

Million Hearts
Promising Innovations: Million Hearts and Minority Health Webinar
Thursday, September 13th, 2012, 2:00 pm - 3:00 pm EST

OPERATOR:

Good afternoon and welcome to the million heart webinar in collaboration with the Center for Medicare and Medicaid services office of minority health and the US Department of Health and Human Services office of minority health. The presentation slides and audio will be available via the Million Hearts website. If you do not have computer speakers please call 1-888-392-4587. A few housekeeping items to remember, all lines are in a listen only mode throughout the presentation. To reach an operator at any time please press star zero telephone key pad. You may submit questions via chat at any time during the webinar in the field next to the messages to moderator type in your questions and hit send. Your question will be visible to the moderator and speakers there will be a brief Q&A session towards the end of the session we will address as many questions as possible. For additional questions, please send these to the e-mail address noted at the end of the webinar. Questions and answers will be posted to the FAQ section of the Million Hearts website. At this time I would like introduce your moderator, Dr. Cara James, director of the office of minority health at the Center for Medicare and Medicaid services.

CARA JAMES:

Thank you. Thank you for joining us this afternoon for the promising innovations Million Hearts minority health webinar. The national initiative launched by the Health and Human Services to prevent 1 million heart attacks and strokes by 2017. As you know heart attacks and stroke disease is a leading cause of death and the third leading cause of death for men and women in this country. Together they account for one third of all US deaths. In addition, there among the leading causes of disability the US with 4 million people reporting disability from these causes. As you know preventing 1 million heart attacks and strokes by 2017 will require the working commitment to change from all of us. The million heart initiative brings together communities nonprofit organizations federal agencies and private sector partners from across the country to work together for a common goal. Today we have brought with you some of these partners have a host of experts in the field of health disparities in cardiovascular disease to share knowledge and experiences in implementing these strategies as you begin to think about ways in which your organization can participate and collaborate with others. We want to thank all the partners have taken the million hearts pledge and committed to making a difference within their communities. We hope the resources and tools provided today will help you reach your goal. As for new partners who want to help give you connected to this important initiative and provide tools and resources to get started

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with this is an open interactive forum there'll be opportunities for you to ask questions and provide feedback throughout the session there also be a question-and-answer time and a brief survey at the end of the session. To get started we have a short question we would like to ask you. Have you taken the Million Hearts pledge? Okay. As we are getting started I want to introduce Dr. J. Nadine Gracias she will discuss the impact of heart disease and stroke within a minority communities and Dr. J. Nadine Gracias is the deputy assistant secretary for minority health and the acting director of the office of minority health at the US to permanent Health and Human Services. The office of minority health is dedicated to improving the health of racial ethnic minorities through programs that will help eliminate health disparities.

J. NADINE GRACIAS:

Thank you. It is a pleasure to participate in this webinar and it has been a pleasure to join or my colleagues from the centers for Medicare and Medicaid services and other agencies throughout the Department of Health and Human Services on this important initiative. For all that has been achieved in cardiovascular disease and health care there is still more research, more practices to be perfected and more awareness to be raised and as you heard from heart disease and stroke they are taking a toll. When it comes to minority communities the impact of heart disease and stroke is truly high. You know that health disparities have been in this country for far too long the minorities are more likely to suffer from chronic disease and heart disease. The reason that we are here today is a telling example cardiovascular disease accounts for the largest proportion of any quality of life expectancy between African Americans and non-Hispanic whites and African-Americans and they have higher blood pressure than non-Hispanic away. Obesity and high blood pressure obesity women of color are less likely to be aware of heart attack symptoms and the need to call 911 when the symptoms arise many those women most at risk for heart disease and its complications are least aware of the threat. Heart disease touches the lives of millions of Americans every year and many of you have seen that reality for yourselves as providers and community members. Yourselves that is what makes the million hearts initiatives is so important and as you have heard that they're working with a broad coalition of public and private partners aiming to prevent 1 million heart attacks and strokes by 2017. Organizations contributing to this effort come from medical and public health associations nonprofit organizations foundations community-based organizations faith-based organizations government agencies business and many more. In local

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communities, we are encouraging and empowering Americans to eat healthy engage in physical activity and avoid smoking. Reducing health disparities in achieving health equity for example by using culturally appropriate educational material supporting community health workers and educators to provide education and outreach and address barriers to care and connecting patients to address community resources for self-management. The good news is that we are taking action to reach this goal of million hearts having many committed members is key to our success. I look forward to hearing from our partners to have promising practices and from all of you have joined us for today's webinar and I will turn it back to Dr. Janet Wright.

CARA JAMES:

Thank you Dr. J. Nadine Gracias for that and for those of you aside question come across about additional slides and Dr. J. Nadine Gracias did not have any slides for the presentation see did not miss anything and next we will hear from Dr. Janet Wright and she is here to talk about and provide an overview of the national committee for quality assurance. And thank you on behalf of all of the folks that are working on Million Hearts. We express our gratitude we are indebted to you for your leadership to and the disparities in cardiovascular outcomes and we appreciate your guidance of this initiative.

JANET WRIGHT:

And I want to thank Dr. Erika Taylor who is the Million Hearts led for our work in disparities and Dr. Denesecia Green in the office of minority health. As of yesterday we were a year old since our launch so we have four years left to deliver a presented million heart attacks and strokes. Dr. James and Dr. J. Nadine Gracias reminded you of these statistics and this gives you part of the rationale for why the federal government would come together around a specific condition and that is because it continues to kill too many of us. It is expensive for us, not only in the loss of our family members and friends but also for the country to bear the burden of the lost productivity and as we have mentioned today, it is the cardiovascular disease is the single greatest contributor to racial disparities and life expectancy African-Americans lose 14 months of life expectancy to cardiovascular disease it is more than twice the other causes of limitations and life expectancy but the other reason we have come together around this is that we have good scientific knowledge of what specific actions we should take to achieve better outcomes and yet we are not getting those treatments into people and encouraging people to accept those treatments in large numbers. This slide shows you as a baseline, 2011, at a population level, only 47% of

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those that should be on aspirin are actually taking aspirin and the numbers dropped from their. We have fewer than 50% of people who have high blood pressure having it under control. Even lower for cholesterol management and the really scary number are of those folks that have decided to stop smoking they have committed to become a non-smoker. Only 23% of them are getting the behavioral counseling and the replacement therapy that has been shown to help. The target: as early want to be from where we want to be from into 2016 and the clinical target refers to those individuals who are in settings of care in healthcare settings as opposed to the population level percentage that you see under target. We have a long way to go and the only way to get there is through partnerships and we hope that all of you on the phone will find yourselves and this initiative and find ways to contribute to the common goal. On the key component slide you see that we are working along community prevention alliance in order to help keep people healthy and make a healthy option the default one by targeting a smoke free workplace reducing sodium content in the food supply and eliminating trans fats. On the clinical side, we want individuals who need care to receive excellent care and the ABCS we want to pull the attention of the professionals and the systems in which they work in the patients for whom they care to the power of that excellence. We know that experts in the ABCS means a precipitous drop in heart disease and stroke rate in order to do that, we know we need to deploy health information technology and systematic measurement and we want to take full advantage of the new models and care that are being launched and developed in order to deliver these better outcomes. We are turning our attention to blood pressure control. We want to wake up in the near future, not only knowing what the blood pressure of the country is but having had a dramatic impact pulling that blood pressure is under control. The slide I am showing you is slightly out of date as of last week and new data has come out adjusting the numbers a bit but the take-home point is the same. We have 36 out of the 67 million Americans with high blood pressure yet to be controlled. We know that a small improvement in that topic number can actually have a dramatic impact on not just event rates but death errata reducing the risk of stroke, heart attack and mortality from a cardiovascular cause. What are dramatic about this, there are 14 million people out there who have high blood pressure and don't know it. We have tremendous opportunity to help improve the detection of hypertension. There are 16 million people who know they have high blood pressure and they are on treatment and yet they are not control. So again, tremendous opportunity in a short timeframe to turn up the engines to get the nation's blood pressure under control. Our team has identified through a number of conversations with lots of people that these things are missing. These are

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the elements that are present; we can get a handle on the nation's blood pressure. I won't give you these in detail.

Blood pressure monitoring does not only happen in a physician's office but it starts with a nurse who have a negative stress of the personal the blood pressure they have the skills they need and the knowledge that helps them identify when they call for help. When they call for help, they are doing so to professionals that they trust, they're getting advice from the source that is most responsive and is most expert at giving them that advice and the data between these two, the patient and the professionals close up the patient's permission between those two settings, blood pressure is required in a church or in a yoga studio or in a gas station, the individual can actually target a specific treating provider for blood pressure readings and to get advice back quickly. The medications that are used to control high blood pressure are no pay or low co-pay because these medicines help prevent the more expensive traumatic ask events like heart attack and stroke in family blood pressure performance, high blood pressure control performance is awarded for the individual poor for professional support systems and data will show web-based pharmacy care home-based blood pressure monitoring increases control and individuals with a highest pressure. So I will just say, all of them are contributing to this effort they have very specific captions and contributions and this is just a subset of the private sector partners that we have so far. I will now, it is my pleasure and honor to turn over to our guest speakers, Dr. Andre Williams who is the chief executive officer for the Association of Black cardiologists and Ms. Lorraine Valdez who is the acting director of the Indian health service division of diabetes treatment and prevention and I am delighted and grateful you are joining us. I will turn it over to you, Andre.

ANDRE WILLIAMS:

Thank you. The Association of Black cardiologists is proud to be a partner with Million Hearts this campaign and for those individuals who have not taken the pledge I would encourage all to take the pledge and you can actually help prevent a heart attack by taking the pledge personally understanding the risk factors and sharing that information with your loved ones. And we have been around since 1974 we have 2500 members it is a national organization made up of health professionals in non-health professionals working together to eliminate health disparities. We champion the elimination of cardiovascular disparities between research and advocacy and I just want to provide a summary of the slide. Our signature program is a program entitled Spirit of the heart. It is a faith-based initiative and it is

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a collaborative initiative to reach underserved communities across the country. We have a Southwest region program getting ready to start out and we have three programs in Houston, Dallas, and Austin. At three programs in Texas the program consists of a community leader's forum, free health screenings and a message from the CEO. Our goal is to share not only the principles of the 1 million hearts campaign the benefits that are available in resources that are available at the local level. Some as a result of the affordable care act. The initiative begins with a community leaders forum we have health risk assessment and a faith-based educational activity. We have programs in Dallas, Houston, Austin, New York City and we recently added Oakland. The mission for the program is to bring partners and individuals and resources in the community together as a call to action to get individuals to be motivated to make changes in behavior so we can have improved outcomes at the local level. Program objectives are to increase awareness; there is a high prevalence of heart disease and risk factors including cholesterol hypertension etc. Improve strategies for identifying high-risk patients emphasize the importance of active risk factor modification and the program begins is bringing the stakeholders together with the community leaders forum. This is an interesting concept of bringing groups that are in the community. That way that are typically communicate and we bring the health systems, the politicians, the religious leaders, community activist together and the focus is on the underserved community which is typically African-American and Hispanic. We bring these communities together and we talked about the challenges that are facing the community, lack of resources, and lack of communication between parties that we encourage the parties to find solutions around these problems. The second day we provide free health screenings for the community. We bring the faith-based community together working collaboratively with the health systems there locally along with members we provide free blood pressure screenings cholesterol, BMI, blood glucose, and that we also provide free consultation. Actually, for us it is the most important element of the activity. We find that many people that go to screening events have health providers and it is more of a confirmation of their condition. We find was this a Dallas one of our health providers and a free nonthreatening consultation, able to communicate the need for change. And to get a by and for individuals to take action to control and improve their health. We also recruit individuals of this event to become community health advocates and they go on to receive additional training from the Association of Black cardiologists and become community leaders and sharing the principles of the Million Hearts campaign. Understanding and sharing those risk factors with constituents. The foundation for the faith-based initiatives is the

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seven steps to a healthy heart. The first step is to be spiritually active and that is or connection with the faith-based community. Individuals who are spiritually active tend to live longer. The second step is to take charge of your blood pressure and the third is to control your cholesterol. Next, to track blood sugar. Eat smart, enjoy regular exercise. Don't smoke and access better healthcare. Thus a have a booklet and a video available of the seven steps. It is interesting, the CDC recently had a webinar where at the present today project in Philadelphia where they took two groups of pre-hypertensive patients who were African-American and one group was provided with the seven steps to a healthy heart the video along with a booklet and automated blood pressure cuff and the other group they provided traditional medicine. The group that received traditional medicine 100% of that group went on to receive medication and became medication dependent for hypertension. The other group that received the ABC materials 36% of that group went on to get their blood pressure under control. So this speaks to the importance of having sensitive material individuals and patients by and to take charge of their health. The third component is the church outreach of the faith-based community outreach. So the third day we dispersed across the city and members deliver messages from area church pulpits. We distribute information regarding the ABC steps we are available to answer questions individuals have in the church and we also encouraged church they don't have a ministry, to set one up the we provide literature as they leave behind for the church as a resource going forward. A new added dimension to our program this year is a partnership with the American College of cardiology in a program called cardio smart. This program provides text messaging to individuals in the community we are excited about this new partnership in the sunset after this program is over we will be able to maintain communication with these individuals. Cardio smart was created by the individual cardiac team at the College of cardiology to engage and inform and empower patients to take control of their lifestyles and medical treatment our goal is to maintain lines of communication with program participants to the Association of Black cardiologists provides what message a week to individuals that attend our programs. The messages will focus on Stefan steps to a healthy heart. We invite individuals in the community to join us in this effort and it is an open program and we have a number of partners in each city and we are always open to additional partners. If you would like additional information go to our website at if you would like additional information go to our website@cardio.org to find out additional details. Thank you.

Thank you for that. To hear from Ms. Lorraine Valdez.

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LORRAINE VALDEZ:

Thank you. I did something wrong. [We can see the slides.] Okay. I cannot. I'm sorry. The background of slide one, adjusting CVD risk and American Indian and Alaska native people. We are going to take a different approach this afternoon and I'm going to be focusing on hypertension. As I was introduced, my name is Ms. Lorraine Valdez I am a nurse by training certified diabetes educator and I am currently the acting director of the division of diabetes treatment and prevention which is under the Indian health service and agency under DHHS. And yes Indian health service has taken the pledge to work in addressing all the elements that are part of the Million Hearts program. I would like to thank everyone for the opportunity to participate and present the information. There approximately 2.9 million American Indians and Alaska native people in the United States and this is according to the 2010 census. The Indian health care system has over 566 federally wreck nice tribes with 2 million American Indians Alaska native people residing on or near reservations. And about half of the facilities are run by the IHS Ms. of the health care facilities and the other half are run by the tribal organizations. Here is a snapshot of the Indian health care system. The Indian health service provides services through a comprehensive primary care network that is provided directly by Indian health service by tribal health facilities and by urban Indian health care programs and over 600 hospitals, clinics, and health stations on or near Indian reservations and the federal system itself which is the Indian health service system consists of 29 hospitals 68 health centers and 41 health stations. In addition to these facilities, there are currently 33 urban Indian health projects that provide a variety of health and referral services ranging from community health to comprehensive primary health care services. Diabetes and cardiovascular disease and American Indian and Alaska native people is certainly a huge epidemic and a problem and it has been for quite a long time. The prevalence of diabetes in American Indian and Alaska native adult is at 16.1% and this is compared with 7.1% in non-Hispanic whites and this is according to the CDC. CDC and diabetes again and American Indian and Alaska native people is costly and we are aware of this and also, it is very devastating. According to the study, the risk is even more closely connected to diabetes that it is in the general population. Something is happening with my screen. The Indian health service has implemented a program to respond to this epidemic of diabetes as well as cardiovascular disease and that is to provide resources and training on treating risk factors as well as a program to monitor care and outcomes that include the risk factors with an annual diabetes audit and this is what I'm going to be discussing.

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You will see a number of resources and training that is made available to the clinical providers, their national providers to work and the Indian health care system. Back in 1986, the Indian health service develops a standard of care for individuals who have diabetes and our system. And since that time, we have developed a series of best practices, algorithms, of which you see an example of this is the algorithm that we have made available and clinical providers can come to our side and download this material for their use. We also have a number of opportunities and I think like most organizations we are doing a lot of training by webinar we have a lot of material online and occasionally, we do face-to-face but primarily we provide materials to local site who are doing face-to-face conferences and seminars and presentations. I would encourage anyone and everyone on this program to go to our side and take a look at all of the material that we have available. This next slide shows our website, our homepage and if you navigate using the menu on the left-hand side, it shows you and your resources and tools, a number of items that are very useful for everyone. This is a page that we have listed, the clinical tools, clinical guidelines, training that we provide a live presentation as well as recorded presentation and over on the right-hand side are best practices information as well as a number of learning hubs in particular one that is showing is displaying the diabetes foot care of and in one place, shows all of the material on our website that is available on the topic of foot care and we have several of these on other topics as well. The Indian health service diabetes program has had a very long history of developing culturally appropriate material and encourages the development of local and tribal specific education and information sharing material. Because, as I mentioned earlier, there are over 560 federally recognized tribes and the whole group, many have various languages, many have various living situations and tribal and cultural histories and it is important to recognize these and sharing our healthcare related information. One of the tools that we have available and that we have adapted from the USDA is called my native plate. This took a lot of work to adapt the original my plate version. We did a lot of field testing and have made this available as a tear off sheet we're going to have them available as laminated placemats and have also developed tips on how to use this and other food related issues such as food insecurity psychosocial issues related to food, whether individuals or groups could have enough money to buy food but we encourage anyone or any group that accesses this information to add their own logos to have their own program names and to make it their own and are now beginning to look at further adapted locally and added to my native plate. This is been wildly populated or the field testing we did with this before we made available nationwide we got a good response and individuals from head start

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programs all the way through diabetes education programs helped motion disease prevention programs find this tool very useful. The next activity I want to mention is diabetes care and outcomes audit that we have in the Indian health system. I mentioned the standards of care that we have available for individuals who have diabetes of the system. The diabetes audit assesses elements of the diabetes care for American Indian and Alaska native people we started the audit process early and with the use of this it closes the loop that helps facilities close the loop and encourages them to use audit results the facility identifies areas for improvement using the audit results. In 2011, there were 92,000 charts that were audited the charts were audited both by the electronic method there were over 330 facilities that participated and this is voluntary participation they do not have to participate with the audit system is such a useful one man adds to the performance measures that we do have a lot of participation and many data elements are related to the CVD risk including hypertension.

It is a good thing the slides are being made available to you after this presentation. Here are some out, measures that I want to go over briefly with you to show you have a can turn the information and how the local facilities can use the data for improvement purposes. You're looking at national data and this is the first slide shows the A1 C, 1969, 1996 2011 dropped a full percentage point and as we know, according to NIH every percentage drop reduces the risk of eye, kidney, and or complications by 40%. The blood pressure which is the next slide has been well controlled and the average blood pressure in 2011 was 131 and the average blood pressure in 2011 was 131/75. Blood pressure control reduces the risk of cardiovascular disease among people of diabetes and reduces the risk of eye, kidney, and or complications by 33%. The next two slides of the first one show the average LDL cholesterol level and it decreased from hundred 18 mg and 1998 to 94 mg/do in 2011. The improved control of LDL cholesterol can reduce cardiovascular complications by 20% to 50%. The last line of this page shows the use of aspirin increasing significantly since 1999 and not all patients should be prescribed aspirin therapy is indicated in those with known cardiovascular disease should be considered in those at risk of developing CDC. So by using the audit data that we were able to track and trend these particular outcomes and we are able to track the indicators that are important in 1 million hearts programs. The last slide I want to go over is a slide from the United States renal data system 2008 and we do know that CVD rates are hard to measure bearing the renal diseases are related out, with outcomes data that is available. And renal disease itself is an additional risk factor and the reductions and the disease rates are

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likely the result of reductions in risk factors especially blood pressure control of the use of these inhibitors this slide as I mentioned before, taken from the rated system 2008 and between 1995 and 2006, the incident rates and American Indian and Alaska natives with diabetes fell by 27.7% this is a greater decline than any other racial or ethnic group at that time. Another way to look at cardiovascular disease.

Okay. Last slide, on some key point's Indian health service has a long history of developing risk in American Indians and Alaska native people with diabetes. The strategy that we have to avoid includes helping facilities work on the ABCs by providing resources and training, the circuit was monitoring risk factors and the third one is disseminating evidence-based approaches throughout the Indian health system. And with that, we will gladly take any questions that will be available.

Thank you for your patience.

CARA JAMES:

Thank you. We are now going to open it up to the moderator who is going to manage the questions for us and I want to thank people for their presentations and these will share with you opportunities at which you can think about ways to get engaged and continue your efforts. Olivia?

OPERATORS:

You may submit your questions on the chat field next to the message for moderators. Please type your questions and hit send. Your question will be visible to the moderator and speakers.

JESSICA WEHLE:

Erica would you like to respond to questions that have been put in the chat box previously while other participants are able to type questions in the chat box and we can move forward in that direction.

ERICA TALYOR:

Okay. We are pulling up a couple of those questions. Okay. We are raising the question. The screening events, are referrals made to the diabetes prevention program such as chronic disease self-management?

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REPENDENT:

Yes, for our partners, and the system so we partner with, those resources are typically available to make those referrals and want to make sure that individuals linked to a home seller doesn't have a primary care physician and we encourage them to get a relationship with a local practitioner.

ERICA TALYOR:

Okay. Looks like we have another question for you. Is it really our job as providers to encourage spirituality and faith? You not think the swelling eight many of those who are atheists and alienate those that are atheist or do not conform to traditional form of spirituality of the tiered church.

ANDRE WILLIAMS:

Our views are based on data, in order to go to church or not are not necessarily the issue. The fact that they are spiritually active and that concludes meditating. Pigeon not necessarily have to go to church to be spiritually active. So they basically fall back to the data with individuals that are spiritually active live longer another issue for us, the church tends to be a huge resource Center and the underserved community. So the church welcomes all to attend the events and we hope that the they understand hear the help message.

ERICA TAYLOR:

Thank you for that. I know that Dr. Wright has been busy answering questions on several of the other ones are coming down have been taking care of. So, do we have any other questions?

JANET WRIGHT:

This is Jan is right. There is one that I meant to say during my presentation, whether they are translated into languages such as Spanish or Asian or Pacific Islander languages we are at work and should have Spanish translations from the materials that are currently available on the website meaning the partner toolkit and much of the information about hypertension and we don't have plans to translate into other languages but we will be looking for resources and partners that can help us do that as the needs arise.

ERICA TAYLOR:

Thank you for that. It looks like you have a question. The question is what my native plate is field-tested with Lakota speaking Native Americans.

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LORRAINE VALDEZ:

Thank you for that question, that is a very good question and the answer to that question, it was not field-tested specifically for a Lakota speaking population but what we did was field-tested with head start teachers, head start parents, not across the board but a small pilot test group as well as individuals patients and their family members at various urban clinics and several tribes in the Indian health system. We encourage taking my native plate and encouraging local providers and educators to use it to adapt it to make it valuable to the individuals who speak traditional languages is very important that we don't have the resources to do that for each tribe for each group that speaks their own language and we encourage you to do that share results with us. The materials that we have including my native plate is non-copyrighted and we encourage the use in local communities and I thank you for that question, that was a very good question. Passive see there is another question from Kelly about the standards of care on Indian health service and whether or not they're based on evidence in the literature and I felt to mention the standards of care for type XXV diabetes for the Indian health system is based on evidence that is based on science and has been in place for quite a number of years and we update these standards of care we were doing it every two years but now it is being updated real-time as new changes came out the literature and science and we are able to go into the website and update guidelines that are available. Thank you for the question.

ERICA TAYLOR:

Thank you for that and looks like we have another question for Andre in terms of the spirit of the heart program. Is this just a one-time screening workshop or is there any follow-up any measurable outcomes?

ANDRE WILLIAMS:

It is just a one-time screening important it should is to get these individuals screened if there is an issue into medical home for a follow-up our partnership with the American College of cardiology would you have follow-up in a communication tool which will send text messages to individuals that have a taxes on it once a week they will get a message from the Association of Black cardiologists reinforcing seven steps to a healthy heart. You mentioned selected cities July to consider Kansas City and St. Louis?

We are looking for 10 cities and certainly Kansas City and St. Louis would be good cities for such a program. We have strong memberships in both cities.

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ERICA TAYLOR:

Okay. We had a question with regards to community health workers and I know that we're working on an answer to that one. Unless I am saying anything any other questions I will give it another try.

LORRAINE VALDEZ

Mrs. Lorraine about us and I would like to recognize Kathy to has a couple of comments and she is the director of the Indian health services health representative program and she has made the programs that they are using my native plate as a teaching and resource tool for training of new CHR's and they find it extremely valuable in their happy to be able to use it. Thank you for that comment.

JANET WRIGHT:

This is Janet Wright I neglected to thank Dr. Chazeman Jackson for her contributions and efforts around reductions and disparities around Million Hearts and beyond. She is with the Department of the office of minority health. Thank you, Dr. Jackson.

ERICA TAYLOR:

Okay. It looks like the last few questions that are coming through for Mr. Williams, I'm going to let him answer these that I think we are going to begin to wrap it up so he can finish on time.

ANDRE WILLIAMS:

I like to start by answering the second part of that question about results of our program. The results we monitor our referrals and we see a huge surge of individuals seeking a specialist cardiologists and we see a huge surge in Scripps being filled and we have not taken action and the underserved community we see a lot of those being filled and no pitches for good health of those individuals. The next question I see, how you are determining what cities you go to with the spirit of hard screening, there is some great data, the national minority health office has a great website of were the muted tones to be in this country. The pockets of made. So that is typically where we look at obviously, we look at a footprint where we haven't been prior to and those other ways, that is the way we typically search for which city. The next question I have, I am a PhD student working on a faith-based pilot focused on older Hispanic males and are you saying older males in your initiative? The challenges getting them to come forward it

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is great because typically there is significant others and spouses attend the pulled a minute so we just started a focus on men's health as well so thank you for your question.

CARA JAMES:

Okay. I want to thank all of you this is been a very interactive and engaging presentation that we have had and I would like to thank Dr.(s) Chazeman, Erica Taylor, and Denesecia Green and I would like to thank them for a wonderful presentation to help educate us about the work you are doing we have a couple of really quick questions that we would like to ask you and so those are coming up and we would like to ask you to stay on the line so we can get a little bit more feedback into how we can make these more useful for you as we go forward. So thank you again to all of our participants and organizers for joining us this afternoon. Thank you.

OPERATOR:

Thank you for your attention, this concludes today's conference. You may now disconnect.

END OF TRANSCRIPT