology and Laboratory—*Ectopic Pregnancy Study Group*
- 1993 Award for Statistical Research and Services—*Pregnancy Risk Assessment Monitoring System Statistical Group*

- 1992 Award for Research: Epidemiology and Laboratory—*Youth Risk Behavior Surveillance System*
- 1991 Award for International Health—*Contraceptive Commodity Management Information System Group*
- 1988 Award for Administration/ Support—*Nutrition Surveillance Group*
- 1988 Award for Program Operations—*School Health Education to Prevent the Spread of AIDS Program*

External Awards

In addition to DHHS awards, several NCCDPHP employees have distinguished themselves throughout and beyond the government arena. Examples include these:

- 1995—Stephen W. Wyatt, DMD, MPH, received a Presidential Citation from the American Academy of Dermatology.
- 1993—Lloyd J. Kolbe, PhD, received the National Health Management Award for Health Education for work in adolescent and school health education. He also received the 1988 Research Council Award from the American School Health Association and the Association for the Advancement of Health Scholar Award.
- 1993—Diane L. Rowley, MD, MPH, received the Hildrus A. Poindexter Award for her continued efforts to reduce infant mortality and to foster the health of pregnant women.
- 1991—Frank Vinicor, MD, received the Charles H. Best Award for Distinguished Service in the Cause of Diabetes.

Executive Level Recognition

Our top management officials are recipients of several distinguished honors:

- James S. Marks, MD, MPH, Director, NCCDPHP—1997 Surgeon General's Exemplary Service Medallion and 1993 Distinguished Service Medal from the USPHS Commissioned Corps
- Virginia S. Bales, MPH, Deputy Director, NCCDPHP—1998 Robert W. Jones Award for Executive Leadership; 1996 Presidential Rank of Distinguished Executive; 1994 Presidential Rank of Meritorious Executive
- Adele L. Franks, MD, Assistant Director for Science, NCCDPHP—1997 Surgeon General's Exemplary Service Medallion

NCCDPHP's former and founding director, Jeffrey P. Koplan, MD, MPH, also received several prestigious awards during his former tenure in that capacity.

- 1991—Meritorious Service Medal from the USPHS Commissioned Corps
- 1991—Director's Award for Excellence from the Indian Health Service
- 1989—Promoted to the rank of Assistant Surgeon General
- 1988—Distinguished Service Medal from the USPHS Commissioned Corps

Jeffrey P. Koplan Award

As a tribute to Dr. Koplan, NCCDPHP established the Jeffrey P. Koplan Award in 1995 to recognize employees who exemplify the high ideals, innovation, and commitment to health promotion and chronic disease prevention that characterized his career. There have been four recipients to date:

- 1998—Stephen W. Wyatt, DMD, MPH
- 1997—Michael P. Eriksen, ScD
- 1996—Leo Morris, PhD
- 1995—Virginia S. Bales, MPH

Major NCCDPHP Publications: Documenting a Decade of Accomplishment and Research

As NCCDPHP's programs have grown in scope and responsibility to answer the expanding call for preventive health services, publications have played an increasingly important role in communicating the center's vision to an expanding professional, policy-making, and community-centered audience. In addition to the more than 150 articles by center staff published each year in peer-reviewed journals, the center's publications include a growing collection of CDC-published books, monographs, newsletters, and recommendations and reports. The list that follows highlights some of these publications, many of which were developed in collaboration with NCCDPHP's partners at the national, state, and local levels.

Adolescent Health: State of the Nation, Monograph Series Number 1 Mortality Trends, Causes of Death, and Related Risk Behaviors Among U.S. Adolescents [1993]

This monograph provides national and state data on the leading causes of death among adolescents and information on selected, associated behaviors, such as carrying weapons and drinking heavily. This information can support school health education programs and other interventions designed to reduce death rates and related risk behaviors among adolescents.

Adolescent Health: State of the Nation, Monograph Series Number 2 Pregnancy, Sexually Transmitted Diseases, and Related Risk Behaviors Among U.S. Adolescents [1995]

This monograph reports the consequences of unprotected intercourse among adolescents and describes the rates of pregnancy, abortion, live birth, gonorrhea, and chlamydia in each state. Educators and health professionals can use this information to plan and improve school health programs and other interventions designed to reduce the rates of unintended pregnancy, sexually transmitted diseases, and related risk behaviors among adolescents.

1995 Assisted Reproductive Technology Success Rates: National Summary and Fertility Clinic Reports [1997]

For many people who want to start a family, the dream of having a child is not easily realized: about 15 percent of American women have received infertility service. This annual report, mandated by Congress, provides some of the information that potential consumers need to make informed decisions about using assisted reproductive technology. This report is intended for the public and presents success rate data in a format that is easy to understand.

The Catalonia Declaration: Investing in Heart Health [1996]

The *Catalonia Declaration's* purpose is to provide new and compelling evidence that investing in policies and programs for cardiovascular disease prevention succeeds in saving both lives and money, and failing to make such investments does the opposite. The *Declaration* contains 12 recommendations and 41 case studies as examples of intervention methods that can benefit countries at all stages of development.

Vol. 36 / Special Feature (SSF)

MMWR

CHRONIC DISEASES

NOTES & REPORTS

CENTERS FOR DISEASE CONTROL, ATLANTA, GEORGIA 30333

September 18, 1987

Dear Colleagues:

Welcome! This is the first issue of a new feature of the *MMWR* on chronic disease prevention activities in the states, at CDC, and in other Federal and private agencies. At the First National Conference on Chronic Disease Prevention and Control, many of the participants asked for a mechanism through which they could learn of activities in other states and communities. We hope *Chronic Disease Notes and Reports* (*CDNR*) will help meet that communication need.

Over the last 2 decades, much has been learned about the causes and prevention of many of the leading chronic diseases. However, much of this knowledge is not being widely utilized in large segments of the population at risk of these conditions. It is the responsibility of the medical and public health community to assure that modern prevention technology is effectively and broadly applied. Private physicians, health maintenance organizations, and other primary providers of care will need to routinely make use of preventive services, screening tests, and advice and counseling that translate the fruits of basic research into practice. For minority and other underserved populations in whom risks for many chronic diseases are great, the responsibility of health professionals is especially acute. As with infectious illness for which important control successes such as sanitation and food-service inspection are applied outside the traditional medical-care system, many effective strategies for preventing and controlling chronic diseases are implemented through other means, for example, school health education and public policies for smoking restriction. In these areas the need for leadership from the public health community is clear. Often, however, these kinds of programs are overlooked or ignored in the medical and scientific literature.

It is our hope that *CDNR* can serve as a forum for the exchange of information about effective programs at the state and local levels, whether carried out by health departments, voluntary organizations, occupational or private medical groups, or ideally, coalitions of these. In addition, we will summarize relevant activities here at CDC and elsewhere in the Federal Government. We believe that with your help this can become a valued regular feature of the *MMWR*. I ask not only for your help in providing information for inclusion in *CDNR*, but also for your feedback on what articles you find most useful and what you would like to see emphasized. With such a dialogue, a spirit of collaboration can be achieved, and the potential of *CDNR* realized.

Sincerely,

James O. Mason

James O. Mason, M.D., Dr.P.H.
Director, CDC

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CDNR was originally published as part of the MMWR series. This first issue, dated September 18, 1987, predated the center. NCCDPHP's current Director James S. Marks, MD, MPH, is listed inside the newsletter as "Coordinator, Chronic Disease Activities."

Chronic Disease Notes & Reports
This NCCDPHP newsletter, now in its 11th year, reports on activities, programs, and research of interest to health professionals involved with the myriad aspects of disease prevention and health promotion. In 1996, the newsletter began to focus each issue on a particular topic or theme rather than offering a patchwork of articles. In addition to feature articles, it also contains a commentary and short notes of interest. Its current mailing list exceeds 13,000.

Chronic Diseases and Their Risk Factors: The Nation's Leading Causes of Death [1998]
This document provides information on the burden of three major chronic disease killers—cardiovascular disease, cancer, and diabetes—in all 50 states and the District of Columbia, as well as state-specific data on the prevalence of key risk factors for these diseases—tobacco use, lack of physical activity, and poor nutrition. This document is designed to increase awareness of the immense burden of these diseases and the potential for preventing many of the associated deaths.

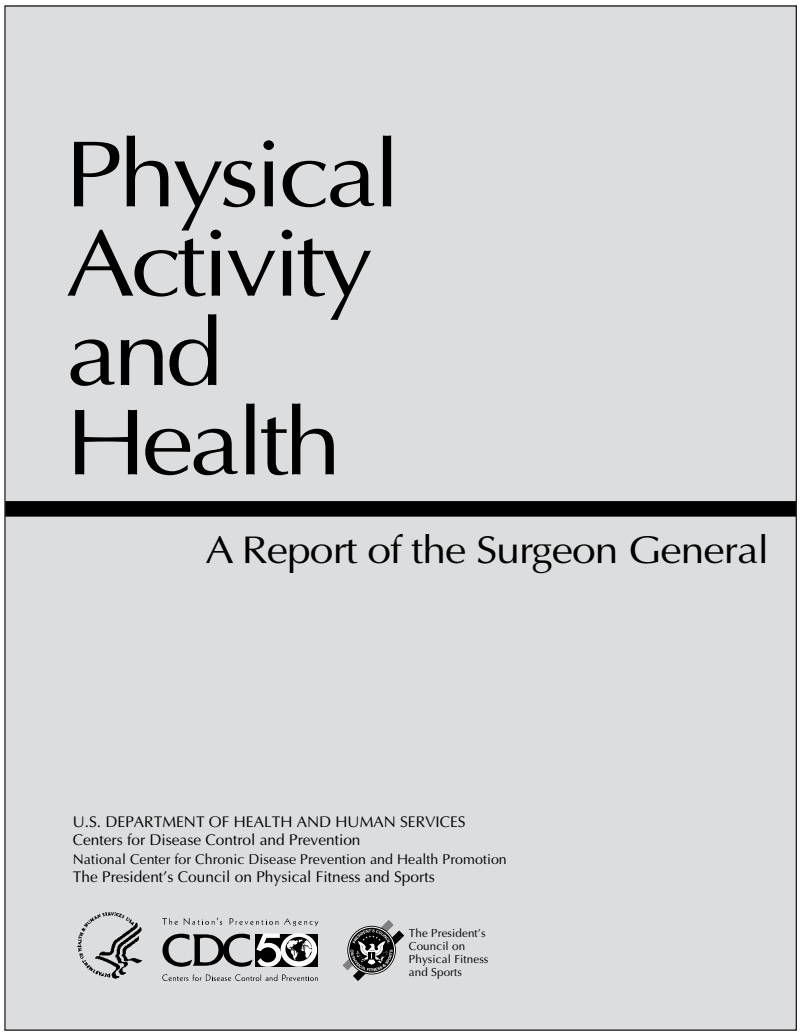
Diabetes Surveillance, 1997 [1997]
This report presents data from CDC's diabetes surveillance system, which collects, analyzes, and disseminates national data on diabetes and its complications. These data are critical for increasing the recognition of the disease, identifying high-risk groups, developing strategies to reduce the economic and human costs of diabetes, formulating health care policy, and evaluating progress in diabetes prevention and control.

From Data to Action: CDC's Public Health Surveillance for Women,Infants, and Children [1994]
This monograph presents the first comprehensive description of CDC's many public health surveillance and data programs that provide information on women's and children's health. It offers health practitioners and planners at the local, state, and national levels a better appreciation of the uses and limitations of these data and provides a clearer perspective on future concerns for monitoring health.

Manual of Intervention Strategies to Increase Mammography Rates [1996]
Developed for Prudential Health Care, this manual is a source of basic information on mammography and intervention strategies, references, and tools that health plans can use to increase mammography screening rates. It is designed to be easy to use, practical, and adaptable to the needs of different health plans.

The National Strategic Plan for the Early Detection and Control of Breast and Cervical Cancers [1993]
Designed for use by public and private organizations at the national, state, and local levels, this plan outlines a general framework for the major activities that should constitute a national strategy for the early detection and control of breast and cervical cancers.

Physical Activity and Health: A Report of the Surgeon General [1996]
The first Surgeon General's report addressing physical activity and health summarizes diverse literature from the fields of epidemiology, exercise physiology, medicine, and the behavioral sciences. Its key finding is that moderate physical activity can help people of all ages improve the quality of their lives and reduce their risk for coronary heart disease, hypertension, colon cancer, diabetes, and other diseases.



NCCDPHP coordinated the development and publication of Physical Activity and Health: A Report of the Surgeon General, which demonstrated the health benefits conferred by moderate physical activity.

Preventing and Controlling Oral and Pharyngeal Cancer: Recommendations from a National Strategic Planning Conference [1998]
This report, the result of concerted efforts of CDC and its partners, presents strategies for action and a list of priority recommendations for preventing and controlling oral and pharyngeal cancer. These recommendations will enable CDC to develop a coordinated national plan to reduce illness and death from oral and pharyngeal cancer in the United States.

Preventing Tobacco Use Among Young People: A Report of the Surgeon General [1994]
This 23rd Surgeon General's report on the health consequences of tobacco use focuses on the vulnerable ages of 10 through 18 years, when nearly all users first try—and become addicted to—tobacco. The report stresses the scope, causes, and consequences of the problem and points to ways to remedy it.

Tobacco Use Among U.S. Racial/Ethnic Minority Groups: A Report of the Surgeon General [1998]
This publication reports on tobacco use and its consequences among African Americans, American Indians and Alaska Natives, Asian Americans and Pacific Islanders, and Hispanics. The report includes examples of numerous racial- and ethnic-specific tobacco control programs used in communities across the country.

Take Charge of Your Diabetes 2nd Edition [1997]
Intended primarily for adults with diabetes and published in both English and Spanish versions, this book provides information and encouragement to help those living with diabetes control their illness, balance their lives, and prevent complications.

Using Chronic Disease Data [1992]
Developed in response to requests from state health departments, this handbook can help public health personnel acquire, analyze, and interpret chronic disease data and communicate the results. It describes the strengths and limitations of mortality, hospitalization, and behavioral risk factor data and provides examples of how public health agencies have used data from several sources to gain support for initiatives and programs.

Worldwide Efforts to Improve Heart Health: A Follow-up to the Catalonia Declaration—Selected Program Descriptions (1997)
This document, which is a companion to *The Catalonia Declaration: Investing in Heart Health,* offers real-word examples of programs that have invested in heart health. The programs described show how groups and individuals in varied settings around the world have forged alliances to prevent, reduce, or control the spread of cardiovascular disease.

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Health Observances

- ***Diabetic Eye Disease Month*—November**
  Prevent Blindness America
  800/331-2020
- ***National Diabetes Month*—November**
  American Diabetes Association
  800/232-3472
  703/549-1500
- ***National Epilepsy Month*—November**
  Epilepsy Foundation of America
  800/EFA-1000
  301/459-3700
- ***Great American Smokeout*—November 19**
  American Cancer Society
  800/ACS-2345
- ***National Birth Defects Prevention Month*—January**
  March of Dimes Birth Defects Foundation
  914/997-4600

Dr. Koplan Takes Reigns as New CDC Director

Jeffrey P. Koplan, MD, MPH, has been named Director, Centers for Disease Control and Prevention. He returns to CDC from his present position as the President of The Prudential Center for Health Care Research in Atlanta. From 1989 to 1994, Dr. Koplan served as Assistant Surgeon General and the first director of CDC's National Center for Chronic Disease Prevention and Health Promotion.

During his 22-year Public Health Service and CDC career, Dr. Koplan has made many contributions in the battle against the major burdens of infectious diseases, environmental hazards, chronic diseases, and unintentional injuries. He has worked in the Smallpox Eradication Program, the Caribbean Epidemiology Centre, and as CDC's Assistant Director for Public Health Practice. He established a national women's breast and cervical cancer early detection program at CDC and was instrumental in focusing attention on the global impact of the health hazards of tobacco. He received the Public Health Service's Distinguished Service Award—the Department of Health and Human Services Commissioned Corps' highest award—as well as seven other PHS awards. He also received the Indian Health Service Director's Special Award for Excellence.

Dr. Koplan holds numerous academic appointments and is currently Visiting Professor of Community Health at Emory University School of Medicine, Clinical Professor of Community Medicine at Morehouse Medical School, and lecturer at Harvard Medical School. He has written or contributed to more than 140 scientific publications on epidemiology, economic analysis, prevention effectiveness and the value of cost-benefit analysis in prevention, health services research, health promotion, and international health.

He earned a BA in English from Yale University, an MD from Mt. Sinai School of Medicine and an MPH from Harvard University's School of Public Health. He was a resident in internal medicine at Montefiore Hospital and Stanford University Hospital and in preventive medicine at CDC. He is board certified in internal medicine and preventive medicine.

New Director for Division of Oral Health

William R. Maas, DDS, MPH, has become director of the Division of Oral Health, NCCDPHP, effective July 1, 1998. He brings 25 years of service as a member of the Department of Health and Human Services Commissioned Corps. He has provided clinical care and directed clinical and community health programs at the community, regional, and headquarters levels of the Indian Health Service before being assigned to the Agency for Health Care Policy and Research in 1989.

In 1997, Dr. Maas was selected and appointed Assistant Surgeon General and Chief Dental Officer of HHS's Office of Public Health and Science. This role involves coordinating dental programs and professional affairs for the Office of the Surgeon General and DHHS.

Dr. Maas is a graduate of the University of Michigan School of Dentistry, with an advanced general practice residency in the Indian Health Service. He earned his Master of Public Health and Master of Science in Health Policy and Management at Harvard University. He is a Diplomate of the American Board of Dental Public Health and a Fellow of the American College of Dentists.

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13th National Chronic Disease Conference Slated for December

The Centers for Disease Control and Prevention and the Association of State and Territorial Chronic Disease Program Directors are cosponsoring the 13th National Conference on Chronic Disease Prevention and Control *Prevention: Translating Research into Public Health Practice*, in Atlanta, December 8–10, 1998.

The conference will consist of plenary, workshop, and skills-building training sessions; roundtables with invited speakers; oral and poster presentations based on submission of accepted abstracts; and exhibits. Topics will include emerging chronic disease issues, public health and medicine, use of epidemiologic data for program planning, prevention research, and issues for at-risk populations.

For more information, contact Bachmann and Associates, Inc., 1400 West 122nd Avenue, Suite 104, Westminster, CO 80234; 303/280-1112; E-mail: rnbachmann@earthlink.net. Information about the conference and the registration form are posted on the NCCDPHP Web site at http://www.cdc.gov/nccdphp/cdconf98. htm.

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