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The Prevention Research Centers Directors: Reflections Covering Two Decades of Leadership

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Abstract

Between 1992 and 2011, the Centers for Disease Control and Prevention's (CDC's) Prevention Research Centers (PRC) Program had a series of five directors. In the following Commentary, four of these five directors offer their reflections on the program during their periods of leadership.

JEFFREY R. HARRIS, 1992–1995

In the early years of the PRC Program, we had three inter-related goals:

1. make the PRCs an integral part of CDC's national and state-based efforts to prevent and control chronic diseases;
2. build a "routine" system for managing the PRCs within the National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP); and
3. bring the individual PRCs together as a network dedicated to applied prevention research and practice.

In 1992, the idea of a federally coordinated and funded approach to state-based chronic disease prevention and control was still new.¹ At the national level, this approach was based in NCCDPHP, with its divisions dedicated to core public health functions (e.g., surveillance); risk behaviors (e.g., tobacco use); community settings (e.g., schools); and diseases (e.g., diabetes). At the state level, the PRCs were a part of a variable portfolio of NCCDPHP-funded programs that included infrastructure, like the placement of state-based chronic disease epidemiologists, and disease-specific programs, like that for breast and cervical cancer screening. Other federal agencies were also involved, particularly the Indian Health Service. One manifestation of this coordinated approach was in PRC Program site

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visits to individual PRCs. The visits were led by researchers and staff from the PRC Program, multiple NCCDPHP divisions, and the individual PRCs. Where possible, the visits would involve the director of the state chronic disease program, the state chronic disease epidemiologist, and Indian Health Service researchers and staff.

A second goal was building a “routine” system for managing the PRCs. Prior to my hiring, Jim Marks managed the PRC Program in the NCCDPHP Director’s Office, with assistance from Diane Jones and Jean Smith, and I succeeded Jim in that role. Toward the end of my tenure, however, the PRC Program moved out of the Director’s Office and into one of NCCDPHP’s divisions.

The third goal still creates challenges for the PRC Program—how to bring together as a national network individual PRCs funded to conduct very specific, often small-scale, research projects. Miriam Settle of the University of North Carolina led the effort by creating “the Matrix,” an inventory of PRC projects. Together, we used this inventory to help PRCs see their commonalities and work across the centers to create large-scale impact.

PATRICIA L. RILEY, 1996–1999

Twenty years ago, I was offered an opportunity and a challenge to steward a unique public experiment designed by some of the leading public health visionaries of the 20th century. These visionaries included William Bridgers (now deceased), founding dean of the School of Public Health, University of Alabama–Birmingham; Robert Day, Professor Emeritus, Health Services, and Dean Emeritus, School of Public Health, University of Washington; and D.A. Henderson (now deceased), Distinguished Scholar of Health Security, University of Pittsburgh Medical Center and Professor of Public Health and Medicine at the University of Pittsburgh, and Dean Emeritus of the Johns Hopkins Bloomberg School of Public Health. Their collective commitment, determination, and belief in the intrinsic value of applied public health research—coupled with the policy and managerial acumen of Michael Gemmell, Director of the Association of Schools of Public Health—enabled the PRC Program to take hold within CDC, an institution initially founded and grounded in communicable disease detection.

In 1996, my initial year of PRC Program stewardship, I encountered a number of challenges, some of which perhaps continue to this day. For example, the program was directed through congressional language to expand the number of PRCs to a 13th center while simultaneously managing a program with level funding. This, in addition to coordinating an external evaluation by the Institute of Medicine² and a Government Accounting Office program review, required handling many challenges at the same time. Yet, that very same year afforded an unprecedented opportunity to operationalize a \$20 million agreement between NIH and CDC. The 5-year agreement supported community prevention studies as a third arm of the NIH’s Women’s Health Initiative. This investment, which ultimately financed 12 individual prevention studies, targeted minority women’s health in settings as varied as a New Mexico Indian Reservation and inner city Baltimore. The prevention research assessed the impact of novel interventions, such as creating community gardens on Indian Reservations and church-sponsored activities of diet and exercise, which today are common

mainstream public health practices. This collaboration was a win–win–win for CDC, NIH, and the PRCs.

My final year overseeing the program was characterized by the challenge of “plenty” coupled with an opportunity for rapid program expansion. By 1998–1999, the U.S. Congress had tripled the program’s appropriation from \$7 to \$21 million, which resulted in an increase of PRCs to 23. The growth in the number of centers, and accompanying broader geographic distribution, resulted in many more communities benefiting from prevention science.

No reflection would be complete without acknowledging the inspiration and dedication of the 23 PRC directors who unwaveringly supported CDC’s PRC team. The enthusiasm and engagement of leaders such as Ross Brownson of St. Louis University; Alan Cross (now deceased) of University of North Carolina–Chapel Hill; and Allan Rosenfield (now deceased) of Columbia University represent the many outstanding PRC directors whose contributions helped to shape the program during an extraordinary time.

MARSHALL KREUTER, 1999–2001

Throughout my career, I have been strongly committed to finding ways to effectively engage communities in our efforts to enhance the public’s health. About the time I was asked to work with the PRC Program, CDC Director Jeff Koplan set out primary goals for CDC, one of which was to strengthen the science of public health practice, and he envisioned the PRCs as a key part of that goal.

I was excited to be a part of the PRC Program for at least two reasons. First, while addressing the goal of strengthening public health science, virtually all of the PRC research efforts were carried out in partnerships established with local organizations and residents. And even though the PRCs were addressing different priority public health issues, they were all doing so in the context of a wide range of local-level differences in economic, social, and cultural factors. For example, the University of Arizona was targeting health in multiethnic communities; the University of Colorado focused on health rural communities; the University of Kentucky addressed residents in Appalachia; the University of Oklahoma focused on Native Americans; and Morehouse University addressed specific health issues in African American communities.

Second, the PRCs formed “networks” based on the health issues they were collectively addressing. These creative “networks” enabled the participating PRCs to actively share their experiences and findings; in some instances, those insights led to important mid-course corrections in their research.

Traditionally, CDC has sought to enhance public health practice on the basis of scientific evidence: hence the term “evidence-based practice.” As I retrospectively think about it though, what the PRCs were breaking ground on is what my friend Larry Green has been calling “practice-based evidence.” That is, they were trying to better understand and measure the effectiveness of their public health strategies given the reality that their target

populations were influenced by social, ethnic, cultural, and economic factors that were widely different.

EDUARDO J. SIMOES, 2002–2011

In my nearly 9 years as director of the PRC Program, I needed all the experience I had in medicine, public health, academia, and more. How does one manage a program that is research, academia, and practice of public health and where all stakeholders are “fully” engaged? It is like being the new coach of a highly prized professional sports team in which assistant coaches, players, supporters, the press, and club’s administration all have an opinion and aren’t afraid to share it.

After a few months of learning and listening, and together with PRC Principal Investigators and directors and the leadership of the former Division of Adult and Community Health, those PRC years were marked by activities in:

1. structuring a transparent administration;
2. improving the independence and fairness of the grant review process;
3. deepening the community participatory process while setting research standards and expectations³;
4. evaluating program’s performance⁴;
5. translating and disseminating the PRCs’ innovative research into public health practice⁵;
6. coordinating federal research efforts through academic programs;
7. promoting a culture of collaboration among PRCs through all stakeholders’ engagement; and
8. emphasizing practice-based research.

Above all, it was time for the PRC Program to become “adult” and deliver better and practical solutions for public health practice: the University of Washington’s EnhanceFitness, West Virginia University’s Not On Tobacco, Harvard University’s Planet Health, the University of Texas’ Coordinated Approach To Child Health, the University of North Carolina’s Nutrition and Physical Activity Self-Assessment for Child Care, St. Louis University’s and Washington University’s Guide for Useful Interventions for Physical Activity in Brazil and Latin America, the University of South Florida’s Eye Safety Program, and others.

Along the way and every day, this partnership of government, academia, and community traveled a bumpy road with improved pavement provided by dedicated federal public health officials motivated by knowledge and a strong sense of duty. All PRC Program teams in research, communication, and operations and their members were outstanding. None represented this philosophy better than Jean Smith (now deceased). She was always kind, attentive to the needs of the PRCs’ Principal Investigators and directors, resourceful, and funny. Whenever there was tension created between the PRC Program and the PRCs, Robert

Hancock (former PRC Program deputy director) and I called Jean Smith to participate in a process of “defusing.” It always worked. There was not a soul who would disagree she represented goodness and warmth; thus, nothing negative could result after her involvement.

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