

**Office of Disease Prevention and Health Promotion**  
**Healthy People 2020: Who's Leading the Leading Health Indicators?**  
**Clinical Preventive Services Webinar, July 26, 2012, 12:00 p.m. ET**

**OPERATOR:** I would now like to introduce Dr. Don Wright, Deputy Assistant Secretary for Health Promotion and Disease Prevention at the Department of Health and Human Services.

**DR. DON WRIGHT:** The series includes a month webinar, email bulletin and active conversation via Twitter and Linked In. During today's webinar you'll hear from distinguished speakers first of all Assistant Secretary for Health, Dr. Howard Koh will introduce this month's LHI topic Clinical Preventive Services. And from the Kokua Kalihi Valley Health Center, a federally qualified center in Hawaii Dr. Ritabelle Fernandes will discuss the Center's experience with implementing a comprehensive curriculum to educate members about heart health and empower them to prevent and control chronic conditions. We're also joined today by Dr. David Meyers and Jovonni Spinner who will participate in today's discussion and the Q&A portion of the webinar.

Before we hear from our other speakers let me give you a brief background on healthy people and the leading health indicators.

For four decades Healthy People has provided a comprehensive set of national ten-year objectives that have served as a framework for public health activities at all levels and across the public health community. Healthy People is about understanding where we are now and in taking informed actions to get where we want to go over a ten year period of time. The leading health indicators, the focus of this series, represents critical health issues that if addressed appropriately will dramatically reduce the leading causes of preventable death and illnesses. These indicators are linked to a specific Healthy People objective. They've been selected to communicate high priority health issues to the public along with the actions that can be taken to address them, with the overall goal of improving the health of the entire population.

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There are 12 leading health indicator topics and this month we're focusing on clinical preventive services. For the complete list of the leading health indicators and to view past webinars, please visit our website at [www.healthypeople.gov](http://www.healthypeople.gov).

At this point I'd like to turn the podium over to Dr. Howard Koh.

**DR. HOWARD KOH:** Thank you Dr. Wright. Many thanks to our Office of Disease Prevention Health Promotion for sponsoring this very successful monthly webinar and we welcome all who have joined us for this month's topic, Clinical Preventive Services. Just a couple minutes on background, the term Clinical Preventive Services is a very broad term that encompasses aspects of prevention and early detection. And we are particularly focused in this topic area on chronic disease.

You may know that each year seven out of ten deaths among Americans are from chronic diseases and if we can improve prevention and early detection key areas like heart disease, stroke, cancer, diabetes, arthritis and other areas we can make our country healthier for the future. This is a key area for public health where we need to do screening based on evidence. But if so we can prevent adverse health outcomes. We can prevent death and save lives and we can also help individuals modify their behaviors and risk factors, which also helps reduce illness and adverse outcomes for the future.

For the leading health indicator topic of Clinical Preventive Services we list four specific indicators that are shown on this slide. First, adults aged 50 to 75 years who receive a colorectal cancer screening test based on the most recent guidelines. Secondly, adults age 18 or older with hypertension whose blood

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pressure is under control. Third, for adult diabetes populations we want A1c values that are lower than a nine percent threshold.

And then fourth we want children to be immunized with recommended doses of an array of vaccines including DTaP, polio, measles, mumps, rubella, and the list you can see here. So these indicators in short cover the areas of cancer, blood pressure, diabetes, immunization and they're very important and we need to stress that with the transformative events surrounding health reform and Affordable Care Act we can bring many of these important preventive services to people without having them pay co-payment or co-insurance.

The next slide focuses on the specific topic that we were reviewing today and that is blood pressure control. And this slide shows blood pressure control among adults with hypertension from 1999-2000, up to 2009-2010. And there's much good news on this slide because you can see that the percent of adults with blood pressure controls went from 27 percent a decade ago up to about 46 percent in 2009-2010. That's the good news. The bad news is it's still well below the Healthy People 2020 target of 61 percent and blood pressure control is absolutely key to lowering risk for heart attack, stroke and other outcomes.

We know that one in three adults, about 68 million people; have high blood pressure this drives up health care costs. So this is a key leading health indicator that we need to focus on for the future. So at this point we're delighted to have a community-based organization in Hawaii who has experience in this area. And now it's my great pleasure to turn this over to Dr. Fernandes.

**DR. RITABELLE FERNANDES:** Aloha. Thank you all for participating in this webinar. For those of you who are expecting to listen to a Filipino Dr. Fernandez may be

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in for surprise. I am from Bombay, India, and Fernandes is my maiden name. This is due to Portuguese influence in India, similar to Spanish influence in the Philippines. There are over 3.4 million people of Filipino decent residing in the U.S. Life style diseases are on the rise among Filipinos. They have one of the highest rates of cardiovascular disease in the country. Filipino death rates from cardiovascular disease is 396 per 100,000 people.

Healthy Heart, Health Family is a curriculum to prevent and control cardiovascular disease specifically created for Filipino Americans by the National Heart Lung and Blood Institute. It was adapted from existing NHLBI community educational curricula designed for African Americans populations entitled With Every Heartbeat is Life, Native Indian populations entitled Honoring the Gift of Heart Health and Latino populations entitled Healthy Heart, Healthy Homes.

Many of you may be familiar with these wonderful curricula's. Each works with the unique beliefs, values and preferences of the population. All of which play important roles in people's approach to health and impact health disparities. Healthy Heart, Healthy Family is designed to be taught by community health workers to small groups of eight to twelve people. Features include Heart Healthy BINGO and other interactive activities, cultural adaptations, Tagalog translational, use of picture cards and six easy to read bilingual booklets on heart healthy living. These booklets are simply beautiful and I highly recommend them in clinic waiting rooms.

Between July 2008 and June 2009 Kokua Kalihi Valley piloted the Healthy Heart, Healthy Family program. Kokua Kalihi Valley is one of Hawaii's 14 federally qualified health centers. Located in urban Honolulu on the island of Oahu, Kokua

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Kalihi Valley has provided service in health professional shortage areas, medically underserved areas for 40 years. Our model is neighbors being neighborly to neighbors.

We offer many services to our clients ranging from medical and dental to WIC and community outreach. We serve many ethnic groups at the health center, the largest being Filipinos who immigrated to Hawaii from the island of Luzon in Northern Philippines. Therefore we reached out to our Filipino clients who had cardiovascular disease factors at the health center. We used informational flyers and posters, direct invitation by health center physicians and community outreach.

The most effective method recruitment was direct invitation from the community health workers. We recruited a total of 99 individuals mostly women with an average age of 69 years. Community health workers are central to the Healthy Heart, Healthy Family program. Community health workers are important in engaging community members. At Kokua Kalihi Valley over the years they have built trust in the community. Also being themselves, members of the population they engage, they are uniquely positioned to reduce cultural barriers and improve care coordination for lower income immigrant clients.

In Healthy Heart, Healthy Family community health workers teach group education sessions, conduct screenings, help participants navigate the health system, provide social support and make referrals in order to link participants to medical and social services. NHLBI and Kokua Kalihi Valley used a train the trainer method in order to train the community health workers. Three community health workers from Kokua Kalihi Valley attended a training in Bethesda to learn

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how to lead the program and later taught eight other community health workers. A total of 11 community health workers participated in this program. They are salaried employees of the health center; they're bilingual and have health or social service training.

The heart of the Healthy Heart, Healthy Family is group education, which works well in Asian-Pacific Islander communities and is a popular strategy at Kokua Kalihi Valley. Collectivistic cultures, such as the Filipino culture, enjoy support and socialization in a group environment. Also the community health workers being employees of the health center meant that they could easily make a medical appointment for the patient who needed preventative services.

They taught the sessions, each two hours in duration, weekly for 11 consecutive weeks. Incentives such as speedometers, water bottles and healthy snacks were provided. The sessions covered topics such as cardiovascular disease risk factors, diabetes and blood pressure. Trainers used their facilitative teaching style to keep participants motivated and to promote adult learning. Organized by health topic area, these sessions provide general information on the topic and educate participants on effective lifestyle modification. Also in addition to receiving blood pressure, blood sugar and other screenings, participants were educated on the use and importance of clinical preventative services in preventing and managing chronic conditions. For example, the blood pressure lesson entitled Help your Heart, Control your High Blood Pressure explains how this risk factor impacts the chances of developing heart disease. The community health worker also suggests ideas on how a family can develop a plan to maintain heart health for all members. Finally, a handout teaches participants the

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importance of having regular blood pressure screenings and taking blood pressure medications as recommended.

To encourage the participants to adopt lifestyle recommendations community health workers work to connect the participants with local activities. For example, for physical activity the community health workers encourage their clients to participate in the physical activity classes offered at the health center.

Kokua Kalihi Valley also partnered with the community to develop a nature preserve that includes community gardens and reforestation efforts which makes exercise and healthy food a natural part of daily life for clients. At the nature preserve we promote container gardens and encourage patients to grow their own vegetables. Many Filipino immigrants were farmers back home in Ilocos Norte and love the opportunity to grow sweet potato tarts. Those residing in public housing do not have easy access to gardens and they readily embrace the idea of container gardens in their apartment balconies.

Our staff also provided cooking demonstrations to teach the patients on good nutrition and how to cook local foods in a healthier manner. Finally, this work continued beyond the 11 weeks of community education. Following the training of the curriculum the community health workers organize monthly activities to keep the group connected and promoted heart healthy behaviors around themes such as Heart Day, Family Day, and Mother's Day.

We are pleased to share the results of our program. 92 of the original 99 participants graduated. We provided them with certificates upon completion of the curriculum. Many of our participants have low health literacy and limited

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education. They were very proud to receive a certificate. The fasting blood sugar decrease from 117 to 109 of the hemoglobin A1c did not change. The mean cholesterol decreased from 186 at baseline to 170 at 12 months. The LDL also reduced from 114 to 103.

Blood pressure reductions were seen at six months, but these were not sustained at 12 months. Findings from the Healthy Habits questionnaire revealed significant improvements on nine of the 25 food consumption items. Compared with baseline significantly greater proportions of participants were reading nutrition labels, eating fruits for desserts, snacking on fruits and vegetables, replacing salt with herbs and spices and baking instead of frying. In addition, the number of participants performing physical activity in the form of aerobic exercise increased from 16 percent at baseline to 39 percent at 12 months.

We also administered the six items Stanford Self Efficacy Scale for Chronic Disease. We found statistically significant improvements in participant's confidence in managing fatigue, emotionally distress and keeping cardiovascular disease from affecting day life.

Our success can be attributed to the way the Healthy Heart, Healthy Family curriculum and strategies were consonant with Filipino cultural values, which contributed to the high retention and active participation in the program. The group education format resonated with two important Filipino cultural values; pakikisama which means togetherness/companionship and Bani ha which means community spirit. In fact participants form close relationships with their classmates. Additionally, education and group wellbeing are highly valued in Filipino culture.

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Community health workers were also key to the success of the program. They can be trained to deliver evidenced based curricula and facilitate improvements to cardiovascular disease health in Filipino Americans. They have the cultural and bilingual tools for building trust and serving as healthcare navigators. For example, one of our community health workers has been working at a health center for over 30 years and is well connected within the Filipino community. She was responsible for recruiting the majority of the participants. Also despite our program ending our community health workers continue to be involved in other group educational programs.

The activities were also engaging to the participants. They enjoyed dancing and the Heart Health BINGO. Finally Healthy Heart, Healthy Family engaged the community. In addition to Kokua Kalihi Valley partnering with other local organizations, participants brought the concept they learned to their fields and families. One participant told us "I really learned a lot and can now help my family too".

The results of our pilot project will be appearing in the August issue of Journal for Health Care for the Poor and Underserved. Thank you for your kind attention. We welcome any questions you may have.

**DR. DON WRIGHT:** Thank you Dr. Fernandes and also you Dr. Koh. I'd like to invite participants who have not already done so to send their questions through the webex Q&A feature or via Twitter using the hash tag LHI. We're also joined in the Q&A session by Dr. David Meyers and Jovonni Spinner. These individuals can answer questions on the role of community health workers; the development of educational curriculum to address health disparities, clinical preventative services

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and actions the Department of Health and Human Services is taking to address this topic. Dr. Fernandes can answer questions on her particular program as well.

You'll be prompted to fill out a survey about your experience with this webinar during the Q&A session. We encourage you to complete the survey so that we can constantly strive to improve the future webinars in our series. Thanks in advance for your participation and feedback.

We already have a number of questions and I'll start with you, Dr. Koh. Dr. Koh what is HHS doing to address health disparities, particularly in the realm of cardiovascular disease?

**DR. HOWARD KOH:** Well, probably everyone on this call knows that health disparities has been an enduring challenge for our country for too long and so about a year and a half ago the Department put out its first ever national action plan to reduce and end racial ethnic disparities. We are very proud of this plan because it was a very public and very aggressive commitment to reducing disparities in insurance coverage, in population health outcomes, trying to do more with respect to improve workforce diversity, promote research and also hold ourselves accountable. So our Office of Minority Health is helping to implement that area and of course the Affordable Care Act has been a major lever in our efforts to make that effort move forward well. So I'd encourage you to get to know about this national plan that was unveiled by the Secretary about a year and a half ago and we're all behind it. At the community level there's also a national stakeholders' strategy for achieving health equity and that National Partnership for Action has also been very, very active. So we're very, very pleased to support these two major initiatives.

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**DR. DON WRIGHT:** Thank you Dr. Koh. Our second question goes to Jovonni. Jovonni, what is the benefit of developing curricula specifically tailored for distinct populations as opposed to more general program materials that can be adapted by the implementing institution?

**JOVONNI SPINNER:** Okay. So we feel that it's very important when you're working with minority and underserved communities that the programs being implemented are tailored to be sensitive to their cultural needs and their language and any issues with low literacy. And that more people are likely to understand and adopt the information being presented to them if it's tailored specifically for their needs.

**DR. DON WRIGHT:** Thank you Jovonni. Dr. Meyers we have a question for you. What is the role of education and counseling in preventive services? And how do we incorporate education and counseling into preventive services?

**DR. DAVID MEYERS:** Wow, great question. Thank you so much. For folks who don't know I work at the Agency for Health Care Research and Quality, which is one of the federal partners here in HHS. We tend to be involved in clinical preventative services through our support of the U.S. Preventative Services Task Force and I'm happy to talk about that later.

In terms of the direct question about the role of education and counseling as we just heard one of the barriers for many people in getting recommended clinical preventative services are their cultural beliefs and attitudes. And culturally sensitive education that leads to both the gaining of information but also the motivation that responds to the needs of individual people not to the needs of the

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health care system are critical in being able to change our national rates of receipt of clinical preventative services.

And for that we see that both the clinical system itself, primary care offices have a role to play, but they do that even better and are more successful when they partner with public health organizations and community based organizations so that people in all aspects of their lives are receiving the same message, the same education and the same counseling about clinical preventative services.

**DR. DON WRIGHT:** Thank you, Dr. Meyers. Dr. Fernandes, a couple of related questions for you. First of all, what in the curriculum particularly resonated with the participants in your program? And then another listener asked these Heart Healthy booklets, where do you get access to those so that we can have them available in our waiting room?

**DR. RITABELLE FERNANDES:** The participants loved the Tagalog translations. The materials were adapted to the Filipino population and that resonated well. The way the educational curriculum and the sessions were structured was enjoyable because they were activities, there was BINGO, they had to take a pledge at the end of the session and that was adapted to their grandmother so it was called Lola's Life Lessons, so it was what would your grandmother say? And all these resonated with their cultural values.

Regarding where to get the booklets, I would let Jovonni from NHLBI answer that question.

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**JOVONNI SPINNER:** So if sites want to order booklets they can go to the NHLBI website. And I'm not sure if we can send that link out to participants after the webinar, but definitely go to the website and you can order the materials there.

**DR. DON WRIGHT:** Thanks, Jovonni. We have another question for you. With whom would you suggest non-clinical organizations interested in implementing Healthy Heart, Healthy Family partners with to provide these clinical services? Are there outreach strategies that you would recommend?

**JOVONNI SPINNER:** For the services piece you can just focus on community education. But if you do want to implement the clinical services part of it I would recommend that you partner with a federally-qualified health center or a community health center, health department, or any other medical provider that's interested in doing the program. Sites should probably start with public providers so they may be more willing to work with the population that you're trying to reach.

And also reach out to their management staff and pose this idea of implementing the program, because it's really important to have a champion and someone on board who can help push the program through and help get it implemented at the different sites.

**DR. DON WRIGHT:** Thank you Jovonni. Dr. Fernandes there's two questions here related to implementation. How many participants did you have in your small group education sections and were there any incentive provided beyond the certificate that you mention?

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**DR. RITABELLE FERNANDES:** Small groups range from a minimum of 12 to we had one group that was as big as 20. And that varied on which day of the week they like to come, which was convenient to them, because they ran the groups on different days and different timings. So it ranged from 12 to 20. And what incentives did we provide? It was small little things, pedometers, water bottles, snacks. We gave out t-shirts to everyone with a logo Healthy Heart, Healthy Family. We created health diaries, My Health Record, which we even translated into Ilokano for our populations because they come from another area of the Philippines. These were all little things that were given out from pens and you know ... it was small incentives, but our participants really enjoyed them.

**DR. DON WRIGHT:** Thanks, Dr. Fernandes, another question for you, Dr. Koh. What is HHS doing to work across offices and to collaborate on issues pertaining to chronic conditions?

**DR. HOWARD KOH:** Well, we have a great emphasis on multiple chronic conditions here at the Department. And until now the health system has really focused on one person with one disease at a time. So if you were one of the four Americans or two of the three Americans over age 65 who had multiple chronic conditions you would have to go from provider to provider, specialist to specialist, and that leads to a lot of frustration and fragmentation of care. So we've had an effort here led by our Deputy Assistant Secretary for Health at HHS, Dr. Anand Parekh to really put out a new framework.

So we have an HHS framework called Multiple Chronic Conditions, A Strategic Framework. And if you go on the HHS website you can get more information on that. And we're trying to have in this era, where we're talking about better health

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systems, to look at patients in their totality and understand it as we all age we have multiple conditions that need to be addressed with a real patient centered, person centered approach.

We just had a meeting with some health insurance leaders a couple of days ago to see if health insurance plans would be interested in paying for such an approach for the future. And, of course, this is just in the early stage. But I think it really puts the patient back in the center and obviously has implications for quality and improved health outcomes for the future.

**DR. DON WRIGHT:** Thank you Dr. Koh. Another question for you Dr. Meyers, a global general question. How do hospitals and community health centers account for and address disparities when they are practicing evidence based medicine?

**DR. DAVID MEYERS:** Wow, another great question. I think one way of framing that would be for folks to look at the new National Prevention Strategy, which is another great tool for moving forward in this area. And the National Prevention Strategy one of the four main areas that the national has put forward for itself is eliminating health care disparities. And when you go, when folks who are interested go look at the document not only does it give these high overarching goals for our nation. But it really breaks it down into what each sector can do to achieve the combined success.

And so there are concrete suggestions for what governments, federal, state and local governments can do, what health care systems, hospitals and primary care offices can do, what community-based organizations can do and what individuals and families can do. And throughout that is of course also woven in what the

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public health community can do. So for folks who are interested in their communities about what hospitals and doctors and nurses can do to help eliminate health care disparities, especially in this area of prevention and clinical preventative services, I recommend they take a good look at the National Prevention Strategy.

**DR. DON WRIGHT:** Thanks Dr. Meyers. Another question, I think we have time for two more questions, but the next one for Dr. Fernandes. How are the community residents included in the planning, implementation and evaluation of this program?

**DR. RITABELLE FERNANDES:** Our community health workers have strong ties with the community. We service a small geographic location, the Kokua Kalihi Valley in Hawaii. And it was very easy to involve them because they are already part of the health center activities, they come to our senior health maintenance group, they access different programs. So, by word of mouth and with many health workers directly talking with them, we could gauge how they wanted to come, how often they want to come, what days of the week would be more convenient to them. So it was largely by word of mouth and community health workers directly engaging the participants.

**DR. DON WRIGHT:** Thank you Dr. Fernandes. And the last question for you Jovonni. Are there plans to expand Healthy Heart, Healthy Families beyond the initial implementation size?

**JOVONNI SPINNER:** So currently NHLBI has funded ten strategic champion projects, which came on board in April of this year. And so of those at least three are

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going to be used in the Filipino curriculum. And these sites are going to build partnerships within the communities to provide training for community health workers and/or implementing community education. And the hope is that they're going to use innovative strategies and approaches and we'll be able to get some more information about how to best implement this curriculum. And also since the manuals are available free of charge on our website there are plenty of other sites that are implementing the curricula out in the field that we're just not able to track.

**DR. DON WRIGHT:** Thanks, Jovonni. I regret that we have run out of time for today's webinar, although we have a number of questions still queued up. I want to thank all of you for joining today's webinar. This webinar is part of a series and we hope that you will continue join us. Healthy People is looking for real stories from organizations that are working to make its goals a reality.

If your organization is doing great work on specific leading health indicator topics we want to hear about it. Go to [www.healypeople.gov](http://www.healypeople.gov) to submit your stories, follow us on Twitter or join the Healthy People 2020 group on Linked In to continue the conversation on this LHI topic or to learn about other LBI topics. To receive notices about upcoming events, please sign up for our email announcement on the Healthy People website [www.healypeople.gov](http://www.healypeople.gov). On behalf of HHS I'd like to say thank you to today's presenters and to everyone who's been involved with planning and implementing Healthy People 2020.

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