

Heart MEMO

Cardiovascular Health for All: NHLBI Sets New Heart Health Agenda

Cardiovascular Health for All. That is the ambitious goal that the National Heart, Lung, and Blood Institute (NHLBI) has set for itself as America approaches a new millennium.

The goal reflects recent initiatives from the Federal Government to improve the Nation's health. Among them is a White House initiative to eliminate racial, ethnic, and geographic disparities in the burden of disease for six areas of health, including cardiovascular disease (CVD). The White House initiative is being led by the U.S. Department of Health and Human Services (DHHS).

The problem of disease disparity also was underscored during a review of the Federal Healthy People 2000 report, which established national objectives in health promotion and disease prevention (see page 6). According to the review, CVD death rates and risk factor prevalences remain disproportionately high in minority and low-income populations.

The report further noted that scientific knowledge about heart treatments and healthy behaviors was not being made available to all Americans.

In response to these challenges, the NHLBI has devised a new heart health agenda. The agenda identifies four "performance goals," each of which targets a stage in the progress of CVD—risk factor prevention, risk factor

detection and treatment, early recognition and treatment of acute coronary syndromes, and prevention of second coronary events and complications from CVD. The goals are shown in the accompanying diagram; their matching objectives are given in the box on page 3.

To achieve the four goals, the NHLBI is funding a wide range of results-oriented "performance projects." A key element of these is the forging of community-based partnerships that will bring CVD information to those in areas or populations at high risk for CVD.

"For 50 years, the NHLBI has made a big investment in research to improve Americans' heart health," explained

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Letter from the Director

DEAR *HEARTMEMO* READERS:

This issue of *HeartMemo* announces the National Heart, Lung, and Blood Institute's new heart health agenda, which has set its sights on achieving cardiovascular health for all Americans in the 21st century.

As you will read in this issue, there has been considerable progress in reducing death and disability from cardiovascular disease during the past 50 years. But recent data show that not all Americans have benefited from this gain. According to the data, part of the reason for the continuing disease disparity is the lack of universal access to health information. Thousands of American lives are lost each year because of underutilization of health information.

Fortunately, there now are new means of bringing this information to every community in the United States. The Institute is planning a number of new initiatives, including the Community-Based Action Centers for Enhanced Dissemination described in the feature article. These action centers will work with NHLBI to design the best strategies for improving cardiovascular health in their communities.

The Institute also has been exploring new communication technologies. It has created new interactive Web sites that provide better use of clinical practice guidelines, distance learning, and fast dissemination of the latest research findings. In this issue, you'll read about the expanded cholesterol Web site, which will be launched on September 1 to celebrate

National Cholesterol Education Month. Other interactive NHLBI Web sites are already up and running or in the works, for example, the popular Healthy Weight Web site described on page 15.

The NHLBI also is beginning to webcast CVD conferences. Health care professionals around the world can now participate in these meetings in real time and, without leaving their computers, learn about cardiovascular trends, treatments, and other important topics.

The NHLBI hopes that you will join us in this new health information network. By working together, we can achieve cardiovascular health for all Americans. ■



Claude Lenfant, M.D.
Director, NHLBI

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NHLBI Director Dr. Claude Lenfant. “And research has given many Americans a huge return on that investment. But not all Americans have reaped the benefits equally.

“We need to enhance CVD prevention and treatment,” he continued. “We need to work more closely with communities. Too many lives are being lost each year because we are not using our existing information to its fullest.”

One example of the new partnership effort aimed at zeroing in

on disease disparity is the creation of Community-Based Action Centers for Enhanced Dissemination. The NHLBI will establish these action centers across the United States in communities at high risk for CVD.

Dr. Gregory Morosco, director of the NHLBI’s Office of Prevention, Education, and Control, explained, “The goal is to tailor cardiovascular health education efforts to each community’s needs. We want to break through traditional modes of communication and bring the developers of health

promotion efforts face-to-face with the users of their information and materials.

“These action centers will help us determine what communication strategies work best for a particular area or population,” continued Morosco. “They will then work with us to carry out appropriate educational initiatives and activities.”

For instance, special education materials may be prepared for a low-income population, or professional practice guidelines from an NHLBI education program might

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SETTING HIGH GOALS

At the core of NHLBI’s new heart health agenda are its four performance goals. These results-oriented goals are linked to measurable objectives. The goals and objectives are as follows:

The screenshot shows a Netscape browser window displaying the NHLBI website. The page title is "Cardiovascular Health For All" and the subtitle is "National Heart, Lung, & Blood Institute". On the left side, there is a "Keep the Beat" logo. The main content area lists four performance goals, each with a red heart icon and a detailed objective.

Performance Goal #1
Prevent Development of Risk Factors
Objective
 Through population and clinical approaches, increase the percentage of children and adults who engage in heart-healthy behaviors to prevent the development of cardiovascular disease (CVD) risk factors.

Performance Goal #2
Detect and Treat Risk Factors
Objective
 Increase the percentage of patients who have their CVD risk factors detected and who implement lifestyle and/or pharmacologic intervention and successfully control their blood pressure and cholesterol levels and weight to prevent the development of CVD.

Performance Goal #3
Early Recognition and Treatment of Acute Coronary Syndromes
Objective
 Increase the percentage of the public, including specified target groups (such as women and minorities) and providers, who recognize the symptoms and signs of acute coronary syndromes and seek timely and appropriate evaluation and treatment.

Performance Goal #4
Prevent Recurrence and Complications of Cardiovascular Disease
Objective
 Increase the percentage of CVD patients who are treated appropriately with lifestyle changes and drugs and who reach low-density lipoprotein (LDL) cholesterol and blood pressure levels and successfully control their weight and other CVD risk factors to reduce CVD events.

BEHIND THE SCENES:
FINDING THE BEAT OF HEART HEALTH


Keep
the Beat

Be Good To Your Heart

National Heart, Lung, and Blood Institute

There is a new look to the National Heart, Lung, and Blood Institute's effort to motivate Americans to be heart healthy. It's a "heart health brand," and it will appear on all materials from NHLBI national CVD programs, initiatives, and other activities, including its performance projects (see the lead story).

"Keep the Beat: Be Good To Your Heart" (shown above) was developed through a process that included market research and consumer testing, as well as a team of artists and designers.

The brand needed to deliver a clear message to Americans to take steps to protect their heart health. The brand also had to support NHLBI's many other public health education messages about CVD and to apply to all Americans, old and young, with and without heart disease.

Once devised, a number of candidate brands were tested with consumers in focus groups and other interviews. The "Keep the Beat" brand proved to be the clear winner. Focus group participants, ages 24 to 70, found it easy to recall, action-oriented, and positive, promoting an "I can do this" attitude. Others interviewed said "Keep the Beat" was catchy, easy to relate to, and positive, making them want to exercise.

Health care professionals also were canvassed and chose "Keep the Beat." They said it was short, rhythmic, and easy to remember and could be applied across a broad range of health promotion activities. They also felt it would appeal to all generations.

The new heart health brand is now ready to become a winner with all Americans and to inspire them to keep their heartbeats healthy.

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be redesigned for use by managed care physicians. Action centers also could share useful approaches and materials.

The NHLBI is currently in the process of identifying the high-risk communities. The Institute expects to establish action centers in Latino, American Indian and Alaska Native, African American, Asian American, and Pacific Islander American communities.

Funding of the action centers should begin by the end of the year.

The action centers are only one example of the new performance projects, which will cover a broad range of activities. The following list is a sampling of other performance projects already under way or in the planning stage:

- Developing a communications strategy for a public education campaign on body weight

- Preparing community, patient, and provider education materials about early recognition of heart attack
- Helping managed care physicians improve the treatment of high cholesterol
- Encouraging children and their families to become physically active and follow a heart-healthy diet

The last project, titled "Hearts N' Parks Y2K" is featured and

“A key element of these performance projects is the forging of community-based partnerships that will bring CVD information to those areas or populations at high risk for CVD.”

described on page 17. Other performance projects will be spotlighted in future issues of *HeartMemo*.

To further improve delivery of information to health care professionals, patients, and the public, the NHLBI also has begun developing a new 21st century “health communications infrastructure.” For example, the Institute already has established special interactive Web sites for cholesterol and weight control. Distance learning and webcasting of conferences and workshops are in the works or soon to be added.

In late September, for instance, the Institute will host its first

webcast conference, in which health care professionals can participate by online computer (see the box). This major CVD conference will assess the magnitude and causes of differences in the death rates and prevalences of CVD and its risk factors. Recommendations will be used to shape future policies and programs, including intervention efforts.

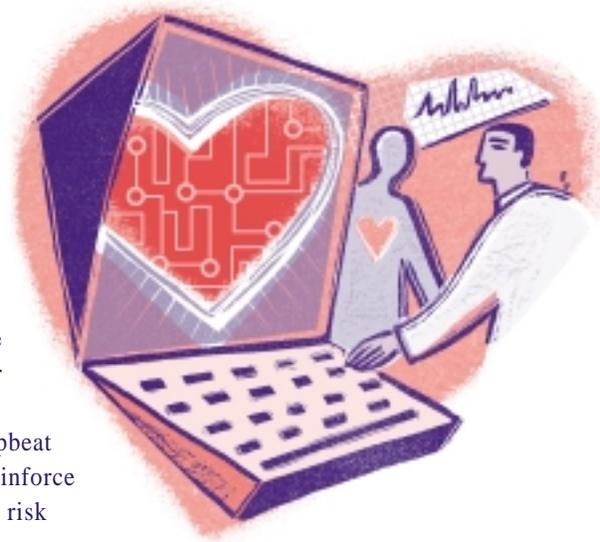
“The power of the World Wide Web to facilitate the flow of information is unparalleled,” noted Morosco. “It gives us not only a way to inform but also a way to share ideas about key CVD issues.”

Finally, to add visibility and momentum to the activities of the CVD performance projects, the NHLBI will begin employing a new national “heart health brand” (see the box on page 4). The “Keep the Beat” brand will appear on all NHLBI CVD-related materials. Its upbeat look was designed to reinforce NHLBI messages about risk

factor control and to motivate more Americans to become heart healthy.

“The brand sends a clear message that ties together the many themes of risk factor prevention and heart health,” said Morosco. “It says everyone can follow a heart-healthy lifestyle, whether they’re old or young. Whoever you are, you can take steps to be healthier and feel better.”

As the 21st century approaches, the NHLBI expects its new heart health agenda to quicken the pulse of progress toward cardiovascular health for all. ■



GET IN TOUCH— NHLBI BROADCASTS CVD CONFERENCE ONLINE

The NHLBI will webcast a “National Conference on Cardiovascular Disease Prevention” from Bethesda, Maryland. The 3-day conference will bring together researchers, health care professionals, and other cardiovascular experts to assess national trends in death and disability from heart disease, stroke, and other types of cardiovascular disease. The results will help determine data gaps as well as future research and program development.

The conference airs September 27–29, 1999. To learn more about the conference, check the NHLBI Web site at www.nhlbi.nih.gov.

Reviewing Healthy People 2000 and Cardiovascular Health

Earlier this year, health care professionals and others were able—because of live satellite transmission, video-conferencing, and the Internet—to take part in a DHHS review of the *Healthy People (HP) 2000* goals for heart disease and stroke. The event, *Healthy People 2000 Progress Review for Heart Disease and Stroke*, was hosted by U.S. Surgeon General Dr. David Satcher, NHLBI Director Dr. Claude Lenfant, and National Center for Health Statistics Director Dr. Edward Sondik. Here was an example of the health care community helping to set the course as the Nation moves forward from the *HP 2000* program to the *HP 2010* program.

HP 2000 is a framework established by the DHHS to help improve the health of Americans. Using this framework, the Federal Government has been setting goals and monitoring health progress. In periodic reviews, various participants have assessed progress that has been made and challenges that remain. The NHLBI leads the *HP 2000* heart disease and stroke priority area, 1 of 22 areas covering 318 health objectives for the year 2000.

During the event, viewers posed questions, mainly by phone and fax, to a panel assembled in Wilson Hall on the NIH campus. The panel comprised representatives from community health groups, Federal agencies, academic medical centers, public health departments, and nonprofit organizations. The participants and panel members came together to discuss ongoing health problems that the *HP* goals might address.

One issue discussed was reducing health disparities among racial and

ethnic groups. Referring to reducing these disparities, Dr. Satcher stated, “The entire Nation benefits when we protect the health of the most vulnerable among us.”

Dr. Lenfant reviewed progress in prevention and treatment of heart disease and stroke. In 1948, the Federal Government began a sustained investment in CVD prevention, early detection, treatment, and control, which has led to changes in surgery and drugs and identification of risk factors. Dr. Lenfant stated, “Professional, patient, and public health education efforts

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“The NHLBI leads the HP 2000 heart disease and stroke priority area, 1 of 22 areas covering 318 health objectives for the year 2000.”

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brought research findings into Americans’ everyday lives, changing both treatment practices and lifestyles. As a result, we witnessed a 59 percent decline in the death rate from CVD between 1950 and 1996.” Such progress demonstrates the effectiveness of science-based public health strategies relying on partnerships between Government and the private sector.

Dr. Lenfant continued, “Despite those remarkable gains, heart disease and stroke remain the first and third causes of death in the United States.”

Dr. Sondik remarked, “The 17 Healthy People objectives in heart dis-

ease and stroke targeted changes in mortality, in risk factors, and in primary care regimens, work site programs, and laboratory accuracy.” Achievements noted during the session included the following:

- The *HP 2000* target for reducing coronary heart disease (CHD) deaths has nearly been attained.
- Goals for reducing the prevalence of high blood cholesterol and for increasing awareness of high blood cholesterol condition were attained.
- Goals for reducing Americans’ total fat and saturated fat consumption were moving toward their targets.

On the downside, although the CHD death rate is nearing the target for year 2000, the rate for African Americans remains considerably higher than the rate for other groups. In fact, the coronary heart disease death rate and stroke death rate for African Americans are at least twice the rates for any other population group.

Smoking, obesity, and physical inactivity have emerged as the most pressing threats to the cardiovascular health of Americans. The long-term national trend in smoking has been down, but progress has stalled. Recent data show an increase in smoking among teens.

Little progress in physical activity was made during the past decade, and the *HP 2000* goals for physical activity are not being attained. Inactivity, along with smoking and obesity, are especially problematic in many minority communities. Disparities in the use of medical technology must be addressed.

Participants and panelists in the session agreed that a balanced

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The National High Blood Pressure Education Program

NHBPEP COORDINATING COMMITTEE CONSIDERS SYSTOLIC PRESSURE AND MORE

The idea of using systolic pressure to measure hypertension and predict future heart disease was a recurring theme during the NHBPEP's Coordinating Committee meeting held this past April. A presentation and panel discussion focused on that topic within the context of a consideration of pulse pressure, and it played a role in other discussions. Invited speakers also described an assessment of inadequate hypertension treatment, the new hypertension performance measure for managed care organizations, and trends in end-stage renal disease.

Systolic, Diastolic, and Pulse Pressures

Physicians traditionally have monitored diastolic pressure to assess and predict health and disease. Dr. Daniel Levy, director of the Framingham Heart Study, presented the results of a study that compared the ability of systolic, diastolic, and pulse pressures to predict cardiovascular events. He noted that disparities in the predictive powers of systolic and diastolic pressures had not been emphasized by many researchers in the past. His study employed data from more than 3,500 subjects from the Framingham study. It revealed that higher systolic, diastolic, and pulse pressures all display associations with higher risk for CHD, with pulse pressure showing the greatest association and diastolic pressure the smallest. Dr. Levy reported similar results in predicting congestive heart failure.

Dr. Levy pointed to the dramatic effect of "upstaging," in which rises in systolic pressure outstrip (or upstage) rises in diastolic pressure. This effect is common as we age; the reverse occurrence—large contrasting increases in diastolic pressure—is rare.

Dr. Levy stressed that, individually, each of the pressures—including diastolic—is predictive of heart disease. Pulse pressure, the strongest indicator, might be used to discover subjects who require special consideration. Finally, there is a need to study discordant blood pressures.

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"Higher systolic, diastolic, and pulse pressures all display associations with higher risk for CHD and congestive heart failure."

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Dr. Joseph Izzo, who represents the Council of Geriatric Cardiology on the Coordinating Committee, reviewed the pathogenesis of hypertension in younger and older persons. In the former, high stroke volume is mainly responsible for increased pressure; in the latter, arterial stiffness is responsible for increased pressure. Dr. Izzo indicated that the reflective wave theory states that pulse waves, moving faster than blood itself moves, can rebound against arterial blockage or narrowing, leading to increased systolic blood pressure. A number of clinical trials demonstrating the clear benefit of lowering systolic blood pressure were cited.

The Coordinating Committee discussed the broader issue of whether switching to a different pressure indicator, especially pulse pressure, would be useful as part of current management strategies. The members agreed that pulse pressure, although a strong predictor of heart disease, would present drawbacks if used as the only indicator in treatment. In addition, it was mentioned that no clinical trial demonstrating the benefit of reducing pulse pressure has been conducted.

Inadequate Management

Dr. Daniel Berlowitz of the Boston University School of Medicine and the Bedford Veterans Hospital presented a review of his recent study of attitudes and practices concerning clinical blood pressure control (Inadequate management of blood pressure in a hypertensive population.

New England Journal of Medicine 339(27):1957-63, 1998). The study demonstrated that most patients with hypertension are experiencing suboptimal control of the disease. High blood pressure is controlled when it is maintained below 140 mm Hg systolic and below 90 mm Hg diastolic. Dr. Berlowitz suggested that clinics need to link process measures and outcome measures to move toward increased treatment. An example of a process measure is a schedule for checking blood pressure; an example of an outcome measure is a recorded change in blood pressure.

In his study, Dr. Berlowitz found that clinicians are not sufficiently aggressive in prescribing antihypertensive medications. He and coworkers developed a "treatment intensity score," which linked process and outcome measures; they also found

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that the following factors were associated with increases in therapy:

- Increases in both diastolic and systolic pressure (discovered during the visit)
- A previous change in therapy
- The presence of coronary artery disease
- That the visit was scheduled rather than unscheduled

Cardiovascular risk factors other than hypertension were not associated with increases in therapy. Of interest, in particular to those attending this meeting, was the finding that increases in diastolic blood pressure were most important in decisions to increase therapy. The upshot, said Dr. Berlowitz, is that physicians are not being sufficiently aggressive in managing hypertension. He hopes that in the future, he can further validate the instrument he developed, include database information, and incorporate feedback.

A number of issues cloud the problem of adherence, including the following:

- Overly blaming patients
- Insufficient monitoring (by the physician)
- Patients who do not acknowledge a problem
- The need to maintain patient-physician relationships
- Misperceptions of side effects
- A lack of specific goals
- Fragmentation of treatment

The HEDIS Hypertension Measure Approved

Dr. Earl Steinberg of COVANCE announced that the new Health Plan Employer Data and Information Set (HEDIS) hypertension performance measure for managed care organizations (MCOs) completed a pilot test

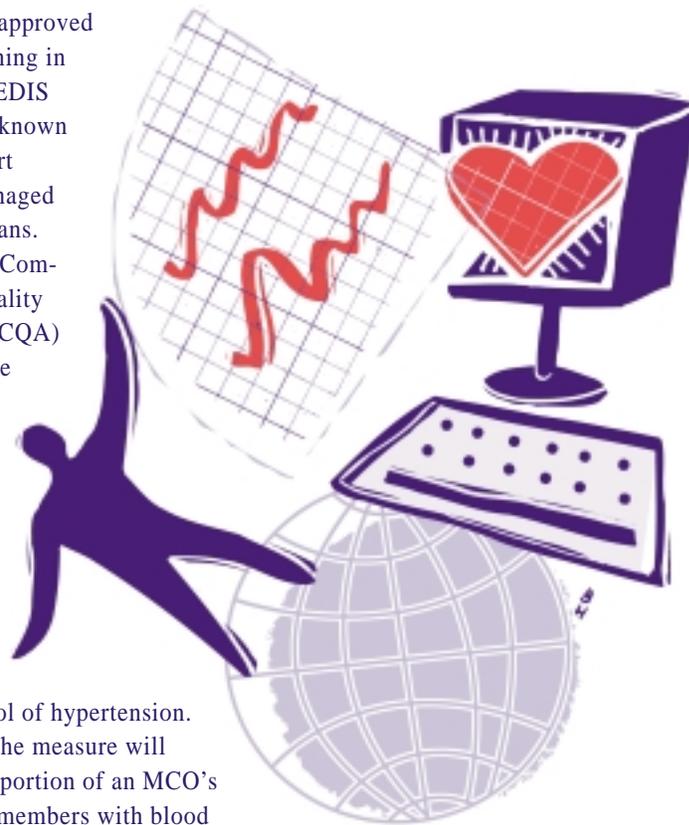
and has been approved for use beginning in 2000. The HEDIS measures are known as “The Report Card” for managed care health plans. The National Committee for Quality Assurance (NCQA) has created the HEDIS measure, which, when used by MCOs, will serve to indicate the degree to which programs address control of hypertension. Specifically, the measure will assess the proportion of an MCO’s hypertensive members with blood pressure brought to below 140/90 mm Hg.

The new measure will increase MCO accountability, allowing health plans to be compared easily. NCQA intends to follow up by assisting MCOs in implementing the new measure and by offering use of the measure to non-MCO settings.

A 25-member committee within NCQA oversees the management and evolution of the HEDIS measures. This Committee on Performance Measurement includes representatives of constituencies affected by the performance measurement program, including employers, health care providers, consumers, quality experts, managed care plans, and policymakers.

The summary of the Coordinating Committee Meeting can be found on the NHLBI Web site:

<http://www.nhlbi.nih.gov>.



NHBPEP REPORT ON HYPERTENSION IN PREGNANCY NEARING COMPLETION

The NHBPEP Working Group on High Blood Pressure in Pregnancy has nearly completed its guidelines on issues in hypertension and pregnancy. Now in the final stages of review and editing, the report likely will become available near the end of the year.

The purpose of the document is to provide guidance to practicing clinicians on managing (1) patients with hypertension who become pregnant and (2) patients who develop hypertensive disorders during gestation. The working group considers this document as a guide that should serve as a tool to be adapted and implemented in individual situations.

To summarize scientific knowledge, the working group brought together a group of experts to review and report on the full scope of issues.

Topics reviewed in detail include the following:

- Classification of hypertensive disorders in pregnancy
- Pathophysiology of hypertension in pregnancy
- Fetal assessment in chronic hypertension
- Differential diagnosis
- Prevention of preeclampsia
- Management of preeclampsia
- Postpartum counseling

The report will update and expand recommendations made in *The Sixth Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC VI)*. Recommendations will include suggestions for future research.

To obtain a copy of the *NHBPEP Working Group Report on High Blood Pressure in Pregnancy*, check the NHLBI Web site at <http://www.nhlbi.nih.gov>.

WORKSHOP TACKLES SALT ISSUES

An NHLBI Workshop on Sodium and Blood Pressure, held January 28–29, 1999, featured excellent presentations about research, nutrition, genetics, and policy. Participants voiced agreement that American diets supply much more sodium than is physiologically needed but it is difficult to reduce salt intake because nearly 80 percent of salt consumed in the American diet comes from processed or convenience foods. The workshop's findings have been forwarded to the NHBPEP Coordinating Committee and other policy-making bodies. NHLBI intends to publish a summary of the meeting, and the Coordinating Committee will issue an update of the 1995 sodium policy statement in the near future.

Speakers invited to the workshop and public attendees discussed the state of research knowledge and stressed the difficulties of diet and salt studies resulting mainly from the complexities of measuring nutrient intake and correlations among nutrients.

The attendees discussed the findings of a number of large studies, such as the INTERSALT study and the Scottish Heart Health Study, and concluded that the preponderance of evidence indicates a modest but consistent relationship between salt intake and a rise in blood pressure. They were cool to the idea of conducting a new randomized clinical trial on sodium reduction and CVD morbidity/mortality.

Workshop conclusions included the following:

- Responsiveness to salt intake increases with age.
- Older people who are overweight may receive greater benefit from sodium reduction.
- Persons with high risk for hypertension exhibit better responses to sodium reduction.
- Hypertensives are more salt-responsive than are normotensives.
- Sodium reduction may be more beneficial in certain genotypes.
- Minerals in addition to sodium affect blood pressure.
- Studies of single nutrients may not be relevant because foods contain multiple nutrients.
- Studies reporting the adverse effects of a very low sodium diet have not been replicated or contain unanswered methodological problems.

AMERICAN SOCIETY OF HYPERTENSION INITIATIVE DESIGNATES FIRST HYPERTENSION SPECIALISTS

Responding to *The Sixth Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC VI)* and the need to identify and recognize those physicians with particular expertise in hypertension treatment, the American Society of Hypertension (ASH) has designated more than 200 physicians as Specialists in Clinical Hypertension. The ASH Specialists Program was begun in 1998 and is the first such program in the field of hypertension. The Program will identify those physicians who can act as local and regional consultants for difficult cases and provide expert advice in guideline development and process improvements.

Dr. Lawrence R. Krakoff, chair of the Executive Committee of the Program, recently addressed ASH members at a conference in New York: "The real challenge we have set for ourselves is to demonstrate that identifying and recognizing specialists in clinical hypertension will prove to be a valuable resource to those on the front lines who treat hypertension on a daily basis, and thus to better the cardiovascular health of our population."

A board-type examination to supplement the credentials evaluation currently used to designate the first group of eligible physicians is being developed.

For more information regarding the Specialists in Clinical Hypertension designation, please contact Maryellen Tria, ASH Specialists Program, Inc., 515 Madison Avenue, Suite 1212, New York, NY 10022; 212-644-0650 (phone), 212-644-0658 (fax), spec@ash-us.org (e-mail). ■

The National Cholesterol Education Program

UPDATE OF THE NCEP CHOLESTEROL TREATMENT GUIDELINES

Since the release of *The Second Report of the Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults (Adult Treatment Panel II [ATP II])* in 1993, substantial scientific evidence has accumulated showing the benefits of cholesterol lowering. A series of clinical trials with statin drugs has proven that large degrees of LDL-cholesterol lowering produce marked reductions in CHD events and deaths in people with and without existing CHD. See the National Cholesterol Education Program (NCEP) article in the winter 1999 edition of *HeartMemo* for more detailed information about specific trials. The new evidence has generally supported the recommendations of the *ATP II* guidelines, which anticipated the results of the trials. Nevertheless, there are several issues in *ATP II* that require updating, and the NCEP Coordinating Committee has expressed support for an update of the guidelines. At its meeting on December 1, 1998, the Coordinating Committee suggested issues to be addressed in the update, discussed them in detail, and recommended that an expert panel be convened to move the effort forward.

The following are some of the central issues that will be addressed in the update:

- Implications of recent clinical trials.** A large number of trials in patients with CHD and in primary prevention have been completed. The panel will evaluate the implications of these trials for therapeutic recommendations.
- LDL-cholesterol target in CHD patients.** Solid scientific evidence from prospective epidemiologic studies, angiographic studies, and statin trials supports the current target LDL-cholesterol level of ≤ 100 mg/dL in CHD patients. Long-term prospective studies such as the Multiple Risk Factor Intervention Trial follow-up and the Framingham Heart Study have shown that CHD is uncommon at total cholesterol levels below 150 mg/dL, corresponding to LDL-cholesterol levels below 100 mg/dL. These studies also have shown that 20 to 25 percent of myocardial infarctions occur in people with LDL levels between 100 and 129 mg/dL. The post-CABG angiographic trial showed that aggressive lowering of the LDL level to 95 mg/dL is more beneficial than moderate lowering to a level of 135 mg/dL. The main results of recent statin trials also support an LDL target of ≤ 100 mg/dL. Although subgroup analysis from some of the statin studies suggests that there may be a threshold LDL level below which no further benefit is derived, the totality of evidence suggests that the lower the LDL, the better. In the process of updating the guidelines, special attention will be given to the LDL-cholesterol range of 100 to 129 mg/dL, in terms of whether drug treatment should be initiated or, if already in place, intensified to further lower the LDL level, and which approaches for reducing CHD risk should be used in addition to LDL lowering. A central question to be addressed is
- “At what LDL levels should drug treatment be initiated?”
- Triglycerides.** Recent studies have reinforced the concept that high serum triglyceride levels (hypertriglyceridemia [HTG]) may sometimes contribute to increased CHD risk. The update will try to provide practitioners with an approach that helps them integrate treatment of HTG with cholesterol management. One approach the panel will examine is whether to regard non-HDL-cholesterol (i.e., LDL + VLDL + IDL*, which is the sum of the cholesterol in all the lipoproteins that promote atherosclerosis) as the target of therapy in patients with HTG, rather than LDL-cholesterol alone. HTG is frequently a marker for the metabolic syndrome, which comprises most or all of the following: overweight or obesity with atherogenic triglyceride-rich lipoproteins (TGRLP), low HDL-cholesterol and small dense LDL, hypertension, insulin resistance and glucose intolerance, and a prothrombotic state. The panel will consider the role of treatment of the metabolic syndrome, using lifestyle interventions together with drug treatment, and will assess whether TGRLP should also be a target of therapy. Effective treatment of the various lipoprotein abnormalities in patients with HTG will require attention to combined drug therapy, such as statins + fibrates.
- HDL-cholesterol.** Recent clinical trials have attempted to raise

* Low-density lipoproteins + very-low-density lipoproteins + intermediate-density lipoproteins.

HDL-cholesterol levels in people with CHD and low HDL-cholesterol (<35 mg/dL) using fibrates and to determine whether this reduces the risk of CHD events and CHD death. The update will address whether there is sufficient evidence to conclude that HDL-cholesterol should be a target of therapy.

- **Primary prevention.** The new guidelines will have to reemphasize the importance of primary prevention. The central role of life habit strategies, such as dietary therapy, physical activity, and weight control, in primary prevention will have to be stressed because they confer multiple benefits beyond LDL reduction, such as lowering triglyceride levels, raising HDL levels, reducing insulin resistance, improving glucose control, reducing blood pressure, and decreasing the tendency to blood clotting. Although cholesterol lowering in CHD patients has been shown to produce a large reduction in subsequent CHD events and deaths, those who already have evident CHD will remain at considerably higher risk than people without CHD, despite effective treatment. In addition, because about 25 percent of patients die as a result of their first coronary event, secondary prevention cannot be considered an ideal overall strategy for reducing CHD and CHD deaths. A study published in the January 9, 1999, edition of *The Lancet* found the lifetime risk for CHD is very high for both men and women (one of every two men and one of every three women will develop CHD in the course of their lifetime). Thus, primary prevention must remain a central focus of the new guidelines. Crucial questions to be answered are when to

initiate drug treatment and what the LDL-cholesterol targets should be.

- **CHD risk assessment.** *ATP II* assesses risk in primary prevention by counting risk factors. For example, in a person without CHD who has a borderline LDL-cholesterol level, the presence of two or more risk factors signals a higher CHD risk and establishes a lower LDL goal for therapy. Other risk assessment systems, such as the Framingham risk prediction score sheets, which weight and score risk factors, may yield a more precise estimate of CHD risk, but they raise several issues. The first is how to make the risk assessment method easy for physicians to use, just as ease of use is a feature of the *ATP II* risk factor counting approach. The second is whether to base CHD risk assessment on absolute (and short-term) risk or relative risk. Basing treatment decisions on absolute risk may not be appropriate for some groups. For example, it may underestimate the need for intervention in young people, whose long-term risk could be quite high, and overestimate it in the elderly, most of whom have a high absolute risk. The third issue is the applicability of the Framingham risk prediction scores to diverse subgroups, including African Americans, Hispanics, women, and the elderly. This question was the principal topic of an NHLBI workshop in early 1999, and the conclusions of that workshop will be considered in the update. Finally and most importantly, the panel will have to focus on how to integrate risk assessment into selecting patients for cholesterol-lowering therapy and choosing the goals of therapy.
- **Dietary therapy.** The role of dietary therapy will be examined and reinforced, and new aspects of diet will be explored. Dietary fat and fatty acids will be considered in relation to whether the focus should be on total fat intake or type of fat ingested. The optimal percentage of calories from total fat, monounsaturated fatty acids, polyunsaturated fatty acids, and *trans* (hydrogenated) fatty acids will be considered, and guidance will be offered regarding the relative contributions of saturated and *trans* fatty acids to cholesterol elevation. Other dietary issues to be considered include the following: What should be said about carbohydrates in light of the possibility that they may be contributing to an overall excess of calories among Americans? What advice should be given about the role of dietary fiber, especially soluble fiber such as psyllium and oat bran? What is the evidence concerning antioxidants such as vitamin C, vitamin E, and beta-carotene? What are the roles of intestinal cholesterol-lowering agents such as phytosterols and stanols?
- **Adherence and compliance.** Adherence to and compliance with life habit changes and medication regimens historically have been problematic. Ways of improving adherence to lipid-lowering therapy, both dietary and drug, will be considered.
- **Diabetes mellitus.** Diabetes greatly increases CHD risk, and some authorities regard diabetes as a CHD risk equivalent. The panel will consider whether the LDL-cholesterol goal for this population should be set at ≤ 100 mg/dL, as for CHD itself. Management of HTG and low HDL-cholesterol, the typical

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dyslipidemia in diabetics, also will be addressed.

- **Combined drug therapy.** Combined drug therapy may be more effective than single drug therapy in treating various lipid disorders. For example, the combination of statin + fibrate may be useful for lowering both LDL and triglycerides and raising HDL in HTG and diabetic dyslipidemia. Combined drug therapy (e.g., statin + resin) also may be needed to achieve a patient's specific LDL-cholesterol target (e.g., ≤ 100 mg/dL in CHD) if the initial LDL is far above the target. The update will provide additional guidance on the use of combined drug therapy.

- **Patient subgroups.** The update will address special considerations for risk assessment and management in the elderly, women, young adults, and racial/ethnic groups.

The expert panel will consist of 20 to 25 members and ex-officio members and will involve several consultants. The panel will operate under the aegis of the NCEP Coordinating Committee, and the members of the Coordinating Committee, together with a roster of outside reviewers, will provide input to the panel's work, including reviewing drafts of the report as they are developed. The primary product will be a stand-alone report (*ATP III*) that provides the most up-to-date guidance on clinical cholesterol management. *ATP III* is

likely to cover the following areas: guidelines/recommendations for cholesterol management, discussion of the issues, identification of the evidence underlying the guidelines, and references. Derivative products likely will include a short executive summary highlighting the guidelines for management, a pocket card displaying the basic algorithms for quick reference in the clinical setting, and a set of slides. As with previous guidelines, materials for patients will also be prepared. The current *ATP II* guidelines and associated educational products will continue to provide a valid and reliable basis for treatment decisions until the update project has been completed. ■

September Is National Cholesterol Education Month

The new theme for this year's National Cholesterol Education Month (September 1999) is "Keep the beat—cholesterol counts for everyone." This theme conveys the idea that cholesterol consciousness is important for everyone's heart health. As it is every year, September is a good time to reenergize cholesterol-lowering efforts. This year, the NCEP will be promoting an increased level of cholesterol education activities directed to three interrelated topics: cholesterol lowering in people with CHD, in primary prevention, and in the elderly. The last topic is particularly timely because the NCEP position paper titled "Cholesterol Lowering in the Elderly Population" appears in the August issue of *Archives of Internal Medicine*.

The degree to which cholesterol education activities can make a real

difference can be gauged by the significant impact such activities have had over the past 15 years, as evidenced by the following trends: (1) increasing awareness about cholesterol and cholesterol lowering among health professionals and the public, (2) decreasing intakes of saturated fat, total fat, and cholesterol, (3) declining average serum cholesterol levels and a falling prevalence of high blood cholesterol, and (4) a continuing decline in CHD mortality rates. Despite these positive trends, average cholesterol levels are still high enough to raise the risk for CHD, and elevated levels remain untreated, especially in patients with CHD.

The NCEP will use several vehicles to help program planners

focus attention on the importance of cholesterol lowering in CHD, in primary prevention, and in the elderly. These vehicles include enhancement of the NCEP Web site, a press kit, and a Cholesterol Month kit.

For Cholesterol Month 1999, the NCEP's popular, award-winning Web site, "Live Healthier, Live Longer" www.nhlbi.nih.gov/chd/, will be

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The National Center on Sleep Disorders Research

NEW BOOKLET ON INSOMNIA FOR PHYSICIANS

Insomnia is a common problem; it can be described as a difficulty falling asleep, a difficulty maintaining sleep, awaking too early, or suffering from nonrefreshing sleep. It leads to daytime consequences such as tiredness, lack of energy, difficulty in concentrating, and irritability. A new booklet titled *Insomnia: Assessment and Management in Primary Care* provides concise, up-to-date information about insomnia. The booklet, written for primary care physicians, is based on an examination of the scientific literature by a working group composed of sleep experts and primary care physicians.

The National Center on Sleep Disorders Research (NCSDR) convened a Working Group on Insomnia as part of its educational activities targeting health care professionals. In 1995, the NCSDR published a fact sheet on insomnia for patients and the public. The NCSDR has been working to address insomnia for the past few years because it is estimated that as many as one-third of patients seen in the primary care setting may experience occasional difficulty in sleeping, and 10 percent of those may have chronic sleep problems.

The new physician's booklet describes acute and chronic insomnia and possible causes of each. A sleep/wake profile provides sleep-related questions that can be incorporated into the general review of systems and can assist the primary care practitioner in detecting insomnia in patients. A management section includes discussion of behavioral and

pharmacologic treatments. General sleep hygiene measures also are included. For example, the following activities may help promote sleep in all people:

- Wake up at the same time each day.
- Discontinue caffeine use 4 to 6 hours before bedtime and minimize total daily use.
- Avoid nicotine, especially near bedtime.



- Avoid using alcohol in the late evening to facilitate sleep onset—it can cause awakenings later in the night.
- Exercise regularly in the late afternoon (this may deepen sleep). Avoid vigorous exercise 3 to 4 hours before bedtime, because it may interfere with sleep.
- Minimize noise, light, and excessive temperature during the sleep period.
- Move the alarm clock away from the bed if it is a source of distraction.

Insomnia: Assessment and Management in Primary Care is the third in a series of publications developed

for primary care physicians. *Sleep Apnea: Is Your Patient at Risk?* and *Problem Sleepiness in Your Patient* address other important sleep-related topics. The NCSDR next will examine the science in the area of restless legs syndrome (RLS), which is characterized by unpleasant sensations in the legs, temporarily relieved by moving the limbs. RLS symptoms increase during the evening hours, making it difficult for a sufferer to fall asleep. A working group composed of sleep experts, primary care physicians, and neurologists will examine the science base and help determine key messages about the recognition and management of RLS for the primary care physician.

Insomnia: Assessment and Management in Primary Care is available on the Web at

<http://www.nhlbi.nih.gov>. It appeared in the June 1999 issue of *American Family Physician*, a journal published by the American Academy of Family Physicians.

COMING SOON— NCSDR WEB SITE

The NCSDR soon will launch its Web site, offering “one-stop shopping” to health care professionals, researchers, patients, and the public. Users will find up-to-date, comprehensive information about sleep and sleep disorders organized in four sections, within which users will be able to perform the following activities:

- **Research.** Search for sleep-related grants and publications, NIH program staff contacts, and recent reports. Keep abreast of the NIH Sleep Disorders Research Advisory Board's activities.

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The National Heart Attack Alert Program

HELPING PEOPLE REACT IMPROVES CARE

Most people, when faced with an emergency such as a fire or car crash, dial 9-1-1 immediately. Yet very often the signs and symptoms of a heart attack fail to generate the same urgent response. Many heart attack patients delay seeking medical care, thereby diminishing their chances of receiving the most effective treatment and of survival. Studies have shown that the median time from the onset of heart attack symptoms to seeking care ranges from 2 to 6.5 hours.

Dr. Mickey Eisenberg, University of Washington, Seattle, Internal and Emergency Medicine, an investigator in a research program to study this problem (described below) stated, "By the time you wait 2 hours, there has been a lot of damage that is irreversible to the heart. The idea is if you do not wait 2 hours—if you can get to help within 1 hour—the damage may be very minimal, perhaps even none at all." (Quoted from the REACT Web site—see end of article on page 23.)

Before launching a nationwide public education campaign to reduce this dangerous delay between first symptoms and treatment, experts from the National Heart Attack Alert Program (NHAAP) recommended studying the effects of community-wide education on the issue. In July 1994, the NHLBI granted awards to 5 field centers to launch the Rapid Early Action for Coronary Treatment (REACT) research program in 20 communities across the United States. Each of 10 intervention communities was compared with a nearby

control community, which did not take part in the intervention program.

The REACT study evaluated the effects of community intervention, including public, patient, and provider education campaigns, on patient delay time (from symptom onset to hospital arrival), use of emergency medical services and hospital emergency departments, use of thrombolytic (clot-busting) therapy, and heart attack deaths. For 18 months, the 10 intervention communities received a variety of educa-



“Persons at high risk for heart attack, and the general public, were exposed to educational messages about the symptoms of heart attack, the importance of early treatment, and the actions that should be taken in case of heart attack.”



tional messages and were helped to organize educational activities to reduce delay times. The program provided health professionals with current information on the medical benefits of rapidly diagnosing and treating heart attacks, on the importance of patient delay, and on their role in educating patients. Persons at high risk for heart attack, and the general public, were exposed to educational messages about the symptoms of a heart attack, the importance of early treatment, and the actions that should be taken in case of a heart attack.

In the 20 study communities combined (those which received the intervention plus control communities), delay times for persons with heart attack symptoms averaged 2 hours and 21 minutes at the beginning of the study. This delay was in fact shorter than the delays found in most previous research. The REACT program then witnessed a surprising trend: patient delay times decreased in all communities (intervention and control), and the decrease in the 10 intervention communities did not differ significantly from the decrease in the control communities.

The education program did increase significantly the use of the emergency medical services systems, in other words, dialing 9-1-1 for ambulance service. In the 10 intervention communities, the use of these emergency medical services rose steadily and significantly for persons who were having heart disease problems. NHLBI's Dr. Denise Simons-Morton, REACT Project Officer, noted, "These are people who really should be using 9-1-1. An ambulance can bring appropriate medical care to the patient quickly, and patients who arrive at an emergency department in an ambulance get taken care of more quickly." Dr. Russell Luepker, University of Minnesota cardiologist, epidemiologist, and chairman of the REACT Steering Committee, noted, "This is an important positive result of the study. The advantages of bringing skilled paramedic personnel and equipment to the patient are well known."

Emergency department presentation of suspected heart attack patients increased somewhat in the

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The NHLBI Obesity Education Initiative

OBESITY EDUCATION INITIATIVE WEB SITE UNDER CONSTRUCTION

Internet users can now access information on overweight and obesity on the NHLBI Web site. Additional materials are on the way, with some being developed specifically for the Web site. The NHLBI Obesity Education Initiative (OEI) intends this production to lead eventually to a separate site devoted to information on body weight, overweight, and obesity. All information displayed thus far is based on *The Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: Evidence Report*, published in June 1998.

The NHLBI Web page <http://www.nhlbi.nih.gov> currently offers the following obesity-related information under its "What's New" header:

Clinical Guidelines on Overweight and Obesity. Viewers can access the full report, an executive summary of the report, a diagram of the evidence model and evidence tables, the press release, tip sheets on healthy eating for patients, a body mass index (BMI) calculator, and a BMI table.

Achieve Your Healthy Weight! Designed for the public, this page helps users to determine whether they are at increased risk for obesity-associated diseases by using the BMI calculator and the user's waist circumference. It also offers the following links, which persons can open to obtain more information about starting to lose weight:

- Key recommendations from the clinical guidelines report

- Recipes, shopping tips, sample reduced-calorie menus, and a food exchange list
 - Guides to physical activity and behavior change
 - A daily food and activity diary
 - Tip sheets on dining out and eating healthy with ethnic foods
 - Selecting a weight loss program
- Additional links include the following:
- A description of the NHLBI OEI
 - Obesity and physical activity information for patients and the general public and for health care and other professionals
 - A BMI calculator

COMING SOON TO THE WEB SITE

A number of items based on the clinical guidelines are in production, including the following:

The Practical Guide to the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults. This abbreviated version of the clinical guidelines was developed to offer practical information to primary care health practitioners, such as primary care physicians, nurses, dietitians, and nutritionists. It includes the guidelines for classifying and assessing overweight and obesity and managing it through dietary therapy, physical activity, behavior therapy, pharmacotherapy, and weight loss surgery. Appendices include reproducible patient education materials, such as reduced-calorie menus. The guide was prepared cooperatively by the North American Association for the Study of Obesity and the NHLBI.

Web-Based PowerPoint Slide Set.

This slide set includes information on evidence-based methodology, background data, clinical guidelines core set, practical tips, and resources. Slide presentations can be tailored to meet the needs of the audience, and talking points will be included.

Electronic Textbook. This textbook allows easy access to much of the clinical guidelines evidence report, with a site map highlighting key information pertaining to the health risks associated with overweight and obesity as well as assessment and treatment. Interactive features allow practitioners to examine the evidence model, associated recommendations, and the treatment algorithm. Practitioners also will be able to use a menu planner, BMI calculator, and information about local environmental cues related to eating and physical activity.

The NHLBI OEI Web site promises to be an important resource for professionals and the public.

GOOD MORNING AMERICA SPOTLIGHTS INFORMATION ON LOSING WEIGHT

On Tuesday mornings from February 9 to mid-June, 1999, 2.5 to 4 million people who watched the popular television show *Good Morning America (GMA)* witnessed a series of educational 4-minute segments about losing weight.

Good Morning America's series on weight loss came about after ABC approached Dr. Louis Aronne, clinical associate professor of medicine at Cornell University Medical College

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and director of the New York-Presbyterian Hospital Comprehensive Weight Control Program, for advice on setting up a worksite weight-loss program. Dr. Aronne informed ABC that the clinical guidelines on overweight and obesity had just been released by NHLBI, and he recommended that the information in the guidelines be translated for ABC viewers. ABC was receptive to the idea, and "Lose Weight with *GMA*" was born. ABC staff worked with Dr. Aronne and Karen Donato, coordinator of the NHLBI OEI, to develop information for the television segments and the ABC Web site.

Many of the *Good Morning America* segments featured guest experts, such as physicians, nutrition consultants, and personal trainers. Dr. Aronne appeared with host Diane Sawyer on the April 27 segment, answering taped questions from viewers. Questions concerned over-the-counter herbal stimulant drugs, fad diets, and weight gain in women receiving estrogen replacement therapy. Dr. Aronne also participated in an ABC online chat for 30 minutes, answering questions.

"This is a win-win initiative,"

says Dr. Aronne. "It's good for

ABC to work with an authoritative organization like NHLBI, and it's good for NIH to work with a media sponsor to reach as many people as possible with important information." Chair of the North American Association for the Study of Obesity Practical Guide Development Committee, Dr. Aronne stated that he was delighted to participate in a project that ensures that the information contained in the clinical guidelines reaches the people who can benefit from it.

Web Link

A message featured on *Good Morning America* segments directs viewers to the ABC News Web site at <http://www.abcnews.com>. Here users can access the *Good Morning America* Web page and the "Lose Weight with *GMA*" program. Users also can find diet plans related to the television series, a food exchange list, a guide to healthy restaurant dining, instructions for calculating BMI, and personal weight loss stories e-mailed by viewers. The Web site links users to the NHLBI Web site, with its information from the OEI and the clinical guidelines evidence report.

The public responded very positively to the *Good Morning America* series. As of early May, ABC received more than 5,000 e-mails and letters from viewers in response to the series; its "Lose Weight with *GMA*" Web site received about 600,000 hits. ABC plans to continue offering "Lose Weight with *GMA*" segments on a sporadic basis (the main series ended in mid-June).

CONFERENCE EXPLORES THE ROLE OF PHYSICAL ACTIVITY IN OBESITY

The American College of Sports Medicine (ACSM) sponsored a scientific roundtable titled Physical Activity in the Prevention and Treatment of Obesity and its Co-Morbidities on February 4–6, 1999, in Indianapolis, Indiana. The program featured presentations on the impact of levels of physical activity on overweight and obesity from the perspectives of current evidence and research issues. Half of the 24 participants were from countries other than the United States. ACSM is an international organization with more than 17,000 members in more than 70 countries.

The focus of the conference was the development of a consensus document that will summarize evidence for the role of physical activity in the prevention and treatment of obesity in relation to other modalities such as diet, drugs, and surgery. As background, the participants were given copies of *The Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults*, which included a review of the evidence on physical activity and overweight. Participants were asked to review the evidence being presented at the roundtable according to the same criteria used in the clinical guidelines evidence report. ACSM plans to release the consensus document soon.

Topics addressed at the conference included the following:

- Determinants of overweight and obesity
- Physical activity and regulation of food intake
- Contribution of a sedentary lifestyle and inactivity to the etiology of overweight and obesity

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Cynthia McFadden and Sylvia Chase on *GMA*
(courtesy ABC News)



Promoting Heart Health With Hearts N' Parks Y2K

The increasing trend in overweight and obesity in adults, adolescents, and children is a growing concern in communities nationwide. About 25 percent of children and adolescents are considered overweight, and 55 percent of the adult population is either overweight or obese.

Data from the Youth Risk Behavior Survey show a decline in physical activity among U.S. youth, particularly in schools and among girls as they reach high school age. To begin to deal with these major health concerns, many professionals want to focus their efforts on primary prevention, specifically through programs that teach heart-healthy behaviors related to good nutrition and increasing physical activity.

The NHLBI is addressing these issues as part of its new focus on performance/partner projects. The NHLBI's Cardiovascular Health Promotion Program (CHPP) is collaborating with the National Recreation and Park Association (NRPA) to promote the adoption of heart-healthy behaviors by children and their families. Hearts N' Parks Y2K, the latest effort of the CHPP, features a teaming of NHLBI and NRPA with North Carolina State University and Southern Connecticut State University. The goal of this pilot program is to create model community-based programs to increase the number of children and adults who engage in heart-healthy behaviors and to demonstrate the impact that community parks and recreation departments have on motivating behavior change.

"The NRPA is a natural fit as a partner because we have members in almost every community in the

United States and are dedicated to promoting health through parks and recreation at the local level," said Kathy Spangler, director of national programs at NRPA. "NHLBI brings to the program a variety of resources on cardiovascular health promotion, including resources for physical activity and nutrition," added Karen Donato, coordinator of the NHLBI OEL.

"Hearts N' Parks Y2K is being promoted as one of the NRPA's millennium projects and will ride the

"The goal is to create model community-based programs to increase the number of children and adults who engage in heart-healthy behaviors and to demonstrate the impact that community parks and recreation departments have on motivating behavior change."

wave of celebrations that will take place surrounding the beginning of the 21st century," explained Ms. Donato. The project consists of three phases: (1) integrating heart-healthy behaviors into new or existing summer programs or activities for adolescents, families, or adults; (2) conducting a process-and-outcomes assessment for each program; and (3) celebrating the pilot program's success by sharing the results of the process-and-outcomes

assessment at the North Carolina Recreation and Park Society meeting November 13–17, 1999, in Charlotte.

Organizers held a kickoff for Hearts N' Parks Y2K on March 31 at North Carolina State University in Raleigh. Dr. Ellen O'Sullivan of Southern Connecticut State University led the event, explaining the program's goals and objectives to more than 30 parks and recreation representatives from 12 North Carolina communities chosen to participate. The communities are Albemarle, Fletcher, Garner, Greenville, Hickory, Madison-Mayodan, Mecklenburg County, Raleigh, Roanoke Rapids, Smithfield, Winston-Salem, and Wilson. The communities are enhancing program outcome measures through their mix of rural, urban, and suburban demographics.

Dr. O'Sullivan explained: "Measuring program outcomes will provide NHLBI and NRPA with the opportunities to build parity with other departments and services; to determine whether our programs and services really do make positive differences in the lives of people and communities; to assist decision-makers and the general public in making choices about resources; to document the results of our efforts; to reinforce the efforts of our staff; and to improve what we do."

Ms. Spangler noted, "At the kickoff, many of the communities expressed interest in operating children's day camps for the pilot program. Rather than simply 'warehousing' children, counselors will aim to 'greenhouse' them, teaching them to make choices that will help them grow strong and healthy."

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Minority Projects

A SUCCESSFUL ASIAN AMERICAN, PACIFIC ISLANDER WORKSHOP

A diverse, creative group of participants proposed culturally specific strategies for cardiovascular health outreach for Asian Americans and Pacific Islanders (AAPIs) on May 8–9, 1999, in San Francisco. *The National AAPI Cardiovascular Health Strategy Workshop: Preparing for the 21st Century* convened more than a dozen expert presenters and more than 50 attendees, who described current health trends among AAPIs and explored new interventions to guard cardiovascular health.

Sponsored by the NHLBI and the Asian and Pacific Islander American Health Forum (APIAHF), the conference included the following presentations:

- Overviews of AAPI cardiovascular health and health interventions
- A national agenda for eliminating health disparities
- Results of an NHLBI-supported heart health workshop in Hawaii
- AAPI cardiovascular health data
- AAPI community-based strategies
- Food habits and physical activities

Following presentations, participants were divided into three groups to establish a set of priorities in the following areas: a national research agenda, community outreach strategies, and community-based services. The goal of these priority-setting sessions was to provide guidance for a national action plan aimed at promoting and sustaining cardiovascular health among AAPIs. Group leaders presented the results of the breakout discussions to the entire assembly on

the morning of the second day, leading to questions and further discussion. One proposed conceptual framework that received general support responded to the multiple competing priorities and diverse cultural contexts of CVD prevention among AAPI subgroups. Many exciting strategies were proposed, including the use of unique types of media and other strategies.

Melen McBride, R.N., Ph.D., of Stanford University and a member of the NHLBI Ad Hoc Committee on Minority Populations, remarked on the “excellent recommendations and practical ideas for community-focused interventions” that resulted from the workshop. She noted, “Participants left for home with greater resolve to reestablish or strengthen contacts in the communities with AAPI subgroups.”

The APIAHF is now gearing up to prepare a summary report to submit to the NHLBI.

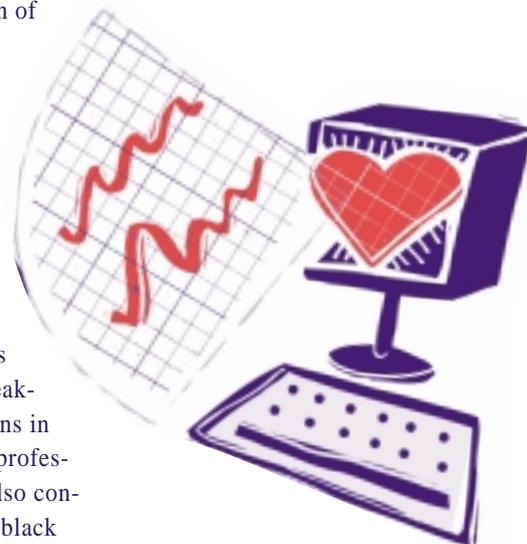
MORE ON THE NATIONAL PHYSICIANS’ NETWORK

As reported in the previous *HeartMemo*, the Association of Black Cardiologists (ABC) has taken on the task of supporting the National Physicians’ Network (NPN), which helps to increase the practice skills of health professionals who provide care to black patients. More than 40 percent of NPN members reported using the NPN Speakers’ Kit to make presentations in community, academic, and professional settings. The NPN also convinced the four historically black

medical schools—Drew, Howard, Meharry, and Morehouse—to include the Speakers’ Kit in their curricula.

By partnering with the National Black Nurses Association (NBNA), the ABC expanded the influence of the NPN to include nurses. The nurses targeted seven historically black nursing schools to promote the NPN Speakers’ Kit.

The project also will offer a World Wide Web-based system of online self-study continuing education programs for doctors and nurses. A team composed of members from the ABC and the NBNA will select the topics and develop content for the continuing education programs. A Web design firm will use the content to develop interactive online self-study programs. Doctors completing the programs will receive Category-1 continuing medical education credits through the ABC; the NBNA will award similar credits to nurses. ■



Around the Nation

NHLBI HELPS CHEVRON REACH AND EDUCATE EMPLOYEES

Health Quest worksite wellness program, an employee health promotion program of Chevron Corporation, recently launched a new effort involving ready-to-use modules for health and safety coordinators at Chevron worksites. Health Quest University (HQU) comprises 10 modules that address employee health risks. Each module features a package of materials including a PowerPoint presentation, reproducible handouts, and lists of videos and brochures that can be ordered. The materials reside on Chevron's intranet, making them accessible from all Chevron worksites.

In striving for safe operations, Chevron schedules regular safety meetings for its employees, which focus on specific safety- or health-related issues. The HQU program frequently provides ideas and resources for these meetings. Chevron also has more than 15 full-time health and fitness professionals who provide health, fitness, and injury prevention programs at the company's chemical plants, oil refineries, and offices. HQU is intended to aid these professionals as well as employees in the company's remote operations, where the health professionals are not available.

The HQU modules contain seven "academic" programs and three "intramural" programs. The academic programs provide information on exercise, back care, cholesterol, healthy eating, shift work, ergonomics, and preventive medical care. Many incorporate information derived from materials of the NHLBI.

The cholesterol and healthy eating programs rely extensively on the "Stay Young at Heart" program, for example, using the quizzes *Check Your Cholesterol and Heart Disease* and *Check Your Physical Activity and Heart Disease*. Facilitators use the quizzes to begin group discussions.

The intramural programs are goal-driven activities, such as eating at least five servings of fruits and vegetables daily and walking 1 mile three times or more per week. The programs feature challenges and contests for work groups to engage in over periods ranging from 4 to 8 weeks. The overriding goal of the intramural program is to raise awareness about health-related issues for an extended period of time.

Chevron's HQU reduced its costs by using the inexpensive yet reliable and scientifically accurate NHLBI resources, such as the *Stay Young at Heart* program and *So You Have High Blood Cholesterol* booklet. HQU benefits in an important way from the visually appealing and low-literacy qualities of the NHLBI handouts, since its employees have diverse backgrounds and educational levels. Chevron's HQU plans to continue to use and promote NHLBI materials to its medical staff members and wellness coordinators in the coming months. Sara Kashima, preventive health specialist at Chevron Corporation, stated, "We have found the NHLBI materials to be extremely helpful, and we encourage other groups and organizations to make use of these resources."



NHLBI COLLABORATES WITH BIG G

NHLBI swung its doors wide open to welcome a collaborative effort with General Mills, Inc., in April. The result was a major extension of NHLBI educational efforts to consumers. The Healthy Heart Handbook for Women, a booklet designed to help women prevent coronary heart disease, was the star of the event. General Mills offered the handbook at a reduced price on 2 million boxes of its Oatmeal Crisp Raisin and Oatmeal Crisp Apple Cinnamon cereals.

In addition to the cereal box offer, Big G also funded a Satellite Media Tour. The tour featured NHLBI's Dr. Teri Manolio, Director, Epidemiology and Biometry Program, Division of Epidemiology and Clinical Applications, who warned women of their lifetime risk for heart disease and offered advice on ways to reduce that risk. Dr. Manolio was featured on about 12 television stations around the country. ■



HeartScience

BLACKS AT HIGHER RISK FROM HEART FAILURE, FINDS NHLBI STUDY

The results of a recent study suggest that black patients with congestive heart failure are at higher risk for death and for worsening of their disease than are similarly treated white patients. The findings, published in the February 25, 1999, issue of the *New England Journal of Medicine*, are based on data collected earlier from the Studies of Left Ventricular Dysfunction (SOLVD).

SOLVD had found that patients with chronic congestive heart failure had fewer deaths and hospitalizations when treated with an ACE inhibitor, a drug that blocks the constriction of blood vessels. In a retrospective analysis of SOLVD data, Dr. Daniel Dries of the NHLBI and colleagues analyzed racial differences. They found that 42 percent of blacks in the treatment component of the study (patients with symptoms) and 22 percent of blacks in the prevention component (without symptoms) died compared with 36 and 14 percent, respectively, of whites. In addition, black patients were at increased risk for progression of the disease.

Past research has shown that the death rate for congestive heart failure is more than twice as high in black patients as in whites, yet not all studies have come to this conclusion. Some studies have attributed differences in death rates to factors such as differences in access to care and differences in the severity of the disease. Some studies have not found a racial difference.

In the new study, the higher risk of death and disease progression among

black patients was found even after the scientists adjusted the data to minimize any influences from age, other coexisting medical conditions, severity and causes of heart failure, socioeconomic status, and medications. Because SOLVD was a clinical trial, management and followup of patients were standardized.

Dr. Dries and his colleagues speculated that the differences between blacks and whites with heart failure may be a result of physiological differences in the neuroendocrine and

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“Black patients with heart failure may have a greater activation of the neuroendocrine system rather than the renin/angiotensinogen system.”

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renin/angiotensinogen systems. These systems release various hormones affecting heart rate and blood flow in response to the heart's decreased ability to pump blood. It is believed that over time, the initial beneficial effects of these hormones are stopped, and they then contribute to the progression of heart failure. The neuroendocrine system governs catecholamines, a group of hormones including norepinephrine. The renin/angiotensinogen system involves the release of angiotensin II.

Black patients with heart failure may have a greater activation of the neuroendocrine system rather than the renin/angiotensinogen system, suggested the study's authors. Another possible explanation is that ACE inhibitors, which block the renin/angiotensinogen system, may

be less effective in halting the progression of the disease in blacks. ACE inhibitors are commonly used to treat heart failure.

SIMPLE LIFESTYLE CHANGES BOOST PHYSICAL ACTIVITY AND CARDIOVASCULAR HEALTH

Small lifestyle changes that increase moderate-intensity physical activity are as effective as a structured exercise program in improving long-term cardiorespiratory fitness and blood pressure, according to a study supported by the NHLBI. The study was performed by researchers at the Cooper Institute for Aerobics Research in Dallas, Texas, and published in January (A.L. Dunn et al. Comparison of lifestyle and structured interventions to increase physical activity and cardiorespiratory fitness. *Journal of the American Medical Association* 281(4):327-334, 1999).

Most Americans engage in too little physical activity. About one in four U.S. adults are sedentary, and another third are not active enough to reach a healthy level of fitness. The Federal Government recommends that adults try to engage in at least 30 minutes of moderate-intensity physical activity on most (preferably all) days of the week. However, Americans often are stymied by lack of time, social support, and access to exercise facilities or are put off by bad weather or a dislike of vigorous exercise.

To find an effective way around such barriers, the researchers enrolled 235 men and women, ages 35 to 60, in what was called Project Active. All participants were sedentary at the

outset, none had CVD, and most were moderately overweight. Each participant was assigned randomly to one of two groups. In the “lifestyle” group, 122 participants learned behavioral skills to help them gradually fit more physical activity into their daily routines. In the “structured” group, 115 participants used a fitness center for traditional forms of vigorous exercise such as aerobics, swimming, stair-climbing, and walking.

Both groups learned behavioral skills that helped them to be physically active. However, those in the lifestyle group received individualized help in tailoring physical activity to their daily routines. For instance, they learned to keep track of inactivity and activity, recording time spent sitting, engaging in moderate-intensity physical activity, and walking (actually counting steps). Examples of lifestyle changes were the following: taking longer walks on the way to office meetings; walking around airport terminals rather than sitting while waiting for a flight; walking around a soccer field during children’s games; and participating in a walking club.

After 6 months, those in the structured exercise group had improved cardiorespiratory fitness more than did those in the lifestyle group. Yet subsequent declines in cardiorespiratory fitness were greater in the structured exercise group. After 2 years, members of both groups had significantly increased their physical activity and improved their cardiorespiratory fitness and blood pressure. And most participants maintained their improved states.

FIRST ESTIMATE OF LIFETIME RISK FOR DEVELOPING CORONARY HEART DISEASE

For the first time, researchers at the NHLBI’s Framingham Heart Study

have estimated the lifetime risk for developing CHD. The risk is high: one of every two men and one of every three women ages 40 and younger will develop CHD. At age 70, the risk is still high: one of every three men and one of every four women will develop CHD in the remaining years of life. The results were published in January (D.M. Lloyd-Jones et al. Lifetime risk of developing coronary heart disease. *Lancet* 353(9147):89-92, 1999).

The lifetime risk estimate for CHD is an average value for the general population. Individuals may have higher or lower absolute lifetime risks depending on whether or not they smoke; have high blood pressure, high blood cholesterol, or diabetes; or are sedentary or overweight.

“When it comes to health, average isn’t always so good,” remarked Daniel Levy, M.D., the study’s principal investigator. “The fact that the average 50-year-old woman is 3 times more likely to acquire CHD than breast cancer during her lifetime has important implications for public health,” he added. The study will help policymakers to assess the risks and burdens for various disease and help the public to understand the importance of preventing heart disease.

The study also has implications for older Americans and the physicians who care for them, both of whom may believe that persons who survive to older ages without developing CHD are no longer susceptible to developing it. Even at age 70 the average person remains at high risk. Therefore, said Dr. Levy, “Greater emphasis should be placed on control of risk factors in older men and women.”

The Framingham Heart Study began 50 years ago in Framingham, Massachusetts. To study more recent trends in risks for coronary disease, NHLBI researchers, collaborating

with scientists from Boston University, identified new cases of heart disease occurring between 1970 and 1996. A cohort of 7,733 volunteers, ages 40 to 94, provided a well-described population with long-term followup and carefully documented CHD events and causes of death. The researchers calculated lifetime risks for CHD for ages 40, 50, 60, and 70. In all categories, men had higher lifetime risks than did women. Earlier estimates of CHD lifetime risk have been limited by reliance on death certificate data and short-term followups.

ULTRASONOGRAPHY PREDICTS HEART ATTACK AND STROKE RISK

NHLBI-supported scientists reported that ultrasonography, a noninvasive test, can be used to predict the risk of heart attack and stroke in older persons with no CVD symptoms. The researchers used the test to measure the thickness of walls of two arteries in the neck. The results produced vital information beyond that available from an assessment of standard CVD risk factors, such as high blood pressure and high blood cholesterol. The work was reported in January (D.H. O’Leary et al. Carotid-artery intima and media thickness as a risk factor for myocardial infarction and stroke in older adults. *The New England Journal of Medicine* 340(1):14-22, 1999).

Ultrasonography is a relatively inexpensive, painless test in which sound waves of frequencies above the range of human hearing are passed through the body (in this case, the neck). Sound wave echoes bounce off moving blood and the tissue in arteries to produce images. The test is currently used in stroke prevention to diagnose advanced disease in carotid arteries. The recent study found that

(continued on page 22)

(“Heart Science” continued from page 21)

the test can detect disease much earlier and can identify persons at risk for both heart attack and stroke.

The study involved a cohort of 4,476 men and women, ages 65 and older, drawn from the NHLBI-supported Cardiovascular Health Study (CHS), a multicenter investigation of older Americans. CHS centers are in California, Maryland, North Carolina, and Pennsylvania. About 40 percent of the participants were men, 60 percent women. Blacks composed about 15 percent of the participants; the rest were white. Researchers followed and reported on the participants for an average of 6.2 years.

The researchers used ultrasound to measure the thicknesses of walls in the common and internal carotid arteries. This assessed the participants’ degree of atherosclerosis, the condition in which fat and cholesterol are deposited on artery walls. Thickened arterial walls become less flexible, and narrowed openings impede blood flow. When an artery becomes blocked, a heart attack or stroke can occur.

Atherosclerotic buildup is not uniform. By combining measurements from both arteries, the researchers gained a more complete picture of the person’s condition than either measurement alone would yield. Results showed that a person’s risk for heart attack and stroke increased in direct proportion to the thickness of artery walls. Persons with the thickest arterial walls had an almost fivefold greater risk for heart attack or stroke compared with persons with the thinnest arterial walls. Even after accounting for standard CVD risk factors, such as cigarette smoking, high blood pressure, high blood cholesterol, and diabetes, persons with the thickest arterial walls had more than double the risk for heart attack or stroke compared with those with the thinnest arterial walls.

VENTILATOR TRIAL STOPPED EARLY

In March 1999, NHLBI stopped its large clinical trial of mechanical ventilator use for intensive care patients so that it might alert clinicians to the success of the procedure being studied. Data on the first 800 participants in the trial of ventilator use for patients with acute respiratory distress syndrome (ARDS) showed about 25 percent fewer deaths among patients who received small, rather than large, breaths of air from a mechanical ventilator. Researchers originally planned to conduct the trial until late 1999.

ARDS is a devastating, often fatal, inflammatory lung condition which usually occurs in conjunction with catastrophic medical conditions, such as pneumonia, shock, sepsis, and trauma. About 150,000 Americans are affected each year, and more than 40 percent of them die. No specific therapies for ARDS patients exist. Treatment involves supportive care in an intensive care unit, using a ventilator and supplemental oxygen to help a patient breathe.

The ARDS study, which began in 1996, was designed to compare the safety and efficacy of two methods of ventilator use. Patients were assigned randomly to one of two groups; one group received larger breaths of air (12 ml/kg), and the other group received smaller breaths of air (6 ml/kg). The plan was to enroll 1,000 patients, ages 18 and older. Mechanical ventilators deliver breaths of oxygen-rich air to the body and remove breaths of carbon dioxide from the body. Earlier studies had suggested that small breaths from a ventilator might not remove sufficient carbon dioxide and large breaths might damage lung tissue. Several small clinical trials had failed to show which approach was superior. ■

(“Healthy People 2000” continued from page 6)

approach is needed to translate research into practice. Essential activities include partnering in communities, tailoring educational efforts for special populations, providing incentives for healthy behaviors, and improving health care systems. We must use secondary, high-risk, and prevention strategies at the same time. We must implement and document guidelines routinely, using a multidisciplinary system for providing feedback and monitoring. We must educate patients about their responsibilities.

Dr. Satcher summed up the discussion by saying, “The challenge is reducing CVD for all Americans. Together, we can ensure the availability of screening; we can support more effective health education messages; we can forge community partnerships; and we can encourage individuals to take responsibility for their health. Together, we can achieve our overall goal of improving public health now and in the next century.” ■

(“NCSDR” continued from page 13)

- **Professional Education.** Click on educational materials for physicians and health care professionals for the recognition and management of sleep disorders. Access accompanying patient education materials and useful resources.
- **Patient and Public Information.** Access a variety of factsheets, an interactive quiz, public service announcements, and useful resources on sleep and sleep disorders.
- **Communications.** Contact the NCSDR staff and the NIH Sleep Disorders Research Advisory Board. Link to sleep-related community resources. Register for updates on this continuously expanding site. ■

(“NHAAP” continued from page 14)

intervention communities compared with the control communities. Although REACT has focused on delay outside the hospital, use of reperfusion and artery-opening procedures (e.g., thrombolysis and angioplasty) within 1 hour also appeared to increase, although only early in the program, in the intervention communities.

Telephone surveys of adult community members showed that the educational program had an important impact on knowledge and confidence. In the intervention communities, more persons felt that they could recognize heart attack symptoms, including chest pressure

or squeezing, shortness of breath, nausea, sweating, feeling faint, and pain in the jaw, neck, shoulders, arms, or back. More persons in the intervention communities indicated that they knew the appropriate actions to take; also, more said they intended to call 9-1-1 in response to heart attack symptoms. Dr. Simons-Morton pointed out, “People need to learn the symptoms of a heart attack and to have confidence that the symptoms indicate a medical emergency. The symptoms can be different from what people think they are.”

REACT investigators believe that in the 20 communities studied, average patient delays may have shrunk to record low levels even before the

education program began, as a result of nationwide trends. This might account for the fact that during the study, delay times drifted downward equally among intervention and control communities.

The REACT study was the first of its kind in the United States. Its lessons and materials will be made available to the NHAAP, NHLBI, the American Heart Association, and other organizations to help refine their efforts to educate Americans about heart attack and how to respond to it. For additional information visit the REACT Web site at <http://epihub.epi.umn.edu/react/welcome.html>. ■

(“Hearts N’ Parks” continued from page 17)

Each community was provided with a choice of educational materials to help them teach heart-healthy behaviors. Materials featured topics such as blood pressure, cholesterol and heart disease, body weight and exercise, special booklets for African Americans and Hispanics, Stay Young at Heart recipes, *JumpSTART Afterschool*, the CATCH classroom curricula, and other educational kits obtained from the NHLBI Health Information Center.

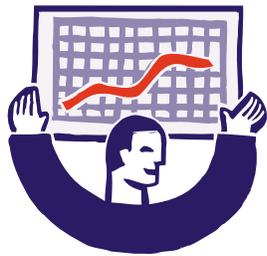
“NHLBI values the ways in which local park and recreation departments are able to reach residents through direct delivery of programs and partnering with other community groups,” explained Ms. Donato. To maximize resources, each community is encouraged to partner with other organizations and groups that can help reach the audience with heart-healthy messages.

These include local health departments, hospitals, cooperative extension, affiliates of the American Heart Association, nutritionists, nurses, supermarkets, police and fire departments, churches, and senior centers.

To promote Hearts N’ Parks Y2K and build on its successes, the communities are encouraged to establish and maintain relationships with local media. NHLBI has created a media kit for local park and recreation departments. The kit promotes NHLBI’s new brand, “Keep the Beat/Be Good to Your Heart,” and identifies ways to enlist the support of a specific media organization in a community, to keep the media involved throughout the year, and to encourage the media to highlight the key health messages. Media materials include a pitch letter, press release, factsheets, and backgrounders. Participants are encouraged to hold media events to inaugurate the

beginning of the programs in late June. All efforts will culminate in a media event held in late November or December 1999 to celebrate the millennium and NHLBI’s dedication to promoting heart health.

To further promote the program, NHLBI is in the process of creating a Hearts N’ Parks Y2K Web site, which may include a bulletin board discussion, a listserv for parks and recreation providers, a showcase of project highlights, the media kit, and a resource order form. In addition, NHLBI and NRPA hope to capture live film at program sites, highlighting success stories. Such material will support the *Hearts N’ Parks Y2K Program Guidebook*, planned to encourage other community sites to develop similar programs nationwide. ■

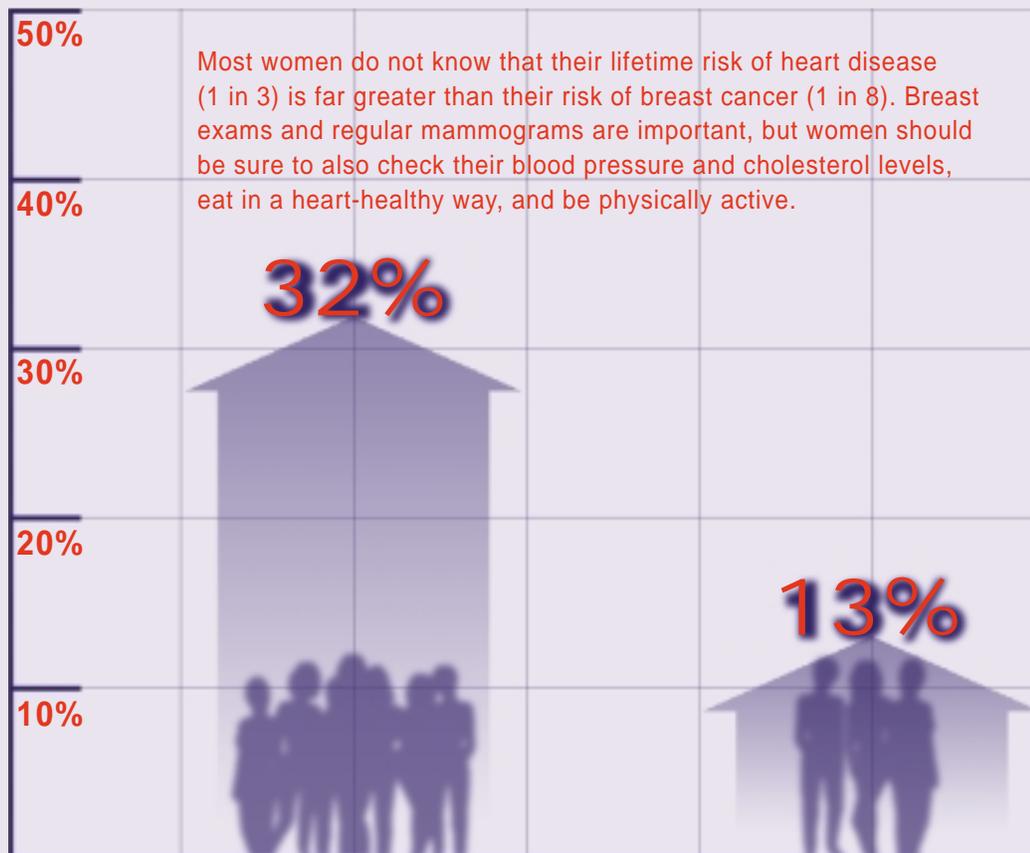


HeartFacts

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HeartFacts

A WOMAN'S LIFETIME RISK OF DEVELOPING HEART DISEASE & BREAST CANCER



Percentage of Women Who Will Develop
Coronary Heart Disease

Percentage of Women Who Will Develop
Breast Cancer

(“Conference” continued from page 16)

- Physical activity in the treatment of childhood overweight and obesity
- Physical activity and the prevention and treatment of weight gain associated with pregnancy
- Physical activity and weight gain and fat distribution with menopause
- Physical activity in the prevention and treatment of hypertension in the obese
- Effects of physical inactivity and obesity on morbidity and mortality
- Economic cost of obesity and inactivity

NHLBI was a cosponsor for the roundtable, which also included the

National Institute of Diabetes and Digestive and Kidney Diseases, the National Institute of Child Health and Human Development, the Centers for Disease Control and Prevention, the North American Association for the Study of Obesity, The Robert Wood Johnson Foundation, Mars Incorporated, and Knoll Pharmaceutical. ■

The NHLBI Information Center Looks to the 21st Century

The Information Center has new phone and fax numbers.

Telephone: 301-592-8573

Fax: 301-592-8563

The Web site address is

www.nhlbi.nih.gov

As the 21st century approaches, the NHLBI Information Center sees enormous challenge and opportunity arising from the accelerating advances in information technology taking place each day. The Information Center increasingly envisions its place not as a "center" but as one partner in an ever-expanding network in which you the readers, and organizations you represent, are equal partners. The goal is to develop an NHLBI Health Information Network that provides the following:

- Easy and rapid access to information for all
- Electronic gateways that facilitate the utilization of current research results in clinical and public health practice
- Networked linking and exchange of information among the publics the NHLBI serves
- Interactivity designed to enhance partnerships, individualize responsiveness, promote more effective communication, and assess public and professional information needs.

Some progress toward these goals has already been made. The information and interactive options found at the NHLBI Web site, the ease of downloading and ordering NHLBI publications via the Web, and the NHLBI Information Center listserv (details found at the NHLBI Web site) are examples of this progress. The goal of an electronic *HeartMemo* with additional-information links embedded in each article is being explored.

This will be an unending process. Much more remains to be done, and we welcome your ideas and interactive collaboration as we enter the 21st century together.

NEW FROM THE INFORMATION CENTER

Founded in 1986, the Alliance for Aging Research has grown to become the Nation's leading citizens advocacy organization for improving the health and independence of older Americans through public and private research.

The following four documents were produced through a partnership of the Alliance for Aging Research and the NHLBI. (For each item, single copies are free from the NHLBI Information Center. Multiple copies can be requested from the Alliance for Aging Research, 2021 K Street, N.W., Suite 305, Washington, DC 20006-1003.)

It's Time for a Heart to Heart (#55-717). This brochure teaches patients about congestive heart failure. Patients can read about the causes and symptoms of heart failure and learn how it is diagnosed. The brochure explains how heart failure can be managed through treatment and lifestyle modifications.

Controlling High Blood Pressure: A Woman's Guide (#55-820). This guide explains how high blood pressure affects your health and tells how high blood pressure can be prevented with simple lifestyle changes or controlled with lifestyle changes and medication, if needed. It includes information on commonly used medications and much more.

Control de la Presión Arterial Alta: Guía para la Mujer de Edad Mayor (Controlling High Blood Pressure: A Guide for Older Women) (#55-875). This is the Spanish-language version (actually, bilingual) of the English-language booklet for older women. It explains optimal blood pressure, encourages blood-pressure screening, and describes six things a woman can do to prevent high blood pressure.

You're in Charge: Your Guide to Good Health After Menopause (#55-1030). After menopause, women face a higher risk for certain diseases. This booklet describes ways women can act to prevent or control a variety of health concerns, including heart disease, cancer, and osteoporosis. ■

(“Cholesterol” continued from page 12)

made even more useful for CHD patients by adding updated information. A new health tip on the site will focus on the importance of reaching an LDL-cholesterol goal of <100 mg/dL in persons with CHD. The site will also be enhanced to address primary prevention. Persons interested in reducing their risk of developing CHD in the first place will be able to obtain information on heart-healthy eating and physical activity in an enjoyable, interactive way. Features of the site, such as the rationale for cholesterol lowering, calculating a saturated fat and cholesterol allowance, and Create-a-Diet, will be made applicable to primary prevention.

Media activities for September, including the distribution of a press kit and materials to convey information graphically, will center on messages about cholesterol lowering in older Americans and the importance of primary prevention. The press kit will include, among other items, a general Cholesterol Month press release; an infographic on cholesterol-lowering tips for the elderly, addressing both the older person with CHD and the older healthy person without CHD and emphasizing heart-healthy eating, physical activity, and maintaining healthy weight; and a feature article, suitable for as-is reproduction in newspapers and magazines, focusing on why primary prevention is important.

To support cholesterol education activities in September and throughout the year, NCEP will produce Cholesterol Month Kit ‘99, a streamlined packet, which will contain sample patient education materials, an article featuring the latest findings relating to cholesterol lowering, and a Cholesterol Month press release. Special features of kit ‘99 will be helpful consumer tips on cholesterol lowering in older Americans based on the NCEP position paper appearing in the August issue of *Archives* and a how-to page for program planners that offers ideas and activities for National Cholesterol Education Month. The kit will be available for downloading from the Web. (Go to the NHLBI home page at www.nhlbi.nih.gov and look under “What’s New.”) Hard copies of the kit can be ordered through the NHLBI Information Center while supplies last.

Cholesterol Month program planners may also find it helpful to be aware that the NCEP plans to launch several new activities this year, including updating the cholesterol treatment guidelines (see the accompanying article), conducting educational outreach to physicians, and improving and enhancing patient educational materials and products, such as the Web site enhancements mentioned previously. NCEP’s outreach to physicians will aim to improve cholesterol management in

CHD patients and in primary prevention. Because of the growing importance of managed care in health care delivery, outreach efforts will include a focus on managed care physicians.

An important component of NCEP’s physician outreach project will be working in partnership with other organizations. A prime potential partner is the National Committee for Quality Assurance (NCQA). NCEP Coordinating Committee organizations will also be involved as partners in the outreach project. NCEP and NCQA are exploring ways of working together to make managed care physicians more aware of the NCEP guidelines and provide them with education and tools for improving cholesterol management. One of NCQA’s major activities is reviewing the performance of health care plans using Health Plan Employer Data and Information Set (HEDIS) measures. NCEP and NCQA have prepared a joint statement that presents the scientific basis for the NCEP clinical goal of an LDL-cholesterol ≤ 100 mg/dL in CHD patients, explains the practical reasons for NCQA’s selection of an LDL target of <130 mg/dL for the new HEDIS cholesterol performance measure, and points out that the two targets are compatible. The joint statement has been submitted for publication. ■

HeartMemo is a National Heart, Lung, and Blood Institute (NHLBI) publication for health professionals working in disciplines and settings related to cardiovascular health. *HeartMemo* reports on the activities of the NHLBI's national education programs, projects, initiatives, and research advances and on other news of interest to the field. Readers are urged to submit information on current treatment and prevention activities as well as research findings and activities.

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***Heart* MEMO**

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This publication is produced by Prospect Associates, Ltd., Silver Spring, MD, under Contract No. NO1-HO-99230 from the National Heart, Lung, and Blood Institute.

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