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NPA PARTERS WEBINAR SERIES  
FEATURING THE NATIONAL HISPANIC MEDICAL ASSOCIATION HEART DISEASE:  
PREVENTION AND ACCESS TO TREATMENT FOR MINORITIES  
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>> ELENA RIOS: This is Dr. Elena Rios, President and CEO of the National Hispanic Medical Association and it's my privilege to moderate today's webinar. I would like to provide a few housekeeping notes. One, this webinar is scheduled to last one hour and it will include a question and answer session after the presentations are completed. You can ask questions throughout the webinar.

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Let me just say, I also -- I'm sorry, I missed this which is very important. That this webinar is being presented by the National Partnership for Action to end health disparities which is a strategic initiative of the office of minority health and the National Hispanic Medical Association.

So I think what we are going to do is start with my presentation and then I will introduce the two speakers.

Okay. So my comments are about cardiovascular disease in minorities in general and who we are, the National Hispanic Medical Association was established in 1994, as a nonprofit. We represent 50,000 Hispanic physicians and we empower physicians to improve the health of our communities at all levels, whether they are in medical societies, residents, students and with our public and private partners. We also have a foundation that provides scholarships.

We have a national health policy focus and in Washington, D.C., we have been helping to sustain the Affordable Care Act which is a very important law. Things like the health exchanges, insurance mandates, subsidies for patients have all been reforms that have been debated this past year. The secretary of health and human services, Dr. Azar is brand new and his policy, we support, which is, of course to have child obesity as a priority. We see that as a direct connection to this conversation with the office of minority health campaign efforts on cardiovascular disease.

We also know that in health policy, it's very important to understand that there's 17% of our economic costs are healthcare. And there's lots of innovations being done by the centers for Medicare and Medicaid community care and coordination, medications and disparities, reductions all being done so we can decrease these costs.

In terms of challenges to heart disease, it is the leading cause of death in the United States and lots of money, an estimate of \$1.2 trillion by the year 2035 will be spent just because of heart disease and for Latinos or Hispanics in general, one out of three

deaths are attributed to cardiovascular disease. And we know it's so important to focus on issues related to access and prevention. Access includes financial access, like having insurance, having subsidies, having some type of patient assistance, for example, with your medications.

But it also includes nonfinancial factors, like limited English proficient patients need linguistic support. Cultural issues, education for low literacy persons. We also need Latinos to become doctors and nurses. In terms of prevention, some of the most important issues are cultural, in terms of diet, in terms of how to educate behavior change, through activity, and especially in our communities, activities and safe spaces, and we need to explain to our families not to smoke. And if they have high blood pressure, to take care of it with medication or through clinical intervention.

And also to have family strategies. Educating the family is very, very important in prevention of Hispanics and other minorities.

And then lastly, the challenge we have in the world of health professions workforce, we need to train all the team involved in patient care, whether it's doctors and nurses or community health workers, dietitians, how to care for our minorities with empathy, with communications that are targeted, cultural confidence, having knowledge of poverty and underserved communities. And that leads us to what we call the social determinants of health, which are things related to the social environment, such as customs and traditions, and discrimination, the physical environment, where you live, where you play, the built environment, and health services themselves having access to quality care, et cetera.

Some of the factors involved with value-based payment and looking at social determinants of health will also help us look at cardiovascular disease more holistically and that includes factors like poverty, housing, family support, or social isolation, education and literacy, food security, employment, transportation, criminal justice involvement, domestic violence and just having a quality lifestyle. These are issues that are being looked at now by institutions as -- as they deliver care to patients to get a better handle on -- on how to -- you know, how to do research on patients and also how to know what kinds of patients could be targeted for other programs, social programs.

In terms of medical education, just a few items. I think it's important to realize that we need curriculum in medical Spanish. We actually had a Spanish seminar at our conference this year, to reach Spanish-speaking patients. We need leadership development to be able to have more leaders that come from within medical education, again, whether they are doctors or nurses, we do need more training about leadership so that community -- community members, in this

case, for example, the National Hispanic Medical Association believes strongly that Hispanic physicians who come from our poor communities and middle-class communities, if they were in leadership positions, they could -- they would be able to influence the types of programs that would be targeted back to those communities and our feeling is that they would strengthen the -- the impact of community programs that could lead to a decrease in cardiovascular disease, et cetera, and behavior change.

We also need faculty developments within our academic centers. We have more faculty that look like us and come from our communities.

And, of course, pre-health student recruitment is important to encourage and find more students to take over and be part of our health system.

Lastly, there's a Congress -- in the United States Congress, there is a heart stroke coalition founded by senators and Congressmen in 1996, and it's just important for us to know that we have leaders from the states where we have Hispanic populations such as Congressman Grijalva of Arizona, and Senator Feinstein from California, and Congressman Lewis from Georgia.

The NHMA's programs services -- and this is just, again, to let you know, a little bit about who we are. We serve as a resource to both the government and private sector. We serve as forum for developing leadership at our conferences, at our -- within our programs and we serve as a network of like-minded health experts very interested in helping the office of minority health and others improve the health of our communities.

Our programs, again, education programs, research programs, and we do have a scholarship. This is our foundation is called the National Hispanic Health Foundation.

And then our contact information, and I will just say that it is important to realize that we have different websites, national, Hispanic medical association, National Hispanic Health Foundation and a portal that's under construction to provide resources in English and Spanish on cardiovascular disease and others.

I will just end with saying we had a special summit series last year with support from Amgen and this summit series resulted in a report with several recommendations on how to reach communities with prevention policies and programs, access, and medical education, and they are on our NHMAMD.org website, and you can find them under our cardiovascular disease summits.

So let me just end there. I'm going to now introduce our speakers. Our first speaker and our second speaker, let me just read their titles. We have with us Dr. Martha Daviglius, who is the associate vice chancellor for research at the University of Illinois College of Medicine, Institute for Minority Health Research.

We also have with us Jovonni Spinner who is a senior public health advisor for the office of minority health at the Food and Drug Administration or FDA.

So now, we will start with our first presenter, Dr. Daviglius.

>> MARTHA DAVIGLUS: Thank you, Dr. Rios. I thank you very much for the introduction, and it is a pleasure to be here giving these talks. And good afternoon to all.

I am going to talk -- next slide, please. And I have to apologize because I do not have Internet connectivity at this minute. So I have to say "next slide."

But I would like to mention that what I'm going to talk today is about the burden of cardiovascular diseases and the risk factors among the Hispanic Latino population in the United States.

I'm going to discuss the results from a national data, from the nutrition and health examination, as well as from the national health interview survey.

Also, we will discuss the results from the Hispanic community, who has established a study of Latinos. Hopefully at the end of my talk, you are going to have a little bit more information why we need to include racial, ethnic diversities and participants in clinical trials for intervention studies which the next speaker is going to talk in more detail about this.

As Dr. Rios mentioned already, cardiovascular disease the mortality is an amazing burden for this country and for the rest of the world.

As you can see in this slide -- next slide, please, the -- this shows the deaths attributed to cardiovascular disease. This is from the American heart association. As you can see here, since 1990, cardiovascular disease mortality has been declined, although, it seems that starting in 2010, it started to increase again, however, don't pay attention to that, because in this graph, it shows only mortality rates for three years. And at this time, it is too premature to see whether it is an increase or continuing the decline.

Next slide.

Okay. This slide shows had the cardiovascular and other major causes of death for Hispanic/Latino men and women. Again, as you can see, many this graph in blue, you will see rates for men, and in red for Hispanic females.

Many have been argued that cancer is the leading cause among Hispanic Latinos but you can see that cardiovascular disease is the leading cause of death, followed by cancer and other accidents.

Next slide, please.

So then, of course, because of that, we have to study Hispanic Latinos, right? Because the question has been, why to study these population? First of all, I already show that -- the issue, the

burden regarding cardiovascular disease.

Second, we didn't know until very recent that this burden could be different with different Hispanic/Latino groups. Because the previous limited data by this large national studies have been mostly available for risk factors or mortality rates as you saw it for Hispanic/Latinos as a group.

And in the case, in other studies more like the San Antonio Heart Study which is very important, very famous, has longitudinal data, but what happened with them is that most of their participants are from Mexican background. So we needed to have more studies on Hispanic/Latino individuals because they will help us to provide better health education to the Hispanic/Latino communities, since we needed to develop culturally appropriate policies that are going to meet the specific needs of this population in the United States.

Next slide, please.

So as I promised, I will show very quickly -- keep that in mind because I only have a few minutes to go through this slide -- what are the data that shows in this case, anything regarding the prevalence of high blood pressure.

If you look at the bars, the two groups of bars, you will see that prevalence of high blood pressure among Mexican Americans are very similar to the -- the female Mexican Americans, but more lower compared to other groups.

So the next slide shows the age adjusted trends in serum total cholesterol. This is from 1988 to 2004. The cholesterol levels declined among all groups. Although Mexican Americans continue to have higher levels of serum cholesterol, compared to non-Hispanic whites. You can compare the green bars to the blue and the red. The blue ones are representing the whites and the red one the blacks.

Next slide, please.

The prevalence of current cigarette smoking. It seems that in these graphs, we are not doing that bad. As you can see, Hispanic males and females have lower prevalence of smoking compared to the non-Hispanic whites and non-Hispanic blacks.

Certainly, there are other minority groups like there may be Americans in green that have higher prevalence of smoking.

Next slide.

Similar for prevalence of obesity. Males from Hispanic origin, in light green have the same prevalence and females a little bit higher at 46%. Please keep that in mind, because what I am going to show you next, we are going to compare with the data from a recent study.

The physicians diagnose diabetes mellitus, as you can see. We also have a higher prevalence of diabetes compared to the non-Hispanic whites. As you can see, the males, as well as females

have almost 70 to 80% higher prevalence rates. But there are others who have much higher prevalence than Hispanic/Latinos.

Next slide, please.

So finally, I will talk to you about findings from the Hispanic community health study, study of Latinos and I will refer here to SOL.

So what is SOL? It's an NIH funded, mostly center community-based study which was designed to examine risk at protective factors for chronic diseases and other conditions in the Hispanic/Latinos population.

In 2008 to 2011, over 16,000 Hispanic Latino men and women, ages 18 to 74 years of age were randomly selected from household in four communities in the United States, Bronx, Chicago, Miami, and San Diego.

Then the participants were from Cuban, Dominican, Puerto Rican, Mexican, Central and South American background. That was the big difference compared to the other studies.

As I mentioned, based on the information starting in 2008, this was the -- it started in October of 2014 and finished a few months ago.

So, here, the next slide. Here we see the age-standardized prevalence of cigarette smoking. As I mentioned previously, we have data from the national health study interview that shows 14% of men and 70% of women smoke.

However -- based on the survey.

However, if we compare it to all Hispanic/Latino men and women, the rates are much, much higher in SOL and also the range, the age of prevalence of smoking is amazing here. So it goes from 34% or 35% in Puerto Rican, and lower -- the lowest with American women with only 9%.

So depending our culture, depending our background, et cetera, these risk factors vary and we have to be aware of that for future interventions.

So the next slide shows prevalence of obesity. We were able to demonstrate that 39% of men and 46% of women were obese. Again, there was a transition from the SOL to the large national data.

>> You have two minutes left.

>> MARTHA DAVIGLUS: Here, even though that we have these similar percents for all Hispanic men and women, as you can see, the variation is large.

So similar, we are going to see -- and you have the slides, but I just wanted to point it out. The cholesterol, you are going to see similar variation.

Next slide, for prevalence of high blood pressures, similar variation.

And for the diabetes type two, similar variation. And what it's telling us, is that, again, this is a group that certainly as a whole has more than one risk factor, in the cardiovascular risk profile, you are going to see that 80% of men and 71% of women have at least one risk factor.

So the next slide, please, is going to show the percent of individuals that -- the risk factors that are going to change from one or more risk factors to even higher number of risk factors.

And in only less than 60 years, we can see that about 28% of men and 27% of women change to have higher number of risk factors.

So being of course, here in this summary -- next slide, please. We wanted to highlight, as I mentioned, the diverse nature of the Hispanic/Latino population. And we wanted to understand how important it is in the risk factors by heritage or background group.

So that is the reason. We need participation of minorities and especially, Hispanic/Latinos in health research because we need to increase the general stability of other research findings.

If we don't have enough minorities included in studies, we cannot generalize the results. We need to increase the equity and provision of healthcare. We need to provide accurate information for a specific race and ethnic group.

So even though it has been an act of NIH in 1993, an act signed too a law by President Clinton, still the participation of minorities, and in all of these funded studies are very small. And we needed to increase their participation by educating them.

>> ELENA RIOS: I think your time is up.

>> MARTHA DAVIGLUS: Yes, that is -- the time is up and I wanted to mention only that the last slide shows the future research needs and we still need it to continue. And to also right now, we have a large study that easily includes 1 million participants. And the good news is that that study is going to have more than 51% of representation of minorities. And that means all of us.

>> ELENA RIOS: Thank you, Dr. Daviglus. Thank you for your great data.

Now, we will have Jovonni Spinner.

>> JOVONNI SPINNER: All right thank you, Dr. Rios.

Soil talk about some of the FDA department of minority health rules around clinical trials to make sure that minorities are aware of why clinical trial participation is important.

I don't have anything to disclaim today.

And over the course of the next 20 minutes, I want to walk you through, you know, what does the office of minority health do here at FDA? What is FDA's role in clinical trials? And then talk a little bit about representation this clinical trials. We heard from the previous speaker and also to really focus in on some of the strategies

that we are using to improve diverse participation in clinical trials.

So our mission here at FDA is we are responsible for protecting the public's health by ensuring the safety and ethical and safety of human biological drugs and our nation's food supply, cosmetics and products that emit radiation.

So one of the unique things about FDA is we oversee about \$2 trillion worth of products in the US which equals about 20% of consumer spending and we are the only agency in the world that does primary view of data, ranging from preclinical to clinical.

So in summary, we are basically a consumer protection agency, and we make sure that we are providing information to the public on our regulated products to make sure that they are safe and effective for everyone to use.

The mission of the office of minority health is to promote and protect the health of diverse populations and we do that primarily through two different programmatic areas. We have a research and collaboration program and then we also have an outreach and communication program, both of which addresses health disparities and also working towards improving health equity. Just to draw your attention to the -- the diagram or the picture on the right-hand side, this gives you a little bit of a sense of what we mean by equity.

So on the left-hand side, it's about equality. So it's really about giving everyone the exact same tool to see the baseball game in this particular image, but on the right-hand side, it focuses on equity. So equity, one person needs two boxes to see the game and another person doesn't need a box at all to see the game.

So in our office, we are making sure that we are meeting people at their place of need. If they are getting print materials or electronic materials or in person, we want to make sure that we are employing a variety of strategies to make sure that we are addressing the needs of diverse populations.

As I mentioned before, we do have two different programmatic areas and I won't spend a lot of time on this slide, but in just really shows the breadth of the type of work that we do here. On the left-hand side that depicts the outreach and communication. We also have a whole repository of health education materials. We are active on social media, we send out a newsletter on a quarterly basis. We have a website and we participate in FDA and HHS working groups to make sure that the minority voice is reflected and heard during agency discussion.

We do events like today's webinar to make sure that people have the information that they need to make a decision. And I want to point out some of the collaborations that we have had between FDA and our stakeholders. So two of the more recent collaborations is

that we have been recently working with the Yale University to develop science at the collaborations and also outreach initiatives which are two of the core focus areas which we established an MOU with Yale University.

And then also, we worked recently with the Puerto Rico for -- the consortium for clinical investigation and with that group, we were able to participate, basically in a clinical trial summit where we were able to share the information and resources that we have as an agency and really to highlight FDA's role in clinical trials.

On the right-hand side is about research and collaboration, in summary, we have two different research portfolios. One is an intramural and the other is extramural. And we want to make sure that we are supporting minority-focused research projects as well and we put out guidance documents and we had a guidance document around the collection of race and ethnicity documents for industry as it relates to clinical trials.

So this slide shows a little bit about FDA's role in clinical trials. So one thing I do want to make sure that I hit home is that we are not actually running the clinical trials, but as I mentioned before, we are the only agency in the world that does primary view of the clinical trial data. And we are making sure that we are establishing regulations and guidance about the data that's in the trials for medical product applications and these medical products include anything from drugs or devices for example.

Then the role that my office plays specifically is making sure that we are raising awareness about clinical trial and we are doing all of this work to make sure that medical products are safe and effective for the intended use population.

And clinical trials are really just one of the ways that we learn about medical products and we want to make sure that -- one of the main goals of FDA is, like, our work really begins after the clinical trials are done. So we are really focusing in on reviewing the data from the trials.

So one of the legislations that kind of guides or governs the work that we do is the Food and Drug Administration safety and innovation act of 2012. And the section that deals with clinical trials specifically is what we refer to as Section 907, and this is all around the reporting of inclusion of demographic subgroups in clinical trials and focusing on the data analysis and applications for drugs, biologics and devices.

And as with any piece of legislation that comes down, there's always going to be some type of reporting mechanism or action plan or other mechanisms which the agency has to decide on how they are going to interpret the legislation and enforce their legislation.

So I will talk a little bit about the action plan that the FDA

developed that was posted later on in August of 2014.

And I just want to mention that this is definitely ongoing work and is constantly evolving as we, you know, gain new resources or gain new insights as we start to hone in on our strategies.

So from the action plan, there are three different priority areas. The first one focuses on quality and that directly correlates to things like a guidance document which I mentioned the one we had spear headed earlier. The second priority is all around participation, which is really where we focus you're work on. So this can include things like public meetings or developing tools to support diverse participation in clinical trials.

And the third priority is all around transparency and one of those strategies is the drug trial snapshot where you can go on the website and you can find out the demographic breakdown of who was actually included in the clinical trial.

So I will go quickly through the next couple of slides. We have already heard about the inclusion of minorities and why it's important, but basically, a lot of clinical trials, you know, have a flaw before they even begin because they don't have the diverse participation that really represents the population going to use the medical product.

So the question here is. Why do we need minorities in clinical trials? So we know that minorities have historically been under represented in clinical trials. I will give you some of the reasons.

Why we have to make sure that we have the diverse representation so we can study the effects of medical products and the people who are going to use them. We also know that some research shows that minorities may respond to a medical product, and this also will help us to better understand health disparities. So those are -- in this case, diseases that occur more frequently or occur in more diverse populations.

One example, just to carry on through the cardiovascular theme, we know that African-Americans have a higher rate of cardiovascular risk factors, body mass and high blood pressure compared to the white counterparts. And this leads to a higher risk of developing coronary heart disease, for example, but we know that African-Americans still remain under represented in clinical trials.

One example I will point out is there was an FDA approved heart failure medication that reduces the risk of death in people with certain types of long lasting or increased heart problems. There was angioedema in blacks. Only 5% of the participants were black, even though black people represent about 13% of the US population, and experience heart failure rates at higher rates than the rest of the population. So that's just one example why it's really important to make sure that we have diverse participation, because

we know there could be different responses.

So this table right here just kind of shows the US population for African-Americans and Hispanics, and that relates to the percentage of participation in industry sponsor clinical trial. So you can see that there's a disparity between the actual number of each of the groups and the percentage of those who were actually participating or represented in clinical trials.

Here's the cardiovascular examples. So these are all the drugs that have been approved for cardiovascular disease since 2015 by FDA. And as you can see, if you look on the right-hand side of the slide, on average, women were represented about 41%. African -- or African-Americans were around 3%, and whites were at 81%. Asians were at 12% and you don't even see Hispanics on the chart at all, or American Indian or Alaskan native. So we are totally missing out on two racial ethnic populations but this chart is really just to show that there is a huge disparity in the percentage of minorities who actually participating in clinical trials as it relates to cardiovascular drugs.

So here's just some of the reasons for decreased participation. There's definitely mistrust and distrust of the medical system. There may be inadequate recruitment or retention. There's also a misunderstanding of minorities' beliefs and values that help to contribute to their decision making process. There's a perception that minorities are ineligible and they may not be able to adhere to the protocols or the lack of awareness.

But the ultimate research shows that they are not participating because they are not being asked. There's a huge disconnect between being asked to be in a research study or not.

So as I mentioned, you know, in general, minorities will participate if asked, and there are quite a few different studies that show overwhelmingly, if ask a patient -- if you ask the minority patient who participate, they will ultimately consider participating in a clinical trials. The historical mistrust and distrust are becoming less and less of an issue, but it's more about communicating the need and the value to the patients so they can make that decision.

So my take home message is: Ask a patient to participate.

So next, I will talk about some of the strategies that we have been using to raise awareness around this topic. So we know that some of our communities may not reach the intended audience in a manner that it can understand. So as I mentioned earlier, we want to make sure that we are meeting people at their place of need or at their comfort level. Research has shown that minorities are early adopters of technology. So we should be using these different platforms to make sure that our messaging is getting out to our targeted audiences.

So with that being said, we actually developed a multimedia campaign. The purpose of the campaign was to raise awareness around why diverse representation is important. And we really wanted to make sure that we combatted some of the myths and to really provide a positive message to reflect spokespersons who look like the population that we are trying to serve. We want to look at why these issues matter and what can be taken and really to help stimulate dialogue, not only on a peer-to-peer patient but on a patient to provider basis. We want to make sure that minority patients are empowered and make sure they have the information to have a meaningful conversation with their healthcare provider.

So with that, minorities and clinical trials campaign, have videos, website, podcast and communications toolkits that you can use to help support and promote the messaging from social media. We have different graphics and also there's a big stakeholder collaboration piece.

So next, what I would like to do is really show you some of the outputs from the multimedia campaign. So in our first version or our first leg of the campaign, we actually -- we used a lady, her name is Shirley Miller and she's actually a patient would is living with sickle cell disease and serves an FDA patient representative and she was able to put together a culmination of videos that really talk about, you know, why this issue is important and what it meant for her to participate in the clinical trial. So we'll start to go through some of the videos so you can get a sense of what the campaign entails.

>> I'm Shirley Miller, and I have sickle cell disease. In order to help researchers find better therapies and treatments for my condition, I have chosen to participate in clinical trials, as well as encouraging my peers to participate.

I learned about clinical trials by attending public meetings, talking to my doctor, and visiting [clinicaltrials.gov](http://clinicaltrials.gov) to search for open clinical trials. You too can be a part of the greater good to help advance medical care. Go to [clinicaltrials.gov](http://clinicaltrials.gov) to find out more.

>> JOVONNI SPINNER: So the next video talks about how to get access to cutting edge therapies.

>> I'm Shirley Miller, and I have sickle cell disease. I have participated in clinical trials as a way to get access to promising cutting-edge therapies and treatments before they come to market. This is an important opportunity to ensure that the benefits and risks are studied in diverse patients like me.

With my help, researchers are able to make new medical products available much quicker so that they can help people in our communities.

To find out if there's a clinical trial that's right for you, visit [clinicaltrials.gov](http://clinicaltrials.gov).

>> ELENA RIOS: Jovonni?

>> JOVONNI SPINNER: So the next one is about recruiting healthy volunteers and you don't necessarily have to be sick to participate in a clinical trial.

>> I'm Shirley Miller, and I have sickle cell disease. I want to encourage you to participate in a clinical trial. Clinical trials are not just for people who have a medical condition. Healthy volunteers are needed too. You should know that your safety is the number one priority. There are strict guidelines that have to be followed to protect you. Your personal information is safeguarded at all times. You can leave the study at any time for any reason.

For more information, visit [clinicaltrials.gov](http://clinicaltrials.gov).

>> JOVONNI SPINNER: So I see that I'm running a little short on time. So I won't go through the remainder the videos, but we do have videos that are in Spanish, and we also partner with veterans health administration to do two videos that were focused in on veterans because we know that they do have special health needs. So we wanted to make sure that since they are underrepresented population that we are developing tools for them as well.

So moving on it summarizing the impact of this work, we know that we have been able to stimulate dialogue around clinical trial diversity and we have seen an uptake on our materials. Based on the campaign results we know we have reached millions of minorities using this multimedia approach and that we have created tools to help healthcare -- help healthcare and participating at different meetings and doing webinars and other training events to help raise awareness. So in terms of our next steps we definitely want to continue strengthening our stakeholder engagement, and also looking at some research strategies that we can go a little bit deeper into looking at the effectiveness of our materials and then also doing some additional PSAs or short videos that are targeting physicians.

>> ELENA RIOS: Jovonni thank you very much. We are going to have a Q&A session. By now you have a slide with the questions. I will just take the prerogative to answer a couple of questions and then I will ask Dr. Daviglus and Dr. Spinner each.

I have a question about the physicians from NHMA and our recommendations from our policy summits last year, that were in Los Angeles, San Antonio -- I mean, Austin, and New York City.

We did look at the importance of prevention and I have to say that we did look at nutrition and physical activities first before looking at medications, and sorry to make it seem that medication first line of therapy, but it's not. You will see that in our report.

Just a word on medications, there's brand new medications and

I think we have to realize that some of the newest medications never get to our communities just because of lack of knowledge, just like the clinical trials. It doesn't get to our communities right away, and we -- this purpose of this webinar is to let more people in our communities know to let others know about the importance of new knowledge.

And I'm going to give one example, and that is high cholesterol. There are -- and FDA showed one drug called Repatha that's actually been shown to help decrease heart attacks due to cholesterol, and I think that's something that we -- we never really discussed, the importance of innovation of medications.

Another question was asked about how to get medical Spanish into curriculum, and I just wanted to say that our seminar that I mentioned that we had at our National Hispanic Medical Association conference, it was funded by the Josiah Macy, Jr., Foundation.

There will be a publication on their website on ideas in how to move forward to have medical Spanish curriculum within medical schools. We did not talk about all the disciplines, and it was just an idea of how we should focus on -- take one discipline first, and then hopefully there will be more -- more continuation of the discussion after our NHMA conference with stakeholders that came together from across the country who were not only academic but from the language and the linguistic experts from this country and other countries.

So Dr. Daviglus, there was a question about the importance of looking at data on vaping. Do you have any data on vaping? Have you looked at that? And there was also a question about do practitioners and physicians deal with all of these negative aspects of health. You know, how much time can they spend answering the questions.

>> MARTHA DAVIGLUS: So answer your first question, no, we don't have it. There's a recent ancillary proposal for this study that if funded, that study will be collecting the data.

The second absolutely. We are having issues because you are right, physicians do not have the time and they ask what is for us? Right?

Not only they have to talk to the patients, so their own patients to participate in clinical trials that they are not principal investigators and that is very difficult, but perhaps by talking to them more frequently, convincing them that this is going to get the beneficial aspect of participating in the case of all of us, that the physicians will have access to the portal, to the participants to the electronic health records, et cetera, and perhaps their job will be easier if we can share their data -- their results with the providers.

But at this time, it is difficult and certainly is not one size fits all. Perhaps there will be other ways of communicating and strategizing how we can partner with physicians and doctors of these patients.

>> ELENA RIOS: And Jovonni, we have a question for you that comes from the Native American leaders. What is being done to increase the participation of Native Americans in clinical trials.

>> JOVONNI SPINNER: What we started to do now is expand our outreach so we could -- we are starting to do more research around some of the barriers to participation that are unique to American Indians and Alaska natives. So we have started to attend some travel meetings and starting to reach out to different tribal leaders so we can have a better understanding of the land scape before we start moving forward with materials development. So right now we are in a formative research stage, trying to make sure that we have all of our information prior to developing campaign specific to Native Americans. So we want to make sure that it's culturally competent before releasing any type of health education materials.

>> ELENA RIOS: Okay. And I don't know if there's any other questions. And I'm sorry, I don't have the screen showing up on my computer with the questions. I have the evaluation and let me just remind everybody to please complete the evaluation.

>> MARTHA DAVIGLUS: Elena, can I also emphasize to whoever sent you to the question regarding the lifestyle modifications. Of course that is the way that we should do before we are going to start to use that, we have to start it to see that prevention is the first tool we have. Prevention before the participant or the person will have any of the risk factors or cardiovascular diseases.

However, as you all know, this is very, very difficult, but we have to try it because for the next generations or -- we have to find out if -- especially for Hispanic/Latinos, culturally appropriate interventions, et cetera, and we are trying to test now.

Because everybody wants different interventions depending where and when the group is coming come, whether it's South America, we all eat very differently. We all have needs for exercising in a different way, and hopefully in the next decade, we are going to be successful because that's for all the interventions for healthy eating, exercise or work while we are having the interventions, while they are having instructors or trainers, et cetera.

But after that, every study shows over and over again that participants will increase their weight, will increase their risk factors as high as what they had it after the meeting or higher levels. That is what we need, prevention and lifestyles.

>> ELENA RIOS: Okay. I have another two questions here on my screen. One of them is are there any requirements placed on clinics,

federally qualified health centers, hospitals or physicians to ensure measurement of and decrease in health disparities? So whoever would want to take that one.

>> ELENA RIOS: This is Elena Rios, I do know that there are class standards that culturally and linguistic health standards that are strongly recommended for federal grants, that deliver care to the underserved through clinics, and that has to do with language and culture. That would help to decrease health disparities, but the issue of health disparities per se is not federal mandate. I think that the federal grants do give, I will say brownie points for those who can actually document that they are increasing participation of the workforce, for example, that comes from underserved communities, that can target underserved communities or disadvantaged communities that would have an impact of decreasing health disparities.

But I think that's something that is going to come through, I think, the payment mechanisms of CMS using social determinants of health as factors to actually measure that that's how we are going to see more increase and focus on disparities in the future.

Does anybody else have anything? Well, Pedro, ask the other question, I'm sorry.

>> Pedro: Yes, there's another one. What suggestions can you make to help decrease the mistrust felt by some minority groups?

>> ELENA RIOS: Dr. Daviglus, did you want to answer that?

>> MARTHA DAVIGLUS: Yes, absolutely. So first of all, of course, it is important that the participants trust the staff, the clinic, the physician, the clinic, in order for them to participate in the research.

So how can we do that? Of course education is the first way, because they distrust us because in the past they didn't understand what they were seeing them for. They participated in a study and they have results that they couldn't understand and nobody guided.

Because when we approach to these potential participants the answer is, you come to this community. You want us to participate and then you leave and we don't even have the results.

So trust is important, and by showing the participant we are there, at each step of research, whenever they need to understand the results, whenever they need to come and -- and have all of these barriers solved for them asks. Many people cannot even have transportation and we expect them to come hours in advance to participate with us, it's not conducive to positive outcomes.

And therefore, we have to demonstrate first that they can trust us and then we can ask them to come and join us in research projects.

And it works for not only the Hispanic community but also for African-Americans and many minority and nonminority groups.

>> Okay. Hello, everyone. I want to thank our speakers for their informative presentations. You will all be receiving information about the -- about your surveys if you have been able to submit them and, please, fill them out while we are still online. A recording of this webinar will be available on the NPA website, within the next few hours.

We hope that you will use this webinar as a resource and we'll share the link with others once it is available.

And I want to thank again the office of minority health and the National Partnership for Action for looking at this important issue of heart disease among minority communities and I hope that you will all join them for future webinars and also just want, on behalf of National Hispanic Medical Association, want to thank you for the honor of being able to be your moderator today. So thank you and enjoy the rest of your day.