Cardiovascular Disease & Hispanics Report

February 2018
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INTRODUCTION

As a part of an ongoing commitment to promote health care equity and quality, the National Hispanic Medical Association (NHMA) convened three invitational regional summits with physicians, health care professionals, public health experts and community leaders. The purpose of the Summits was to become aware of the trends of cardiovascular disease among Hispanics and ways to decrease the incidence or to improve the quality of life for patients with the disease by developing consensus recommendations. The recommendations focus on how to increase access to health care and wellness care, prevention services, and medical education to reduce cardiovascular disease among Hispanics.

The three summits were held on April 18, 2017 in Austin, TX; June 27, 2017 in New York City; and August 17, 2017 in Los Angeles, CA with about 300 participants that included physicians, health care professionals, community leaders and policy-makers. The agendas, the overview presentation and the participants are included in the Appendix section of this report.

This report summarizes the key points discussed during the summits by the health expert speakers and participants along with the recommendations for improving programs and policies, at the federal and state level, in the health care system and in the community, which can improve the cardiovascular disease profile of the Hispanic population.

The first section summarizes the charge to the participants from myself as the President & CEO of NHMA and an elected official from each region of the country – Diana Arévalo, State Assemblywoman, District 116, San Antonio, Chair, the Mexican American Legislative Caucus; Marcos Crespo, Assemblyman from New York State; and Hilda Solis, Los Angeles County Supervisor. The second section summarizes the overview of CVD and Hispanics, while the last three sections then address access, prevention and medical education discussions and recommendations to advance Cardiovascular Disease Leadership for Hispanics.

Elena Ríos, MD, MSPH, FACP
President & CEO
National Hispanic Medical Association
WELCOME REMARKS

The Summits began with opening remarks from Dr. Elena Rios and from regional politicians – Diana Arevalo, Texas State Assemblywoman, Mexican American Caucus; Marcos Crespo, New York Assemblyman, Chair, Puerto Rico-Hispanic Task Force; and Hilda Solis, Supervisor, Los Angeles County.

Dr. Elena Rios welcomed the participants at each Summit, presented the National Hispanic Medical Association, called for an introduction of the participants and discussed key issues pertaining to access, prevention and medical education and Hispanics to set the stage for the day.

Some highlights:

- Hispanics are the least proportional ethnic group in the U.S. without health care insurance and face social determinants of health (chronic stress from poverty, substandard housing, few parks, food deserts, limited transportation or social services) and limited health care facilities, which are major barriers to access to health care services as well as to healthy lifestyles. Subsequently, Hispanics have high rates of obesity, diabetes, hypertension, limited nutrition and physical activity which are all major risk factors for cardiovascular disease.

- Hispanics are very strong in cultural values and family support, in general, but have limited educated parents (especially immigrant parents) or exposure to higher education and lack role models of physicians or health care professionals in their families. Thus, there is a lack of knowledge on the pursuit of medicine or health professions careers, lack of participation in health care research.

- Hispanics are marginalized in our communities and need leaders in the community, the health care system, and the government that can address their needs and challenges in order to develop a cardiovascular agenda that is culturally competent and programs that enhance the participation of Hispanics with programs they need to decrease cardiovascular disease.

- The research presented today on cardiovascular disease will show knowledge about our subgroups and risk factors, and new drugs provide hope to decrease morbidity, but there is a clear need for additional research and data in order to better understand effective interventions and best practices to reduce health disparities, especially for cardiovascular disease patients.

- Hispanics have been accepted to medical school and health care professional schools at disproportionate levels compared to their growing population and, thus, we need to advocate for government funding for programs that encourage students to be competent in critical thinking, math and science, and to pursue health career education pathways from the U.S. Department of Education and other agencies.
Lastly, the National Hispanic Medical Association welcomes the participation of the national advocacy organizations and the speakers and participants to work toward a common goal of improving health equity for all Americans.

There will be an expert presenting on the overview of cardiovascular disease and Hispanics based on the latest research followed by a question and answer period. Then we will have 3 panels of speakers, working group sessions, and reports from the groups on their recommendations to: 1) increase access to health care and wellness care; 2) increase awareness and prevention services; and 3) develop medical education, including advocacy for patients. All will be targeted to discussing strategies for the Hispanic community and the health care system.

The final report will be a summary of the health experts’ presentations, discussions and key recommendations from the participants.

The Elected Officials encouraged the participants to provide their expertise to NHMA to advocate in Congress for our communities. They provided important messages:

**Diana Arévalo, State Assemblywoman, District 116, San Antonio, Chair, the Mexican American Legislative Caucus**

As the oldest and largest Latino legislative caucus (42 legislators) in the country we take our role seriously in increasing access to healthcare. We welcome you to Austin today and look forward to working with each and every one of you to help enhance healthy communities, healthy families and healthy kids. Texas remains ground zero in terms of percentage of uninsured persons. And, unfortunately, Latinos are the largest group among them, with 52% of the uninsured population being Latino. That creates an un-level playing field in terms of access and affordability to healthcare for thousands of Latino families across the state.

- Parody for mental health services by putting in state law that behavioral health and substance abuse services are covered at the same level as physical health services under insurance plans.
- Farm to Table Caucus a few sessions back to help with community efforts, because as you know, if we teach our kids to have healthy habits young it will help them lead a longer and healthier life.
- A younger population is combatting obesity and heart disease due to unhealthy habits. And this legislature can support policies that reduce those risks, but we also need your help in coming up with new ideas, innovative solutions to overcome these challenges.
- Raise the legal purchasing age for tobacco to the age of 21

**Marcos Crespo, New York State Assemblyman, Chairman, Puerto Rico Hispanic Task Force**

It's not easy to do, but I know that each and every one of you plays an important role. At some point as policymakers we need to listen to your recommendations. You are the experts that understand how these things impact patients, and you know what are the things that patients are telling you, the feedback that you are getting. How do we get the right data in order to match that with the policies that we need?
• Education reform for Latinos who are growing, not only as patients but hopefully as medical professionals as well, and academic professionals, making sure that we create a pipeline for Latinos to get into the field.

• The Puerto Rican/Hispanic Task Force, we host conferences called the SOMOS conference. Dr. Rios has been a part of them for many years, and one of the issues that we have consistently spoken about is healthcare because of how important it is to Latinos and the numbers, and the impact that it has.

• If you simply focus on the healthcare crisis that is happening on the island of Puerto Rico, when 3.5 million Americans no longer have doctors available to them, and it is not their fault that they left, when reimbursement rates are the lowest in the country, when the utilization rate of the Medicaid and Medicare system is the highest in the country, and when we are the only community that has been forced into a cap on reimbursement, there is no question or there shouldn't be a doubt as to how we ended up in a crisis, and I say that because one of the things that we focused on in the conferences is advocacy for Puerto Rico and parity for Puerto Rico as it relates to its healthcare system. The movement and migration of people out of the island is having an impact on health systems in other states as more families leave the island, that patient that could have been given care for a nominal amount of money in Puerto Rico is now going to be eligible for services in other states where it costs exponentially more.

• How do we get our kids into healthier environments, into spaces that promote health as part of your growth?

Hilda Solis, Los Angeles County Supervisor:

I am now in my third term on the Board of Supervisors, and we now are at a tipping point because the leadership has changed with members who understand that we have to change our most poor neighborhoods and support social services in order to improve the health of our communities.

• I would urge you to consider your own neighborhoods that are faced with poverty and think how to change the social determinants of health that can impact that community, whether Hispanic, African American or Asian.

• We’re finding that the tools that will help us to be culturally and linguistically competent, and understanding how to transform services to these different populations is becoming more increasingly important for Los Angeles County and our hospital and our medical services.

• If we don’t then we’re going to find ourselves actually continuing on a spiral that isn’t going to lead to much success because we’re going to continue to see people using our emergency units, our trauma center, and that, as we all know is a recipe for failure because of the high costs involved.

This report is summary of the presentations and the recommendations to improve Cardiovascular Disease among Hispanics focused in four specific areas: 1) General overview of cardiovascular disease among Hispanics; 2) Prevention and diagnosis of cardiovascular disease in the Hispanic community; 3) Access to cardiovascular disease healthcare services; and 4) Education and Advocacy for Healthcare Professionals.
OVERVIEW OF CARDIOVASCULAR DISEASE AND HISPANICS

More than 56 million Hispanics currently live in the United States, which constitutes 17 percent of the total population. They represent the second fastest-growing racial or ethnic population in the United States and are expected to constitute 30 percent of the total U.S. population by 2050. Hispanics are a diverse ethnic population, varying in race, national origin, immigration status, and other socioeconomic factors. Despite the growing numbers of Hispanics in the U.S., many continue to face health disparities. Additionally, the diversity among U.S. Hispanics presents many challenges.

Cardiovascular disease is the leading cause of death among Hispanics in the U.S. Cardiovascular disease includes coronary artery disease and incorporates other cardiac conditions such as: congenital heart disease, arrhythmias and congestive heart failure. The American Heart Association recently issued a scientific statement highlighting the public health burden of cardiovascular disease in Hispanics and called for the development of culturally tailored interventions and the prioritizing of Hispanics in the nation’s heart health improvement goals. An underlying issue in this call is the acknowledgement of an insufficient understanding of Hispanic heart health in general, and specifically with respect to differences by Hispanic background. Additionally, cardiovascular disease among Hispanic is sometimes called a paradox – since Hispanics have lower cardiovascular disease in total mortality rate despite the adverse socioeconomic status and elevated risk factors.

According to the American Heart Association, the following document the high-risk factors of Hispanics for Cardiovascular Disease. 76% of Hispanics are non-smokers, only 23% have a BMI that is normal, only 2% meet the dietary components recommended by the AHA, only half of them perform the exercise that is recommended, 150 minutes per week of moderate or vigorous activity. In terms of blood pressure, 53% have the ideal blood pressure and 59% have total cholesterol of less than 200. In terms of fasting plasma glucose 65% have the ideal rate. 27% of Mexican American stroke patients obtain treatment within three hours and 35% recognize the heart attack warning symptoms. 46% of Hispanics can recognize all five stroke symptoms and also it was noticed that Hispanics that arrived to the emergency department with stroke symptoms had longer waiting time to see a physician.

The following data from the American Heart Association highlights the most recent statistics in the rates of cardiovascular disease among Hispanics:

- Hispanic adults age 20 and older, 2011-2014, 31.3 percent of males and 33.3 percent of females had cardiovascular disease.
- In 2014, cardiovascular disease caused the deaths of 24,875 Hispanic males and 21,571 Hispanic females.
- Projections show that by 2030, an additional 3.4 million US adults aged ≥18 years will have had a stroke, a 20.5 percent increase in prevalence from 2012. The highest increase (29 percent) is projected to be in Hispanic men.
- 69.4 percent of adults over age 20 in the United States are overweight or obese; 36.3 percent are obese. Among Hispanic adults, 79.6 percent of males and 77.1 percent of females are overweight or obese. Of these, 39 percent of males, and 45.7 percent of females are obese.
- Among Hispanics age 20 and older, 2011-2014, 28.9 percent of the males and 30.7 percent of the females had high blood pressure.
Minority groups remain disproportionately affected by Diabetes Mellitus. The prevalence of total diabetes in Mexican Americans was 35 percent higher than whites (11.6 percent versus 8.6 percent, respectively).

A recent American Heart Association report projects that by 2035, there will be 123 million Americans with high blood pressure, 24 million with coronary heart disease, 11 million suffering from stroke, and 7 million Americans with atrial fibrillation. Additionally, by the age of 45, the cardiovascular disease risk is 50 percent, and at 65 years it increases to 80 percent. Black Americans will have the highest rates of cardiovascular disease by 2035 followed by Whites and Hispanics.

In addition to the staggering human toll it takes on Americans lives and health, cardiovascular disease wreaks havoc on our economy. Cardiovascular disease cost our nation $555 billion in 2016 making it the costliest disease today, and this will only increase over time.

**SOL Study**

The Hispanic Community Health Study / Study of Latinos (HCHS/SOL) is the largest and most comprehensive cohort study to date funded by the National Institutes of Health. It is a multi-center epidemiologic study in Hispanic populations to assess the role of acculturation in the prevalence and development of disease, and to identify factors playing a protective or harmful role in the health of Hispanics. The target population of 16,000 persons of Hispanic/Latino origin, specifically Cuban, Puerto Rican, Dominican, Mexican, and Central/South American, were recruited through four Field Centers in Miami, San Diego, Chicago and the Bronx area of New York.
In summary, the SOL study revealed substantial variation in the risk factor of cardiovascular disease and the burden across the diverse Hispanic Latino groups, so it’s not fair to lump Hispanics into one group as noted in the chart above. These findings highlight the diverse, heterogeneous nature of the U.S. Hispanic/Latino population and underscore the importance of understanding variation in risk factors and diseases by Hispanic/Latino background.
PREVENTION OF CARDIOVASCULAR DISEASE AND COMPLICATIONS AMONG HISPANICS

Community

The overall U.S. health system spends very little on prevention programs and is the major issue when developing programs to educate Americans about cardiovascular disease awareness and changing risky behaviors. The U.S. spends 17% on healthcare and only 9% on social services which is prompting population health interventions to cardiovascular disease, which are calling for a range of prevention programs – from individual clinical prevention programs to social prevention programs.

The prevention of cardiovascular disease starts with an understanding of what a low cardiovascular risk profile, or what favorable levels of cardiovascular risk factors are for Hispanics. For example, what are the total cholesterol levels in each of the Hispanic subgroups? It was shown in the SOL Study that the levels are the lowest among Puerto Ricans and highest among Central Americans, looking at the difference. This is one of the most important contributions of the study for the prevention of cardiovascular disease treatment. 81% of Hispanics have at least one major cardiovascular risk factors and this is true for 79% among women. This community faces major barriers and challenges to overcoming health disparities, particularly in physical activity and healthy diets. So because based on that, Hispanics have all of the major risk factors. There are underlying barriers on the personal level, social cultural barriers, health care services barriers, and neighborhood barriers. How do we expect that they eat healthy, or they can exercise in high crime or food desert areas where healthy food is so expensive? How can we expect to overcome these problems to physical activity barriers if we don’t address the polluted environment?

Education programs that discuss prevention of cardiovascular disease are generally not targeted to certain populations. Hispanic health education programs are effective because they are targeted to the family across the generations who may occupy a single household. In addition, providers who discuss disease management with a patient should supply active participation in their management such as checking blood pressure or developing a medication list and what is each used for, doctor list with contact information and ask to review the information at clinic visits, and information about nutrition and physical activity.

Public Health Departments have a role to fund programs with metrics to see ROI impact, geomapping for health disparities that can then support more targeted campaigns to educate about salt, sugar, portion size education campaigns.

In 2015, the Centers for Disease Control and Prevention (CDC) reported U.S.-born Hispanic population have a greater incidence than foreign-born Hispanics in the U.S of the major risk factors for cardiovascular disease - diabetes, smoking, hypertension, obesity and coronary artery disease.

Education to increase awareness of how to prevent cardiovascular disease should be targeted to youth but the generations are so close together in the Hispanic home, female Hispanics in Austin are about ten years younger than the rest of the population, as far as when we’re seeing them. And so this is why we need to educate, or earlier screening and earlier intervention. In terms of the key way to increase awareness of cardiovascular disease among the Hispanic community, several speakers highlighted the importance of family focused efforts. Often times the younger generation are the ones who are the liaison with health professionals, and therefore, have the opportunity to educate and inform the rest of their family.
Of course, smoking cessation is also important to target youth. Middle-schoolers in Texas are two times more likely to use E-cigarettes in the Hispanic population compared to other groups. But we do have, the tools we do have are diabetes education classes that are usually free to the public.

Promotoras (community health workers) play a key role as a trusted source of communications for community agencies that provide disease prevention education for Hispanics. It was discussed that the role of the community health workers needs to be expanded to clinical trials and research. They can also be sources of information on alternative medicine used by patients especially who are immigrants from Latin America or the Caribbean. Physicians need to understand alternative medicine as well as Eastern medicine techniques for relaxation – yoga, and other methods to decrease chronic stress.

Hispanic youth need to have role models and information on how to eat healthier and increase physical activity, given the increasing obesity in Hispanic families. School meal and exercise programs are important to be supported and to be expanded to be offered after school and during summer for the community. Nutrition curriculum about better food, drinking water not sugary drinks, less sodium, and the issues of smaller portion size are key lessons that children can teach to their parents and influence the household.

Adults have support groups through such programs as Mended Hearts that include speakers – a model that could be adopted by more health care systems. Future research is needed on quality of life for Hispanic elderly since they tend to rely on social security income and need help from family or neighbors for transportation to the doctor or social support and activities of daily living.

**Health Care System**

While money is not an issue, what is an issue is the decision-makers who can call for the redirection of funding for programs targeted to Latino communities for healthy lifestyles and to decrease social determinants of health – for example, poverty, jobs, housing and education programs. The second priority should be providing incentives for the community institutions such as hospitals to lead the programs, for example, for healthy food. Each hospital must support community benefit for their nonprofit status such as a health fair.

Another key issue in the health care system is advancing preventive programs that include treating mental health – especially depression – in order for patients to focus on risk factors, especially obesity. Health care should include prevention that can lead to major changes in high risk factors in subgroups.

Employers should be invested in their employees’ health, and the health system can incentivize wellness programs. After all, a healthier workforce, results in more production and efficiency. Lower health costs benefit both the employer and the employee. Also, if health costs are lower, employers may pass a smaller percentage of the bill on to workers. Small business owners may also be able to take advantage of tax incentives for workplace wellness programs. Employers, like some do already, should encourage their employees to work out during the work day by hosting group exercise classes or giving each employee 30 minutes a day to do some sort of physical activity.

Many Hispanics watch Univision or Telemundo as their main source of information and news. Since many are not aware of the symptoms or warning signs of potential cardiovascular disease, a health care
program that educates journalists and supports Hispanic media campaigns could be quite impactful in raising awareness among the Hispanic community of cardiovascular disease prevention.

**RECOMMENDATIONS: Prevention Education for Hispanics with Cardiovascular Disease**

**Community**
- Promote awareness of cardiovascular disease prevention.
- Nutrition
  - Incorporate nutrition classes in education for children/adolescents
  - Develop Latino-based diet cooking, shopping programs – home involvement
  - Reduce fast food/sodas/sugar advertising, focus on home cooking/water

**Health Care System**
- Provide individuals and families with information and tools to be able to follow provider's advice in daily life, such as health literacy, language services, health system navigation, and self-care in community.
- Improve Behavioral Health, creating an effective behavioral system that is efficiently integrated with other health sectors in order to ensure that the complete needs of complex patients are addressed.
- Culturally competent translation services
- Data collection/metrics to measure racial/ethnic health disparities.
- Support coordination with health care providers and payers to show the value of greater investment in community-based prevention approaches that address underlying determinants of poor health and chronic disease
- Providers need prevention education
  - Know who has biggest influence on patients – need multigenerational education (technology, apps, cell phones)
  - Understand what motivates people to make healthy changes
  - Print materials in Spanish & plain language
  - Respect the social condition of the patient
  - Use the American Heart Associations “Life’s Simple 7” Metrics
  - Assess mental health

**Federal Government**
- Nutrition
  - Continue to support WIC, SNAP, school meal programs
  - Promote farmer’s markets in food desert locations that offer healthy foods
  - Funding needed for prevention education about cooking Hispanic diets in healthy ways
- Exercise
  - Home care should include education on activity
  - School policies should include PE - should have educational component with strong evaluation & data collection for better outcomes
  - Know what patients’ like to do – increase routine of dancing, walking, jogging
  - Worksite Programs – stress reduction, healthy behaviors
  - Support family programs –parks, community centers, senior centers
ACCESS TO HEALTH CARE AND WELLNESS CARE FOR HISPANICS WITH CARDIOVASCULAR DISEASE

Community access to healthcare and treatment

Access to health care and treatment is key to decreasing cardiovascular disease among patients. There are various factors that must be taken into account for policies that raise access to health care, in general, and for Hispanics, specifically. In 2011, the Hispanic population was disproportionately 30.1% of the U.S. uninsured population, thus facing serious challenges in having appropriate access to health care.

Hispanic patient advocates need to be fostered through leadership development to share their stories and participate in media opportunities to increase community awareness about programs working to increase access to health care. These patients need to be messengers because their stories will resonate with the greater population.

National patient and physician organizations have resources to empower patient advocates to raise their voices to policy-makers and educate them about their concerns and strategies for programs that can improve access to cardiovascular health care and wellness care.

An example of a major access issue is patients being denied innovative therapies such as PCSK9is by their insurance companies, which decrease hypercholesterolemia and have been shown to significantly decrease myocardial infarctions. PCSK9 inhibitors that are intended for our highest risk population with atherosclerotic cardiovascular disease – oftentimes with one to three additional risk factors such as smoking, diabetes, peripheral artery disease or others. These individuals require a PCSK9i in addition to their statin or as a replacement if they have statin myalgias or muscle aches and are unable to take their medication.

PCSK9i is a monoclonal antibody that helps to prevent the LDL receptor from recycling and helps to reduce myocardial infarctions. Just recently, there was a FOURIER trial that showed 15% reductions in cardiovascular disease events and hospitalizations. We are looking forward to seeing longer outcome trials as this is a hallmark drug for the cardiology world that can give hope to patients

These organizations recognize the need to include more Hispanic health care providers to be leaders in their education programs geared towards Hispanic populations and increase awareness about patients being denied access to prescribed treatments by sharing their stories through op-eds/LTEs and social media amplification.

Schools for the community

Policies for Livable Active Communities and Environments work with cities to incorporate health elements into their general plans.

We’re also aligning our Department of Public Health, Department of Mental Health and Department of Health Services to unify all of the different services each of our departments’ offers so patients see a seamless system that makes it easier for them to navigate --- with one Health Equity Office.

As examples of health care programs that improve access to health care, the Los Angeles and New York City Public Health Departments were showcased.
The LA County Health Department planned a chronic disease campaign in 2010 that received millions of dollars from CDC to improve knowledge of cardiovascular disease and other chronic diseases in LA County. Campaigns included:

- Salt shopper campaign demonstrating how much salt is in a can of soup or in a loaf of bread with posters on bus shelters, on the sides of buses, on the videos playing in the grocery stores, in the communities that have are more disproportionately impacted
- The sugar pack campaign - a glass with sugar packets in it
- 2012 a choose less, weigh less campaign which was about portion control and not supersizing. Whatever you’re going to eat just try and have less of it ideally.
- Choose Health LA campaign – restaurants
- Choose Healthier Kids - menus, water as default beverage

We address the social determinants of health and things that impact chronic diseases overall. Our nutrition program, our cardiovascular health program, our tobacco control program, all work together in concert to address the underlying causes and work at the policy system and environmental levels to make high upstream changes that can impact a lot of the downstream outcomes.

We have also been working on cardiovascular and school health for years to get school districts to come into compliance with state physical education law. Physical education is the only subject for which public schools are required to have a certain number of minutes offered. For elementary school that’s 200 minutes of physical education each 10 school days for 7 through 12th grade, that’s 400 minutes of physical education each 10 school days. We have also promoted joint and shared use of facilities by the community after school.

The Plates program which stands for Policies for Livable Active Communities and Environments is a program that works with cities to incorporate health elements into their general plans. General plans are policy documents that guide cities for 10 to 20-year time spans for how they’re going to plan for growth in their cities, what kinds of businesses that they bring in, whether or not they put sidewalks on their new housing tract, bicycle or pedestrian master plans, smoke free policies – all impact health so they do have a role, and that they can keep that in mind when they’re making their policy decisions.

There is a huge issue with the silent killer in diabetics that says you can die of a heart attack. The two are very closely linked so we have been targeting diabetes and making sure that our work in that area aligns with health plans to get the National Diabetes Prevention Program (NDPP) covered for their enrollees. We’ve had quite a lot of success in trying to get some of our local health plans to adopt the NDPP program and cover it for patients that are interested and qualify for that.

The LA Health Department has a healthcare provider directory where the providers can go and have a health and human services resource where for a patient if they’re homeless, shelters, health insurance, exercise at pools, food pantry and align medical and mental health services for the most vulnerable.

In New York City, the Public Health Department is brainstorming ways to increase access to help this population lower their blood pressure, stay healthy, and avoid a lot of the complications of hypertension and other cardiovascular conditions. We are also looking at the prevalence across communities and by neighborhood, and it's uneven in the city. This is broken out by what we call the United Hospital Fund
neighborhoods, and in the future, we are going to try to make them more relevant to community districts to promote advocacy with local government.

As you can see it is really uneven by poverty, and also by where race and ethnicity resides. Prevalence is 1.4 times higher in very high poverty neighborhoods than in low poverty neighborhoods, and particularly for the Hispanic population, it's 1.4 times more prevalent. Hypertension is 1.4 times more prevalent than other ethnicities compared to whites. There are three levels of intervention that the city has been thinking through. One thing is bringing tools to primary care that helps identify their patients, especially for missed appointments and follow-up care around cardiovascular disease. We work with over 300 primary care practices, most of them solo two-person independent practices. Many of them have Spanish speaking and multi-lingual patients to really think of how they can leverage their information systems and identify patients for follow up and continuous care, and to help them think of not just the care that happens during the visit but how they can maintain the recommendations they have given the patient as they move on with their lifestyle and day-to-day routine.

We've provided these health providers with a couple of tools. One is what we call a dashboard that helps them proactively look for patients that are coming for a visit but don't have follow-up visits or don't have their blood pressure under control. They can also use their electronic health records to look for patients who haven't come in for a visit and had high blood pressure readings the last time they were at a visit, and they haven't been in for three to four months and to think through what are the outreach that they could do with their patients. This is especially important for the Spanish-speaking population since many of them are probably working multiple jobs, many of them have language barriers, and are those with undocumented status who may be concerned about coming back to a large healthcare system. We really encourage that the clinicians' office determine a work flow and transfer task for doing outreach.

Primary care can't do everything, and one thing we've been trying to do is identify community-based resources that we can share with clinicians that they can refer their patients to. One of these is what we call shape-up New York City, and these are free exercise classes that are offered around the city in multiple languages. We put up fliers in Spanish, Bengali, French, Chinese, and other languages so people can see the posters and know where to go. We have given providers maps too so that they know whether the classes are nearby where they practice and can refer them too. The other thing is that we have been really trying to make sure that there is a trained workforce for health coaches that are bilingual. In the past year, we trained about 150 lifestyle health coaches for the city to disburse in community-based organization and a third of them were trained in Spanish to be able to provide that.

Then the one thing I just want to highlight is the electronic system. It's a web-based portal that we have provided to physicians that are agreeing to refer their patients to lifestyle change courses. We show them how to identify people with hypertension or pre-diabetes, and they can refer them to these free courses around the city. It is meant to be a bidirectional interface so they could know whether their patient went to the class and then get information back of whether they have lost weight or attended. This is just a little bit of a screen shot of how we are tracking whether patients are being referred, and then on the right side is a screenshot of the portal itself of where doctors can use this portal or anyone can actually use this portal and refer them to community-based lifestyle or we call them evidence-based intervention classes. Users can pick whether it's Spanish speaking or not so you are not sending someone to an English-only speaking class, which won't be very useful in this population.
We have a very more policy-focused approach, and part of making a multi-pronged approach for tackling hypertension or cardiovascular disease is really thinking about our environment, and so this is really speaking to our food environment.

The New York City Health Department has been a leader in bringing national change in reducing the salt content in a lot of prepared or packaged foods. I think over the past 7 years they have been able to lower about 7% of the sodium content, and now the FDA is promoting to further reduce the sodium content. People should have a choice of how much salt is in their foods and argue for standards in which there isn't so much high sodium in pre-packaged foods that people might buy off the shelf. The other thing is we serve over 240 million meals a day that is funded by our City government. More than half of them are in schools and so they have implemented food standards that would help people stay healthy, especially kids. We recently started a sodium labeling warning for any retail chain restaurant with more than 15 places in the country with a serving of food over 2300 milligrams of salt so a person can recognize they are having their full days’ worth of recommended sodium. People should have more knowledge to make a decision of whether they can eat that food or not. Lastly, Mayor DeBlasio announced our Hypertension Initiative at the end of May 2017 to mobilize over one hundred organizations to share their programs in different communities to assist patients in controlling their high blood pressure or other cardiovascular conditions.

We recently started a sodium labeling warning for any retail chain restaurant with more than 15 places in the country with a serving of food over 2,300 milligrams of salt, so a person can recognize they are having their full days’ worth of recommended sodium in one sitting. People should have more knowledge to make a decision of whether they can eat that food or not.

Mayor DeBlasio announced our Hypertension Initiative at the end of May. We created a coalition.

One thing we really want to do is mobilize this ongoing hypertension initiative. We haven't had any change in the hypertension prevalence in the city despite all of the efforts that the health department and many of you in the health system have been trying to assist patients in controlling their high blood pressure or other cardiovascular conditions.

One action or policy that medical professionals, agencies or organizations can do that would be effective in expanding access to cardiovascular disease healthcare services for Latinos is providing greater access to education. When I commented on cardiac prehab, I would like to see more access to that kind of educational modality available before someone has a heart attack, before someone has bypass surgery.

Preventative Services give providers a chance on how to communicate better with their patients, but we must consider how we bring that type of education training or feedback to the providers that aren't reaching their patients.

How do we make those linkages between community services that are available because there are a lot of really good faith-based, community-based organizations that are very interested in doing this work, but they often feel like once they get to the clinical setting, the communication breaks down, or there is just that pass through doesn't connect or stick, so how do we bring policies that make it easier.

When you talk about access, you need to talk about financial cultural, linguistic, and institutional barriers. No discussion about institutional barriers, waiting time, waiting to be seen or getting an appointment – the many aspects that have to do with changing the culture of the institution. One
particular element is referral to physical activity as part of the healthcare provider effort in tracking whether people did attend or didn’t go.

One of the main barriers for Hispanics accessing healthcare is language. Limited proficiency in English affects Hispanics’ ability to seek and obtain healthcare and reduces access to health information in the media or online. In addition, communication is central to the process of healthcare delivery and has profound effects on patient-provider relationships and on the healthcare people receive. When you look at public versus private hospitals/clinics, there is a dearth of interpretation services at private hospitals and clinics. If resources were expanded to private healthcare entities that would help address the language barrier for Hispanic patients and their health provider. Another issue to keep in mind, is the need to increase cultural competency among translators. A complete understanding of the cultural nuances will allow translators and interpreters to effectively and appropriately deliver intended messages. Lastly, when communicating with patients it’s important to use plain English and avoid using medical jargon that can cause confusion.

Another barrier for Hispanics in terms of health access is transportation. According to a Cancer Practice survey, 60 percent of Hispanic reported that transportation was a major barrier to treatment, compared to 38 percent of white respondents. Transportation barriers lead to rescheduled or missed appointments, delayed care, and missed or delayed medication use. These consequences may lead to poorer management of cardiovascular disease and thus poorer health outcomes. A dedicated grant program in coordination with community organizations should be developed that allow states and local governments to allocate transportation services to their residents as necessary.

Health Care System

Changes are needed in the health care delivery system – time with patients, reimbursement guidelines for practice priorities, language and cultural competence of the providers. Changes are also needed with insurance company protocols in order to streamline authorizations and forms that inhibit access to needed drugs or devices for cardiovascular disease patients and to have step therapy protocols used to control costs. The latter means having to wait for 72 hours (24 hours in an emergency situation) with a first step drug before switching back to original prescribes drug.

With regards to PCSK9is, based on claims information from all 50 states, there were almost 35,000 rejections nationwide with only a fraction of appeals. With a 43 percent rejection rate, and several states with a predominantly single payer, patients do not have a lot of options. Hence, advocacy tactics to get patients access to these treatments, prescribed by their doctors, is crucial.

In the case of prior authorizations, oftentimes physicians aren’t reimbursed, and patient outcomes are suffering. For the physician offices that have a high success rate of approvals, they have a significant amount of staff specifically trained to relentlessly follow-up with insurance companies. Ultimately, the health care system focus should be on the therapeutic need of the patient rather than short-term cost savings versus long-term health outcomes.

Too often in healthcare we see a “silo” effect in terms of communication and coordination between clinics, hospitals, and community health workers. There needs to be increased coordination by implementing models, such as patient-centered medical home. We should not limit ourselves to considering U.S. based health models, other countries, such as Cuba, have been quite effective in reducing their mortality rate and having a high rate of preventive services for chronic diseases. And in
terms of follow-up with patients, there should be a set of standardized guidelines developed to outline the steps how to effectively follow-up with patients. A patient centered approach coupled with standardized guidelines should have a positive impact on changing a patient’s lifestyle and adherence to diet or medication. Another layer of coordination needs to involve the health insurance company. It is in their best interest to have healthy customers, and therefore should invest in practices/tools to ensure patients see a physician regularly and are taking their medication. Insurance companies should work with physicians and health providers to create a model that incentivizes and rewards healthy behavior.

There is a low level of health literacy and utilization among Hispanics. According to a recent National Institutes of Health study, 45 percent of Hispanics reported a low literacy rate. People with low health literacy use more healthcare services, have a greater risk for hospitalization, and have a higher utilization of expensive services, such as emergency care and inpatient admissions.

When you talk about access, you need to talk about financial cultural, linguistic, and institutional barrier. No discussion about institutional barriers, waiting time, waiting to be seen or getting an appointment, the many aspects that have to do with changing the culture of the institution.

One method to help physicians communicate complex diagnosis to patients is through diagrams and pictures. Often times a diagram lays out the issue in a more digestible manner instead of the physician verbally explaining the problem. Patient navigators should work with Hispanic patients with heart disease on how to most effectively utilize the health system. Utilization of health services by Hispanics can also be incentivized through reduction discounts (e.g., reduced co-pay and discount on medical exams) additionally, there needs to be a better understanding how to apply for Medicaid and Medicare.

Technology can be used as a tool to increase access and awareness of healthcare services in the Hispanic community. There is a current mobile app called Good Rx that shares the individual price of a particular medication and provides a price comparison among different pharmacies in the patient’s vicinity. This is just one example of how technology can empower and educate patients to achieve better health outcomes. There is a clear need for the development of more health mobile apps that actively engage and educate the individual in terms of their health.

**RECOMMENDATIONS: Access to Health Care for Hispanics with Cardiovascular Disease**

**Community**
- Urban Planning needed for transportation, housing, parks, walking zones
- Disease-focused community outreach, local collaboration and communication
- Advocacy for patient, caregiver and family-centered care
- HCPs explaining patients their rights if they are denied access to a prescribed treatment and pointing them to appropriate patient organizations that have the resources to help them gain treatment access
- Encouraging patients and physicians in the Hispanic community to share their stories on being denied access to treatment
- Senior centers should be a focus for outreach/include more patients with CVDs
- Safe Havens Centers and Sanctuary Health Centers and zones for immigrants

**Health Care Insurance Industry**
- Population Health programs including philanthropy
• Evidence-Based Programs
• Adherence to follow-up appointments
• Transparency on medications formularies, networks of physicians
• Adjust authorizations, applications for enrollment and appeals processes
• Expand modalities of primary care services to include reimbursable email, phone-based care, web portals for self-management, group visits, and integrated medical and behavioral health visits.
• Expand public and private insurance coverage of and reimbursement authority for community, preventive services per evidence-based guidelines.

Government
• Support the Step Therapy Bill (Sponsored by Representatives Brad Winstrop (OH), Raul Ruiz (CA)
• Increase state funding for targeted Medicaid
• Increase state funding for low SES population programs like clinics, local health departments, coalitions with non-profits, Latino health professional organizations
• Expand access to comprehensive statewide data with flexible reporting capacity to meet state and local needs.
• Utilize educational initiatives for physicians:
  o Incorporate physician reminders in EHRs
  o Checklists for CV disease
    ▪ Learn what to look for
    ▪ Learn about the benefits of lifestyle changes
  o Have standardized guidelines for follow-up & monitoring adherence
• Coordinate the inclusion of social services – seniors, meals, transportation, home health. Refer people who are unemployed to employment agency or housing if they don't have housing or food on the table to a food pantry.
  o Coordinated care: (RNs): health plans & providers about chronic disease patients.
  o Clinical guidelines for lipid screening (ACC/AHA differ) should be consistent and used.
  o Enforce access based on Language and Race/ethnicity, Social Determinants of Health.
  o Address how services are utilized/Address Barriers (e.g., Long wait time)
• Dwindling Capacity of Providers, develop patient navigators/caregiver programs
  o Serious Access Issues (PCP to Patient ratio)
  o Coordinate Care across point of care: acute/chronic/rehab/long term/home
  o Provide equitable and affordable access to high quality health care using a patient-centered approach
    ▪ Expand modalities of primary care services to include reimbursable email, phone-based care, web portals for self-management, group visits and integrated medical and behavioral health visits.
    ▪ Connect Home Health Care with community programs (focus on the middle class for solutions of funding new programs)
    ▪ Expand use of health information technology to remind, provide feedback and incentivize clinicians and health care systems
• Institutional Racism/Biases of Providers
  o More care coordinators to translate the care/funding needed/connect the dots
  o Access through partnership with providers – health systems and CBOs/insurance philanthropy should increase
• Targeted list of doctors & clinics for reduced/discount services/copayment – charity care
• Care Givers
  o Training should include Hispanics with heart patient’s needs
  o Certification and testing for community health workers
• Expand access to comprehensive statewide data with flexible reporting capacity to meet state and local needs
• Provide equitable and affordable access to high quality health care using a patient-centered approach
• Expand modalities of primary care services to include reimbursable email, phone-based care, web portals for self-management, group visits, and integrated medical and behavioral health visits
• Expand public and private insurance coverage of and reimbursement authority for community, preventive services per evidence-based guidelines
MEDICAL EDUCATION FOR HISPANICS WITH CARDIOVASCULAR DISEASE

Overall, cardiovascular disease can be decreased among Hispanics if medical education included more training at all levels – medical student, residency and continuing medical education, and if health care professions education in general included more training about producing social determinants of health knowledge (How to have healthier communities?) and medical effectiveness research (What drugs work better for Hispanics?) and health services research (How to increase use of health care services for Hispanics?) targeted to Hispanics. Without Hispanic decision-makers in health care institutions, we recognized we must discuss recommendations for the medical education system to increase Hispanic matriculates as well as to train the students on the need for Hispanic health inclusion in their research. Research outcomes then can lead to more effective programs in health care delivery, behavioral health care delivery for our communities.

There is limited research and data on the impact of cardiovascular disease among Hispanics. Another way to begin building the data is to require or incentivize industry and academia to include a minimum percentage of Hispanics in clinical trials. Currently, the Hispanic population is 17 percent of the country, so the requirement could be reflective of that number, and increase as the Hispanic population grows. Better data and more diverse clinical trials will show effective interventions, highlight health trends, and best practices. Additionally, there should be a requirement for pharmaceutical companies to include a prevention component for any clinical trial can result in the discovery of new and effective prevention measures.

It is well known that there is a shortage of health professionals, especially in medically underserved areas. To increase the pipeline of a diverse health workforce, community hospitals and clinics should be more involved in their local community, such as participating in careers days in local middle and high schools. The career day platform provides a great opportunity to talk about the importance of making the right choices in terms of eating healthy, and the impact that can have on your health. Additionally, more internships in the health sector should be targeted to middle and high school students, since it is at that age that they need to begin thinking about building their academic record to be competitive for a career in healthcare. NHMA has been advocating for funding from the Higher Education Act to provide increased health career advising and mentoring for students at Hispanic-Serving Institutions in Title V programs, where there is a vast number of potential Hispanic applicants to medicine and nursing and research. However, it was strongly recommended to start in middle school and high school with science and math (STEM) programs to have health careers awareness and site visits to health care facilities to expose students and encourage them.

The role of technology, especially among millennials, has become a staple of their everyday life. Technology and healthcare companies have the opportunity of developing innovative mobile apps to educate individuals and improve their health. For instance, among millennials, the gamification of a health based mobile app can increase and incentivize participation, and as a result develop healthy habits and improve overall health outcomes. Additionally, since the family is significant in Hispanic culture, there is a need to close the gap of information between younger and older generations. The younger family members can teach their older family members how to use the health mobile apps, and in turn promote healthy habits.

Many Hispanics watch Univision or Telemundo as their main source of information and news. Since many are not aware of the symptoms or warning signs of potential cardiovascular disease, a media campaign could be quite impactful in raising awareness among the Hispanic community.

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There is a critical need, given the increasing diversity of the country with Latinos projected to become 25% of the U.S. population and Latino physicians to be at 5% of physicians, to expand training on cultural competency for physicians who provide healthcare to Hispanic patients and their families. In order to decrease cardiovascular disease among Hispanic patients, the medical education enterprise needs to educate physicians on the risk factors and morbidity and mortality data based on Latino Subgroups. It is also important to have a focus on coordinated care that is patient and family based, and especially to build interprofessional training in order to be able to make a difference across the disciplines of health care professionals who care for Latinos.

Medical education accreditation has promoted curriculum that includes cultural competence and, in some instances medical Spanish, in major Hispanic markets, but has been slow to occur in other areas. There was a strong sense that there needs to be movement to change health professional education from the accreditation perspective to increase curriculum guidelines that link learning with the Latino community. This direction will be important to improve knowledge, attitudes and skills for physicians to improve prevention and management of Hispanics and cardiovascular disease and its complications and should be developed and expanded at all levels of the medical education trajectory – Premedical, Medical Student, Resident, and Continuing Medical Education.

A priority must be to educate the medical students starting in their first year incorporating humanism so that the students understand that it is important to learn how to interact with various people, and making sure that they understand values, respect health-seeking behaviors have good interactive skills. It is equally important that continuity of care is taught to them in these environments where they can really see the impact of the social determinants of health. Some medical students in Texas adopt a colonia, students in Los Angeles adopt a Latino family and learn about the barriers they face to healthy lifestyles.

Yet another item discussed to increase interest in a medical education that can impact Hispanics with cardiovascular disease was the introduction to research in the area, including an example from Einstein School of Medicine which provides summer internships.

An example of Residency Education was presented from the University of Texas Rio Grande Valley Medical School where residents follow patients from the hospital to outpatient clinics and go to the community for so many weeks and do a presentation on strategies for prevention of cardiovascular disease and other topics. Physicians who are Spanish speaking participate as interviewers of the comprehensive stroke center survey, which increased the community participation. And they said that they're starting to model that in some of the other hospitals as well.

One example of a College Student Program is from Vanderbilt University which trains a small group of underrepresented college premedical students from Historically Black Colleges and Universities and Hispanic Serving Universities with mentoring and immersion in the community to see how issues affect cardiovascular disease. Yet another item discussed to increase interest in a medical education that can impact Hispanics with cardiovascular disease was the introduction to research early in education to inspire more to go on to research in the area of Latino health, including an example from Einstein School of Medicine which provides summer internships for a small number of high school and college students.

What is now known as implementation science, in addition to these cultural and social determinants of health, represent a need for a different set of skills as physicians. What is needed is knowledge about
implementation science, like what it takes to really translate efficacious clinical trials that have been demonstrated to work in the community to be effective in improving health equity in cardiovascular disease.

The ultimate goal of medical education is to train for physicians to practice clinical care based in the U.S. health system and that must include how to interpret evidence-based interventions and also quality care guidelines in our clinical programs – whether driven by reimbursements from Medicare or private insurance plans. Hypertension, obesity, diabetes, hyperlipidemia guidelines should be part of the training of physicians.

Diversity is needed in all sectors of health care ---healthcare systems and national health organizations, particularly non-profit organization. We also need leadership diversity with individuals who have true knowledge outside of healthcare services to promote organizational change with a broader view of diversity inclusion and culture.

One method is to develop interest groups in national organizations that include physicians. For example, attendees of the American Heart Association Scientific Sessions Meeting, including cardiologists, nurses, have had an interest in meeting to develop discussions with their colleagues about how to care for Hispanics with cardiovascular disease. Another example is the National Hispanic Medical Association Leadership Fellowship which provides training for physician leadership to better make decisions in positions that would impact Hispanic communities to improve healthy living. NHMA also provides forums at its Annual Conference, Regional Forums and Congressional Briefings for physicians and other health care stakeholders and policy-makers that instructs them on how to adjust programs and policies for prevention, access and advocacy for Hispanic patients with cardiovascular disease risk factors and management and research.

Another key element of medical education is to work with technology companies and advance AI for medicine. Technology is now used in medical education from virtual anatomy to diagnostic assessment tools to e-Medical Records and medical emails in treatment protocols as well as in education and continuing medical education webinar/video and online asynchronous learning linked through social media and internet based platforms. Medical Spanish courses on smart phones with translation of phrases as needed are also widely used with a need for standardization and certification.

Lastly, the presenters also talked at length about increasing the cultural competency of all health providers. The inability for health professionals to understand their patient’s background and culture, makes it quite difficult to successfully address the risk factors of cardiovascular disease. It’s been in all of these work groups that we have been talking about but basically the challenges come from different perspectives, different sources, environmental, structural, individual - the cultural barriers but also systemic from the healthcare system in terms of the cultural competency, the limited access to specialty care and also the sub-optimal screening and control of risk factors that occur in this population. Once a patient is diagnosed, once a Latino population start to develop disease or develop hypertension, it takes several years before it is actually diagnosed and the control is also problematic in terms of access to the proper medications, adherence, etc. How can medical schools train the next generation of providers so that we can decrease these barriers and obtain better health outcomes in terms of cardiovascular outcomes in the Latino population?

I think one of the things that can be done is when we know that cardiovascular disease is so important is to learn to screen everyone. A lot of our women population will have cardiovascular disease. Women
do not have the same disease as men, because their hearts are smaller. They have more vasospastic disease. They present differently. They may be tired, they may be short of breath, they may have other symptomatology that you may not be aware of. Then you must learn how to work with your patient – talk to them with the key messages: Quit smoking; lose weight if you’re overweight and explain how you’re going to do that. Lastly, exercise, especially aerobic exercise in the water with no impact, is the best type of exercise.

**ADVOCACY in MEDICAL EDUCATION**

In order to improve the role of physicians and health care professionals who provide education to Latino patients, key methods were discussed by cardiologists as well as advocates on how to be an advocate for their patients.

Physicians should present the heart and its coronary circulation and show what it means to have a myocardial infarction. It occurs in a tree of circulation that is full of atherosclerotic disease. It’s not that one little artery closes and you had a little MI. No, there’s plaque everywhere so it is very important for their patients to understand that this is a system problem, not just related to their heart. You can have a stroke next year. Physicians then need to be trained to be advocates – on how to teach Hispanic patients and families how to change their diet – not just tell them to change their diet (given the cultural diets that won’t be substituted for American food overnight); how to cook without lard or oil; how to eat vegetables like corn on the cob without the toppings; how to eat guacamole without chips; how to eat soft tacos instead of fried tacos, and with smaller portions and more healthy vegetables.

Advocacy for patients means that physicians understand cardiovascular disease risk factors and educate their younger patients as well as the family of older patients about how to change their diets, for example. One must also discuss the comorbidities, the need for more active lifestyle, and the impact of cardiovascular disease on their jobs and the country’s economy.

It is really the physician’s responsibility to focus on outcomes and care for their patients who have cardiovascular disease so they don’t have to be hospitalized which is so expensive. Physicians should follow them closely and change drugs frequently. This takes time with patients, especially dealing with insurance authorizations, which is another key patient advocacy area that needs attention.

Lastly, advocacy is important for physicians to be leaders in the policy arena for their patients by working in organized medicine and voluntary health organizations. For example, familial hypercholesterolemia, a risk factor for cardiovascular disease, was the basis for the establishment of an organization that advocates for more research and data collection to identify more Americans with this disease.

The current healthcare payment model is very much service based, and unfortunately that does not address the health disparities among minorities. There is growing recognition that a broad range of social, economic, and environmental factors shape individuals’ opportunities and barriers to engage in healthy behaviors. To address this gap, a payment structure for social assessment of risk, social status, and patient engagement should be developed and integrated into the current system. This will incentivize and promote a more comprehensive understanding of the patient before recommending treatment options. Achieving health equity among Hispanics will require addressing the social and environmental determinants through both broad population-based approaches and targeted approaches focused on those experiencing the greatest disparities.
There is a need to increase collaboration between community-based organizations, non-profits, professional associations, and advocacy groups to form a cohesive voice representing patients. Since patients interact with different health professionals (physicians, nurses, community health workers, etc.) it is only logical that the same collaborative approach be used to educate and inform policymakers. One example is at the NHMA annual conference where leaders from the various minority medical associations are convened to discuss the areas where they can work together, and use a unified voice to bring about change in current policy.

There is a clear lack of diversity in the health workforce. Only 6 percent of all physicians are Hispanics. And a recent JAMA study shows that minority physicians take care of the bulk of minority and underserved patients. There needs to be a concerted effort to build the pipeline of Hispanics interested in healthcare professions at all levels. An effective practice could be the development of a regional mentoring network to encourage Hispanics and other underrepresented individuals to pursue a career in healthcare. An individual’s career choice is often influenced from an interaction with a trusted source (family member, friend, counselor, etc.), and if that process can be influenced then we can bolster the pipeline. Above all, medical and health professional schools need to produce more individuals who are willing to work in areas where the uninsured, the under-insured and minorities access their care.

In addition to training existing physicians, there is a need to update the medical school curriculum to include Spanish and cultural competency courses that are part of the core classes that each medical student must take to graduate. Medical education reform is a critical component in reducing health care disparities. The growing Hispanic population will only require more physicians and health professions that are culturally competent. Additionally, the concept of community health and earlier interaction with diverse patients’ needs to be further integrated. A patient’s behavior is often rooted in their culture and customs, and a more comprehensive understanding can help physicians appropriately diagnose patients.

There is also a recommendation to include “basic advocacy” as part of ongoing training (i.e. Continuing Medical Education Credits) for all health professionals. Physicians and health professionals are on the front lines, and as a result can make great advocates, but often do not make the connection to engage with policymakers at the local, state, and federal level. It is our job as a community to raise awareness around issues, since a policymaker will not consider an issue unless it is perceived as a problem in their eyes.

Health care navigators or clinical coordinators play a key role in the delivery of care since they interact regularly with the patient. One model that had worked effective is in transplant clinics. In this model, the clinical coordinator ensures the patient are compliant with their medication, schedules appointments, and manages any additional requests from the patient to help them with their recovery. This type of personal attention is quite effective in improving health outcomes, and should be adopted with cardiovascular disease patients.

Since Hispanics value family so much, it is important that health providers understand this to more effectively communicate not only with the patient but the family as well. If you are trying to institute a change in an individual’s diet, it is important to ensure the family is supportive and possibly partake in the diet as well. The closeness of a family can sometimes make it difficult for patients to adhere to a physician’s suggestion, but if the family members understand the importance and how it will improve health outcomes they will be much more supportive.
Lastly, we need to open a dialogue with accreditation agencies for all healthcare providers to pitch the idea of increasing the number of hours that they have in their curriculum as far as understanding diverse populations, such as Hispanics. Unless we change the way health providers are trained, we won’t be able to have systematic change. The continued education will result in health professionals that are better trained, and as result can more effectively connect and engage with Hispanic patients.

RECOMMENDATIONS: Medical Education Innovations for Cardiovascular Disease and Hispanics

- Didactic Curriculum Innovations
  - Introduce preventive medicine/social determinants of health into curriculum
  - Team based training needed – especially with pharmacists, dietitians, nurses, doctors
  - Pilot programs with teaching clinics, community hospitals and Latino residents, doctors – mentoring
  - Medical Spanish mandate for all medical students

- Cultural Competence Training
  - Making it more visual to educate – (using visuals to better educate by considering different learning styles and attention grabing)
  - Trust building, Case Studies/Families
  - Scope of work issues – need more nurses, allied health, pharmacists participation

- Community-based Training/Outpatient or Clinic Training
  - Incorporate Humanism with Interactive/Inter-personal skills
  - Offer a course that immerses health professionals in the community to develop understanding

- Create an affinity group with National Hispanic Medical Association about educating healthcare professionals

- Offer internships/Immersive experiences to work with/and in the Latino communities
  - And with a mentor (humanism, CVD) – understanding the patient population & improving advocacy on the patient’s behalf

- Elevate the role of our Latino physicians and other health professionals

- Accreditation
  - What is the role of accreditation/Accreditors around Diversity, Cultural Competence preparation and Continuing Education?

- Pre-Medical Student Training
  - How do you leverage community service/service learning in the early phases of education to increase students’ awareness of health careers --- STEM, Community College students
• Patient-Centered Health Research
  o Hospital staff going into the community (Latino) to present about preventive care among Latinos
  o Joint Community & Medical Representatives to provide credibility on both levels
  o Less than 2% medical faculty are Latino
  o NHHF since 2015 - Research Mentoring Programs for Jr. Faculty and Residents/Jr. Faculty Research Training at our Annual Conference
  o More diverse research on SES & impact on cardiovascular health

• Clinical Trials
  o 18% of Hispanic/Latinos participation in clinical trials

• State funders of research should focus on Latino and Latino-serving providers and studies on Latino healthcare strategies for utilization, prevention and health status improvement
NEXT STEPS:

NHMA will work with Summit participants, national organizations, and policy-makers to disseminate the recommendations, and help implement them at the state and federal level. NHMA will distribute the report widely and specifically call for the education of Congress about those policies that address Access to Health Care (the Affordable Care Act continuation, the expansion of Medicaid, the enrollment campaigns to Hispanics); Prevention Services (National Diabetes Prevention Program, Million Hearts Program, Sol Study); Medical Education – expand the pipeline of pre-Health Professional students (Higher Education Act to increase STEM -Title 3 and Hispanic Serving Institutions - Title 5 for mentoring and advising to students to pursue preparation for application to health careers; Cultural Competence among leadership and health professionals in health care system; increase Hispanic health research (Sol Study, All of Us Research Program, NIH diversity and health disparities research funding; NHSC and Community Health Centers and VA Training for heart disease patients care and community resources links)

About NHMA

Established in 1994 in Washington, DC, NHMA is a non-profit association representing the interests of 50,000 licensed Hispanic physicians in the United States. The vision of the organization is to be the national leader to improve the health of Hispanic populations. The mission of the organization is to empower Hispanic physicians to lead efforts to improve the health of Hispanic and other underserved populations in collaboration with Hispanic state medical societies, residents, and medical students, and other public and private sector partners. For more information: www.NHMAmd.org
APPENDIX:

National Hispanic Medical Association
Cardiovascular Disease and Hispanics Leadership Summit
J.W. Marriot, Rooms 402 and 403, Austin, Texas
April 18, 2017

Today’s Agenda

8:00am-9:00am  Registration and Breakfast

9:00am-9:15am  Opening Remarks
Elena Rios, MD, MSPH, FACP
President and Chief Executive Officer
National Hispanic Medical Association

9:16am-9:21am  Legislative Update
Representative Diana Arévalo
District 116
Texas House of Representatives

9:23am-9:43am  State of the State / Overview of CVD and Hispanics
Carlos Jose Rodriguez, MD, MPH, FACC, FAHA
Associate Professor of Medicine and Epidemiology
Wake Forest University

9:44am-9:54am  Break

9:56am-10:01am  Summit Format, Guidelines, and Housekeeping Items
Monica Martinez, PhD
Event Moderator and Former Presidential Appointee to the White House Commission of Educational Excellence for Hispanics

10:04am-11:02am  Discussion Panel and Q&A: Prevention and Diagnosis of Cardiovascular Disease in the Hispanic Community

10:04am-10:12am  Martha L Daviglus, MD
Professor of Medicine; Director, Institute for Minority Health Research; Associate Vice Chancellor for Research, University of Illinois at Chicago

10:12am-10:20am  Elizabeth J. Jackson, CNS, MSN, CLS, FNLA
Clinical Nurse Specialist, CardioTexas, St. David’s Medical Center

10:20am-10:28am  Venus Gines, MA, P/CHWI
Professor, Baylor College of Medicine; HHS National Promotores (Community Health Worker) Steering Committee
10:28am-10:36am  Joseph Rivera  
Cardiovascular Patient Advocate and Assistant Regional Director  
Mended Hearts

10:37am-11:02am  Moderated Panel / Question & Answer Session  
Monica Martinez, Event Moderator

11:07am-11:27am  Working Group Session – Prevention and Diagnosis

11:27am-11:42am  Working Group Reports – Prevention and Diagnosis

11:45am-12:25pm  Break for Working Buffet Lunch

12:28pm-1:22pm  Discussion Panel and Q&A: Access to Cardiovascular Disease Healthcare Services

12:28pm-12:40pm  Stephen Marmaras  
Director, State and National Advocacy, Global Healthy Living Foundation

12:40pm-12:48pm  Carlos Jose Rodriguez, MD, MPH, FACC, FAHA  
Associate Professor of Medicine and Epidemiology  
Wake Forest University

12:48pm-12:56pm  Joyce Ross, MSN, ANP, CLS, CRNP, FPCNA, FNLA  
President, National Lipid Association

12:57pm-1:22pm  Moderated Panel Discussion / Question & Answer Session  
Monica Martinez, Event Moderator

1:25pm-1:45pm  Working Group Session – Key Barriers and Strategies

1:45pm-2:00pm  Working Group Reports – Key Barriers and Strategies

2:01pm-2:11pm  Break

2:14pm-3:04pm  Discussion Panel and Q&A: Education and Advocacy for Healthcare Professionals

2:14pm-2:22pm  Martha L Daviglus, MD  
Professor of Medicine; Director, Institute for Minority Health Research;  
Associate Vice Chancellor for Research, University of Illinois at Chicago

2:22pm-2:30pm  David Auzenne, MPH  
Director, Health Promotion & Chronic Disease Prevention  
Texas Department of State Health Services

2:30pm-2:38pm  Elianne Ramos
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<td>Moderated Panel Discussion / Question &amp; Answer Session</td>
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<td>Closing Remarks</td>
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National Hispanic Medical Association (NHMA)
Cardiovascular Disease and Hispanics Leadership Summit
New York Academy of Medicine
Tuesday, June 27, 2017

Agenda

8:00 am-9:00 am  Registration and Breakfast

9:00 am-9:15 am  Opening Remarks
Elena Rios, MD, MSPH, FACP, President and Chief Executive Officer,
National Hispanic Medical Association

9:15 am-9:30 am  Legislator Remarks
Honorable Assemblyman Marcos A. Crespo, Assembly District 85, New
York, Chairman, Puerto Rican/Latino Task Force

9:30 am-10:00 am  State of the State Keynote: Overview of CVD and Hispanics
Martha L. Daviglus, MD, PhD, University of Illinois College of Medicine
at Chicago

10:00 am-10:10 am  State of the State Keynote: Question and Answer Session with Dr.
Martha Daviglus

10:10 am-10:40 am  Discussion Panel One – Prevention of Cardiovascular Disease in the
Hispanic Community
   o  Beatriz Rodriguez, MD, PhD, University of Hawaii at Manoa:
   o  Ramanathan Raju, MD, MBA, Senior Vice President &
     Community Health Officer, Northwell Health

10:40 am-11:00 am  Panel One Moderated Panel Discussion

11:00 am-11:30 am  Panel One Working Group Session

11:30 am-11:40 am  Panel One Working Group Reports

11:40 am-12:40 pm  Lunch

12:40 pm-1:10 pm  Discussion Panel Two – Access to Cardiovascular Disease Healthcare
Services
   o  Sarah Shih, MPH – Assistant Commissioner, Primary Care
     Information Project, NYC REACH

- 30 -
o Elizabeth J. Jackson, CNS, MSN, CLS, FNLA, Clinical Nurse Specialist, CardioTexas, St. David's Medical Center

o Jacelyne Bonilla, Community Health Worker, Bronx-Lebanon Hospital Center, Department of Family Medicine

1:10 pm-1:30 pm  Panel Two Moderated Panel Discussion
1:30 pm-2:00 pm  Panel Two Working Group Session
2:00 pm-2:10 pm  Panel Two Working Group Reports
2:10 pm-2:25 pm  Break
2:25 pm-2:55 pm  Discussion Panel Three – Education and Advocacy for Healthcare Professionals: Making a Difference for Patients

  o Phillip Duncan, MD, Former Chairman of Association of Black Cardiologists (ABC)
  o Sarah Aoanan, Community Outreach Manager, State and National Advocacy, Global Healthy Living Foundation
  o Carmen R. Isasi, MD, PhD, Albert Einstein College of Medicine

2:55 pm-3:15 pm  Panel 3 Moderated Panel Discussion
3:15 pm-3:45 pm  Panel 3 Working Group Session
3:45 pm-3:55 pm  Panel 3 Working Group Reports
3:55 pm-4:05 pm  Closing Remarks
  Dr. Elena Rios, National Hispanic Medical Association
4:05 pm-4:30 pm  Break
4:30 pm-5:30 pm  Networking Reception
National Hispanic Medical Association
Cardiovascular Disease and Hispanics Leadership Summit
University of Southern California (USC) Caruso Center
Los Angeles, CA
August 17, 2017

Today's Agenda

9:00 am – 10:00 am  Registration and Breakfast

10:00 am – 10:20 am  Opening Remarks
Elena Rios, MD, MSPH, FACP, President and Chief Executive Officer
National Hispanic Medical Association (NHMA)

10:20 am – 10:35 am  Legislator Remarks
Hilda Solis, Supervisor, Los Angeles County

10:35 am – 11:05 am  State of the State Keynote Address
Martha L. Daviglus, MD, PhD, Professor of Medicine, Director, Institute
for Minority Health Research, Associate Vice Chancellor for Research,
University of Illinois at Chicago

11:05 am – 11:10 am  Overview of Summit Format, Guidelines, and Housekeeping Items
Monica Martinez, PhD, Event Moderator and Former Presidential
Appointee to the White House Commission of Educational Excellence
for Hispanics

11:10 am – 12:00 pm  Panel One – Prevention and Diagnosis of Cardiovascular Disease in the
Hispanic Community

  • Video Presentation - Debbie Martinez, Program Manager,
    National Forum for Heart Disease and Stroke Prevention
  • Ron Manriquez, Western Regional Director, Mended Hearts
  • Margo B. Minissian, PhD, ACNP, Nurse Scientist, Cardiology
    Nurse Practitioner, Clinical Lipid Specialist, Barbra Streisand
    Women's Heart Center, Cedars-Sinai Heart Institute
  • Ileana L. Piña, MD, MPH, Associate Chief, Academic Affairs,
    Professor, Department of Medicine, Montefiore Medical
    Center
  • Yehuda Handelsman, MD, FNLA, FACP, MACE, Medical
    Director and Principal Investigator of the Metabolic Institute
    of America
12:00 pm – 12:20 pm  Panel One Moderated Panel Discussion
12:25 pm – 12:50 pm  Panel One Working Group Session
12:50 pm – 1:00 pm  Panel One Working Group Reports
1:00 pm – 1:45 pm  Break for Buffet Lunch
1:45 pm – 2:20 pm  Panel Two – Access to Cardiovascular Disease Healthcare Services
  •  Sarah Aoanan, Community Outreach Manager, State and National Advocacy, Global Healthy Living Foundation
  •  Eloisa Gonzalez, MD, MPH, Director, Cardiovascular and School Health, Los Angeles County Department of Public Health
  •  Joyce Ross, MSN, ANP, CLS, CRNP, FPCNA, FNLA, Immediate Past President, National Lipid Association
2:20 pm – 2:40 pm  Panel Two Moderated Panel Discussion
2:40 pm – 3:00 pm  Panel Two Working Group Session
3:00 pm – 3:10 pm  Panel Two Working Group Reports
3:10 pm – 4:00 pm  Panel Three – Education and Advocacy for Patients and Healthcare Professionals
  •  Susan Campbell, MPH, Vice President of Public Policy, WomenHeart
  •  Martha R. Preciado, MD, Go Red Por Tu Corazon Ambassador, American Heart Association; Assistant Professor of Medicine, UCLA
  •  Katherine Wilemon, Founder and CEO, The FH Foundation
  •  Cassandra A. McCullough, MBA, CEO/Executive Director, Association of Black Cardiologists, Inc.
4:00 pm – 4:20 pm  Panel Three Moderated Panel Discussion
4:20 pm – 4:40 pm  Panel Three Working Group Session
4:40 pm – 4:50 pm  Panel Three Working Group Reports
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<tr>
<th>Time</th>
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<tr>
<td>4:50 pm – 5:00 pm</td>
<td>Closing Remarks</td>
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<td>Dr. Elena Rios, NHMA</td>
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<tr>
<td>5:00 pm – 6:15 pm</td>
<td>Networking Reception</td>
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National Hispanic Medical Association
Cardiovascular Disease and Hispanics Leadership Summit
April 18, 2017

List of Attendees

- Elena Rios, MD, MSPH, FACP, President and CEO, National Hispanic Medical Association (erios@nhmamd.org)
- Carlos Jose Rodriguez, MD, MPH, FACC, FAHA, Associate Professor of Medicine and Epidemiology, Wake Forest Baptist Medical Center (rblaine@wakehealth.edu)
- Elianne Ramos, Principal and CEO, Speak Hispanic (ergeekgodess@gmail.com)
- Martha Daviglus, MD, Professor of Medicine, Director, Institute for Minority Health Research, Associate Vice Chancellor for Research, University of Illinois, Chicago (daviglus@uic.edu)
- Venus Gines, MA, CHWI, Professor, Baylor University College of Medicine, HHS National Promotores (Community Health Worker) Steering Committee (venusgines@gmail.com)
- Joseph Rivera, Assistant Regional Director, Mended Hearts (suesljd@sbcglobal.net)
- David Auzenne, MPH, Director, Health Promotion and Chronic Disease Prevention Station, Texas Department of State Health Services (david.auzenne@dshs.texas.gov)
- Stephen Marmaras, Director, State and National Advocacy, Global Healthy Living Foundation (smarmaras@ghlf.org)
- Joyce Ross, MSN, ANP, CLA, CRNP, FPCNA, FNLA, President, National Lipids Association (jlr@joycerossnp.com)
- Elizabeth Jackson, CNS, MSN, CLA, FNLA, Clinical Nurse Specialist, Cardio Texas, St. David’s Medical Center (ej9802@gmail.com)
- Ezequiel Peña, Ph.D, Associate Professor, Director, Psychological Services for Spanish Speaking Populations, Our Lady of the Lake University (epena@ollusa.edu)
- Enrique Garcia-Sayan, MD, FACC, FASE, Assistant Professor, Division of Cardiology, Director of Echocardiography, Associate Chief of Cardiology, Lyndon B. Johnson Hospital (Enrique.d.garciasayan@uth.tmc.edu)
- Wady Yamil Aude, MD, Clinical Assistant Professor, University of Texas, Rio Grande Valley, Department of Internal Medicine (wadyaude@aol.com)
- Francisco Fernandez, MD, Professor, Department of Psychiatry, Neurology, and Neurosciences, University of Texas Rio Grande Valley School of Medicine (Francisco.fernandez@utrgv.edu)
• Margarita Birnbaum, Reporter, American Heart Association (margarita.birnbaum@heart.org)
• Kella N. Lopez, MD, Pediatric Cardiologist, Texas Children’s Hospital (knlopez@bcm.edu)
• Francisco Fuentes, MD, FACC, Professor, Cardiology; Director, Cardiology Fellowship Program, The University of Texas Health Science Center at Houston Medical School (Francisco.fuentes@uth.tmc.edu)
• Lana Frantzen, Ph.D, Vice-President, Health & Wellness, National Dairy Council (frantzenl@dairymax.org)
• Lindsay Videnieks, Alliance for Patient Access (lindsay@alianceforpatientaccess.org)
• Ryan Gough, Partnership to Advance Cardiovascular Health (rgough@advancecardiohealth.org)
• Viola Benavente, Ph.D, RN, CNS, Assistant Professor, St. David’s School of Nursing, Texas State University (vbg6@txstate.edu)
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• Samuel Santiago, CDE, National Manager, Diversity and Inclusion, American Heart Association
• German Hernandez, MD, University Medical Center of El Paso (drgermanhernandez@gmail.com)
• Sabrina Bueno Uriegas, MD, Physician (sabrinabueno@gmail.com)
• Daniel Terreros, MD, Professor of Pathology, Cellular Physiology and Molecular Biophysics, Texas Tech University Health Sciences Center- El Paso (Daniel.terreros@ttuhsc.edu)
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- 37 -
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- **Sarah Aoanan**, Community Outreach Manager, Global Healthy Living Foundation
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- **Jacelyne Bonilla**, Community Health Worker, Bronx-Lebanon Hospital Center, Department of Family Medicine
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- **Paul Bousquet**, Associate Board Member, Association of Hispanic Healthcare Executives
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- **Vicky Coll**, Regional Director, Health Equity, American Heart Association
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- **Johanna Contreras**, Director, Heart Failure, Mount Sinai Hospital
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- **Honorable Assemblyman Marcos A. Crespo**, Chair, Puerto Rican/Hispanic Task Force
  ([munozjustoy@nyassembly.gov](mailto:munozjustoy@nyassembly.gov))
• Martha L. Daviglus, MD, PhD, Professor of Medicine, Director, Institute for Minority Health Research, Associate Vice Chancellor for Research, University of Illinois, Chicago (daviglus@uic.edu)
• Kathleen Delgado, MS, RDN, Nutritionist, The Children’s Aid Society (kathleen113@gmail.com)
• Phillip Duncan, MD, Former Chairman, Association of Black Cardiologists (pduncan@cardiochmn.com)
• Judith Flores, MD, FAAP, Chairwoman, National Hispanic Medical Association (jfloresmd@hotmail.com)
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• Elena Rios, MD, MSPH, FACP, President and CEO, National Hispanic Medical Association (erios@nhmamd.org)
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• Beatriz Rodriguez, MD, PhD, University of Hawaii at Manoa (brodrigu@hawaii.edu)
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National Hispanic Medical Association  
Cardiovascular Disease and Hispanics Leadership Summit  
University of Southern California (USC) Caruso Center  
Los Angeles, CA  
August 17, 2017  

List of Attendees

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- **Maria Alvarado**, Community Health Promoter, American Heart Association  
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  (malvarez@childrenspartnership.org)

- **Sarah Aoanan**, Community Outreach Manager, Global Healthy Living Foundation  
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- **Karen Aragon**, Health Educator and Coordinator, Building Skills Partnership  
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- **Andrea Araujo**, David Geffen School of Medicine  
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- **William K. Averill MD, FACC**  
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- **Carolina Barahona**, Community Health Director, American Heart Association  
  (Carolina.barahona@heart.org)

- **Robert Beltran, MD, MBA**, Senior Executive Medical Director, Brand New Day  
  (rbeltran@universalcare.com)

- **Maria de la Luz Brizuela**, Community Promotora, Los Angeles Mental Health Department  
  (lucybrizuela2013@gmail.com)

- **Alex Bustamante**, Director of Medical Services, Fort Belvoir Community Hospital  
  (alexander.i.bustamante.mil@mail.mil)

- **Susan Campbell, MPH**, Vice President of Public Policy, WomenHeart  
  (scampbell@womenheart.org)

- **Ana Carr**, Community Health Director, American Heart Association  
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- **Maria Carrillo**, Chief Science Officer, Alzheimer’s Association  
  (mcarrillo@alz.org)

- **Ronald Castillo**, Chief Analytics Officer, MiMentor  
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- **Jane Chung**, Director of Innovations, AltaMed  
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• Martha L. Davglus, MD, PhD, Professor of Medicine, Director, Institute for Minority Health Research, Associate Vice Chancellor for Research, University of Illinois, Chicago
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• Elena de la Cruz, Director of Communications, American Heart Association
  (elena.delacruz@heart.org)
• Tessa Dixon, Director, Patient Liaison, St. Mary’s Hospice (tdixonsmhospice@gmail.com)
• Lawrence Fernandez, Program Manager, H.I.S.T.O.R.I.A.S., Los Angeles Centers for Alcohol and Drug Abuse (lferndandez@lacada.com)
• Jose Flores Arredondo, Senior Regional Medical Liaison, Amgen (jfloresa@amgen.com)
• Gustavo Friederichsen, Chief Executive Officer, Los Angeles County Medical Association
  (gustavo@lacmanet.org)
• Andrew Gonzalez, David Geffen School of Medicine (Andrew.gonzalez@championsfh.org)
• Eloisa Gonzalez, MD, MPH Director, Cardiovascular and School Health, Los Angeles County Department of Public Health (elgonzalez@ph.lacounty.gov)
• Claudia Goytia, Government Relations Director, American Heart Association
  (Claudia.goytia@heart.org)
• Robert Guzman, Co-Founder and Vice President, SHPE-LA (agconsul@pacbell.net)
• Yehuda Handelsman, MD, FNLA, FACP, MACE, Medical Director and Principal Investigator of the Metabolic Institute of America (yhandelsman@gmail.com)
• Farid Hassanpour, DO, MBA, Chief Medical Officer, California Health and Wellness
  (fhasanpur@centene.com)
• Josefina Jiminez-Pinzon, Supportive Services Coordinator, Coalition for Responsible Community Development (jjiminez-pinzon@coalitionrcd.org)
• Akilah Kamaria, Executive Director, Blue Fields Digital (akamaria@socialisao.com)
• Martha Lainez, Health Educator, American Heart Association (marthalainez@yahoo.com)
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• Ron Manriquez, Western Regional Director, Mended Hearts (rmanriquez2@gmail.com)
• Judy Marks, (judymarks2003@yahoo.com)
• Debbie Martinez, Program Manager, National Forum for Heart Disease & Stroke Prevention (Debbie.martinez@nationalforum.org)
• Cassandra McCullough, CEO/Executive Director, Association of Black Cardiologists, Inc (cmccullough@abcardio.org)
• Victoria Mercel, Community Health Promoter, American Heart Association (mercelvictoria@yahoo.com)
• Pamela Middleton, MD, Pediatrician (drpamdst@gmail.com)
• Margo B. Minissian, PhD, ACNP, Nurse Scientist, Cardiology Nurse Practitioner, Clinical Lipid Specialist, Barbra Streisand Women's Heart Center, Cedars-Sinai Heart Institute (margo.minissian@cshs.org)
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• Franco Reyna, Program Manager, National Kidney Foundation (franco.reyna@kidney.org)
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