

*Vital Signs* Town Hall Teleconference  
Heart Age and Addressing Cardiovascular Disease Risk:  
The Role of States and Localities  
Q & A  
September 8, 2015  
1:00 pm CT

Judy Monroe: Well thank you. This is Judy Monroe again and I want to thank all of our speakers for the excellent presentations. You know the concept of heart age, I can't help but sit here as I heard Dr. Yang talk about the risk factors for heart disease.

My own father passed away 34 years ago from heart disease. My mother, who is still living, has been a widow for 34 years so she clearly had a different heart age than my father, but she also did not have any of the risk factors actually that were listed. So it makes a big difference.

So I want to ask everyone to remember that you can get into the queue to ask a question or make a comment by pressing star 1. Say your name when prompted. The operator will announce when it is your turn to ask your question. Please specific which presenter your question is directed to or if it is a question for all of the presenters.

I encourage all of you to take advantage of this opportunity now to share your own strategies, lessons learned, success stories, and pose questions to the presenters or to each other. We have quite a few states and organizations on the call so it is a forum for you to discuss, collaborate, and question different methods, practices, and experiences. So let me ask, Operator, do we have questions in the queue?

Coordinator: Dr. (Monroe), so far we do not, but that is correct. Just press star 1 and record your name when prompted to join the queue.

Judy Monroe: Good, so while folks are thinking about it, don't be shy to ask questions. We have about ten minutes or better, so let me kick off a question. Let me turn to Melanie. Melanie when you were talking about the work that you are doing with the Alabama Department of Public Health, could you talk a little bit more, what was the most important step that you took during the implementation phase of your protocol?

Melanie Rightmyer: Okay, thank you. This is Melanie. The most important step was related to making sure that everyone had a voice in order to have buy in and even begin the implementation steps. We are so new to the outside agencies that we are still in the process of I think proving ourselves and you know making sure that we are trustworthy and that sort of thing.

So as we were facilitating and guiding and leading this process, it has been a great exercise because we have made landmark partnerships. We've got Blue Cross - Blue Shield, CAHABA Medicare contractor, and Medicaid all at the table for the first time in our history, alongside sitting with the Department of Public Health.

But also, just really, really making sure everyone has that voice. So doing that SWAT analysis so that you can see the gaps, address the gaps before you plunge in, and decide yes, this is representing the State of Alabama. Yes, this is the way we are going to do it. Because if you have a group that is missing, then that is going to mess with your reputation and that kind of thing.

Judy Monroe: Thank you, great advice. I mean I think the public/private partnerships have been mentioned a couple of times on the call, which is really powerful, and

you really are highlighting the importance of trust and you develop trust through listening. So operator, I think we have a question in the queue.

Coordinator: You certainly do. Kathryn Boylan you may ask your question.

Kathryn Boylan: I was curious with the lady from Minnesota about, you said that you've used the phone a great deal. That is a challenge for us with under income folks. Either they don't call back and you said it looped around and they called them but they don't want to use the minutes on their phones for anything like we might have to offer in the way of education or therapy. So we also have a quit line in Ohio and it just doesn't work locally in our knowledge, very poor response and continuity with our under income folks. Just wondered if you had any neat ideas to make that work.

Laura Oliven: Thank you and I can appreciate that. We have heard also that there are issues with people wanting to guard their limit, so we also have the option that individuals can enroll through the Web so that they can at least get some services and make connections if they have access to a computer. ClearWay who provides the services for underinsured and uninsured also is offering a new suite of services that goes beyond just phone counseling, and I believe there is texting.

So one other thing that we did when we went into public housing, we went in and brought social workers and CHWs and brought phones to them so that they could - that recipients could use our phone minutes. But the other opportunity is to encourage individuals to go to meet with their doctors. There is no minutes involved with a live medical intervention and that is kind of the second part of our initiative to encourage people to visit with their doctor and there they have access to counseling, and RT, and potentially prescription drugs. Thank you.

Judy Monroe: So while we are waiting on other questions, let me stay with Minnesota a minute, Laura, just to expand on that a little bit. I believe you mentioned that there was a description about the American Indians I think with your SHIP you've got 11 tribes. Is that what was said? What else is Minnesota doing to address the disparities in tobacco use among smokers with those highest use rates such as American Indians. I would be very interested in how you are working with your tribes.

Laura Oliven: Yes, the AI tobacco—the American Indian tobacco use is of great concern for us in Minnesota and we have initiated an extensive grant funded outreach to approximately ten of our tribes and also to American Indians in the metro setting.

We have done extensive training of individuals so that they are qualified tobacco treatment specialists. We are working with the tribes and other members in the population on smoke free policies. There is coordination with the clinics to increase access to services and in addition to that, we're working with many of the tribes on something called point of sale initiatives, which try and limit access especially for use so that we are trying to prevent the next generation of smokers from becoming addicted.

The less access that you have to tobacco, the less likely they are to begin smoking. So you can see that we use a multi-level comprehensive set of evidence based strategies to help address this concerning trend in our American Indian youth. Thank you.

Judy Monroe: So if you do have a question, we have a few more minutes if folks on the line have additional questions. Operator, do we have anyone?

Coordinator: Yes, Zara Sadler your line is open.

Zara Sadler: Inter-Tribal Center for Social Change on the Qualla boundry in Western North Carolina. My question is regarding health age and whether or not there are any best practices that address type of activities, meaning recreational activities and recreational settings that includes the built environment. Do any of the presenters have any data on that or best practices?

Judy Monroe: Yeah so a question for everyone, any speaker, built environments. No one? Yeah, I think Dr. Yang may have...

Quanhe Yang: This is a very good question. We know that physical activity or physical inactivity is a risk factor for cardiovascular disease. We actually encourage people to have regular exercise to improve cardiovascular health and health in general, and the new question is if you change the environment to provide more cycle paths or something for the environment. That's probably where it helps people to get moving and get regular exercise to improve their heart disease. I mean quickly improve their heart age.

(Zara Sadler): I see. So it is a model that is primarily predictive at this point and is clinically based then.

Quanhe Yang: You mean for this particular heart age environment.

(Zara Sadler): The factors in the model, the variables in your model, or primarily...

Quanhe Yang: Right, the physical activity is not a part of the modeling.

Quanhe Yang: This particular model includes the major cardiovascular disease risk factors like smoking, blood pressure treatment, diabetes, BMI, and the cholesterol too, in the other model. But the thing physical activity is not a part of it, but physical activity is important for cardiovascular disease. Inactivity is important in cardiovascular disease risk factors.

Zara Sadler: Okay thank you.

Judy Monroe: Thanks for the question. I think we have time for one more and operator I don't believe we have anyone in the queue. Is that correct?

Coordinator: That is correct. It is star 1 if they would like to queue up.

Judy Monroe: So if you have a question, this is the last chance for questions. And while we are waiting, LorieAnn I am going to come to you in New Jersey. So as you were talking about you know all of the work that your department of health is doing, can you talk a little bit about how you go the buy in from high level leadership at the regional planning collaboratives, and the Federally Qualified Health Centers. Can you expand on that a little bit?

LorieAnn Wilkerson-Leconte: Yes, thank you for your question. We actually enjoy quite intimate relationships here at the Department of Health and interagency relationships, so we leveraged some of the connections we have in the Office of Primary Care, which oversees the FQHCs and the Office of Policy and Strategic Planning, which has been working with the RPCs on developing the health information organizations.

They were able to facilitate introductions, help us shape our marketing plan to these groups, and they helped us to present the project. I think the key for us is that our internal partners knew that the FQHCs and the RPCs were ready for

an opportunity like this, so it really took very little effort for us to really find a common ground, some synergy, and really get buy in. And I am fortunate to say that during the assessments, our evaluation portion of the assessment is held with the leadership at the table, so with the chief medical officer or the chief executive officer.

And it is the same in the FQHCs because I think as I stated in my presentation, we just really got caught up in this right place at the right time type of season and it has really worked out well, and I do credit our partners internally for our success in getting that type of buy in.

Judy Monroe: Thank you for that. It looks like we have questions. Is that right?

Coordinator: Yes, you do have a question. Sharon Spence you may ask your question.

Sharon Spence: Hi, yes, good afternoon. I was just curious regarding the incorporation of faith based organizations to address cardiovascular disease risks from the perspective of the states and the localities.

Judy Monroe: So anyone- any of the speakers want to take that one.

Melanie Righmyer: This is Melanie in Alabama. It is a whole other story but a great success. Here in Alabama, there is one university. It is a privately owned Methodist run university in Birmingham, Alabama, called Samford University, S-A-M-F-O-R-D. They have a parish nurse weekend certification program that nurses can participate in and become certified as a parish nurse and develop their programming.

We work with them about the blood pressure being a priority to trying to get them on - consistently with checking blood pressures every Wednesday night

before bible study or in between Sunday school and church the first Sunday of the month.

And we give them a lot of educational materials. We've helped develop in Tuskegee, Alabama, and Macon County especially. About 25 churches have blood pressure protocols in place that they have blood pressure like little areas that have been separated out where folks can come in and check their blood pressure.

They are taught how to do that. There is prompts on the wall and that kind of thing. We are still working with a very specific group of—called the Thelma Walker Brown Parish Nurse Coalition of Macon County and you will have some champions you know within your parish nurse coalitions. This particular group is just outstanding and they go above and beyond and they are making a difference in that whole county. They started in Tuskegee and they just spread out from there.

Judy Monroe: Great, thank you. So I think our time has come to close out, but before we sign off, I do want folks to take a look at the next to the last slide. It is Slide 51 and it shows you the Prevention Status Reports, or the PSRs, which highlight for all 50 states and the District of Columbia the certain policies and practices that are designed around ten public health problems that are really important including health care associated infections.

These are all on the web. You can go to your PSR to see for your state where there might be opportunity to improve the policies and practices around these issues. If you visit the link at the bottom of the slide, you can see all of the PSRs by state or topic or you can go to the link on the September Vital Signs Town Hall Teleconference Webpage to go directly to the 2013 Heart Disease and Stroke Prevention PSR.

Finally, please let us know how we can improve the teleconferences. You can email suggestions to [ostltsfeedback@CDC.gov](mailto:ostltsfeedback@CDC.gov). That's O-S-T-L-T-S feedback, all one word, at CDC.gov, and we hope that you will join next month for our town hall on Tuesday, October 13, and we will be focusing on nutrition and physical activity next month. Thank you to all of the presenters, for your great presentations and for the conversation, and have a great week.

Coordinator: This does conclude today's conference. Thank you all for your participation and participants may disconnect at this time.

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