

CITY COUNCIL
CITY OF NEW YORK

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TRANSCRIPT OF THE MINUTES

of the

COMMITTEE ON HEALTH & WOMEN'S ISSUES

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February 5, 2009

Start: 1:20 pm

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HELD AT: Council Chambers
City Hall

B E F O R E:
JOEL RIVERA
HELEN SEARS
Chairperson

COUNCIL MEMBERS:
Charles Barron
James Sanders, Jr.
Sara M. Gonzalez
Letitia James
Melissa Mark-Viverito
Darlene Mealy
John C. Liu
Kendall Stewart
Maria del Carmen Arroyo
Inez E. Dickens
Rosie Mendez

A P P E A R A N C E S (CONTINUED)

Dr. Lynn Silver
Assistant Commissioner for Chronic Disease Prevention
and Control
New York City Department of Health

Dr. Melissa Schori
Medical Director
Lincoln Medical and Mental Health Center
New York City Health and Hospitals Corporation

Dr. Mary Ann McLaughlin
Board of Directors
American Heart Association

Dr. Holly S. Andersen
Director of Education and Outreach for the Ronald O.
Perelman Heart Institute
New York Presbyterian Hospital-Weill-Cornell Medical
Center

Dr. Hannah Lipman
Geriatric Cardiologist
Montefiore Medical Center

Dr. Cynthia Taub
Director of Non-Invasive Cardiology
Weiler campus of Montefiore

Dr. Safiya Addison
Director of the Community Health Outreach Program
New York Methodist Hospital

CHAIRPERSON RIVERA:: Good

afternoon, ladies and gentlemen, my name is Joel Rivera, I'm the Chair of the City Council's Health Committee. I want to thank my colleague Helen Sears, Chair of the Women's Issues Committee for holding this joint hearing today with us.

We are here to discuss women's heart disease in New York City. Heart disease is the leading cause of death in women throughout our city and nationally. Our country lost 455,000 women to heart disease in 2005, 12,000 of whom were from New York. The American Heart Association estimates that more than 41 million women have at least one form of cardiovascular disease. The term heart disease represents several different types of heart conditions, including coronary heart disease, heart attack, angina, congestive and chronic heart failure and irregular heartbeat.

One of the barriers that exists with respect to heart disease in women is the misconception that it is primarily a men's illness. We need to do everything we can to dispel this myth, heart disease is more prevalent

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2 in women than in men. We can only do this through
3 education and advocacy. One major opportunity to
4 accomplish these goals can occur tomorrow as we
5 recognize national Wear Red day--and I was told I
6 should have been wearing red today, but I said
7 it's tomorrow, not today.

8 CHAIRPERSON SEARS: That's right,
9 you can borrow my red watch.

10 CHAIRPERSON RIVERA: I'll borrow her
11 watch.

12 One major opportunity to accomplish
13 these goals can occur tomorrow, as I said, as we
14 recognized the day. This is a day sponsored by
15 the American Heart Association in which
16 individuals across our country can show their
17 support and raise awareness about women's heart
18 disease. The campaign encourages women to be
19 empowered and knowing the facts about heart
20 disease, understanding their risk and becoming
21 more active and adopting fitness plans and eating
22 healthier.

23 Today's hearing is just one event
24 which allows us to focus on this critical public
25 health issue. I encourage many of you here today

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to participate in this national day.

In our city, the Department of Health and Mental Hygiene has several initiatives aimed at reducing the risk of heart disease. Specifically, the department has been very active on issues of nutrition and in stressing the importance of proper diet. Nutrition and diet can go a long way in improving one's personal health and reducing their overall chance of heart disease. The department has also made great strides in helping New Yorkers reduce their dependence on tobacco. We hope to hear more about what they are doing to target women in their efforts.

Today we will explore the state of heart disease among women in New York City and examine programs and preventative measures that can be taken to lower the risk.

I would like to thank the staff of the committees for their hard work and I want to welcome the Council Members who are here with us today, we have Council Member Maria del Carmen Arroyo, Council Member Kendall Stewart, and, of course, my co-chair for today's hearing

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Councilwoman Helen Sears.

And I just want to state for the record, we are joined by students from Cabrini school and from Washington Heights, who took the A train straight down here. Thank you for joining us here today.

And, with that being said, I want to give time to my co-chair to say a few words.

CHAIRPERSON SEARS: Thank you very much. I want to thank everybody for really coming today. I'm Chair of the Women's Issues Committee, and I wish to thank Chair Rivera and the Health Committee for really working with us on this very important issue.

Heart disease is the number one killer of women. Some time back people would have thought that was a myth and that women didn't get heart attacks. Heart attacks, stroke, and other cardiovascular diseases kill more women than the next five causes of death combined, including cancer--now that's a pretty staggering statistic. And unfortunately, according to the American Heart Association, women do not know that heart disease is their biggest health threat. There are several

1
2 sociological and scientific factors that prevent
3 women from getting appropriate heart health care,
4 including economic factors, lack of adequate
5 research on women, gender stereotypes, and the
6 fact that symptoms of heart disease may be
7 different in women than for men. And because of
8 these gender disparities in research, prevention
9 and treatment, more women die from cardiovascular
10 diseases than do men. Now that's quite a
11 reversal, men were leading in that area and now
12 the women are surpassing them.

13 More needs to be done to educate
14 women on the dangers of heart disease, more needs
15 to be done to address the gender issues in
16 treatment prevention, and women should be given
17 the tools to take steps to control their heart
18 health and that starts with education.

19 Today we will hear testimony about
20 this serious health issue and explore ways in
21 which New York City can assist women to be able to
22 take steps for prevention and also ensure that
23 they receive adequate treatment.

24 We will hear testimony from the
25 Department of Health, Mental Hygiene, the Health

1
2 and Hospitals Corporation, physicians, and
3 advocates for women and health.

4 I think I would really like to
5 stress as Chair of the Women's Committee that
6 education for women is probably one of the most
7 important things. Women are known not to pay too
8 much attention to their health--that's just a
9 given. More men work out, more men are, even
10 though some may be afraid to go to doctors, but
11 somehow men seem to pay more attention to it. And
12 I think somehow, it behooves all of us to see that
13 we don't put such a scare in women, but somehow
14 they have to be enlightened as to the fact that
15 they are really treading on very dangerous grounds
16 when they ignore their health--

17 [Pause]

18 So I'm glad and I think Chair
19 Rivera again and everyone here for really taking
20 part in this and I want to thank my Counsel,
21 Rachel Cordero and Joan Povolny, who is the Policy
22 Analyst for the Women's Committee to put together
23 so much of what they've done. So thank you, thank
24 you all and we'll begin.

25 CHAIRPERSON RIVERA: Dr. Lynn

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2 Silver, Assistant Commissioner for the Bureau of
3 Chronic Disease Prevention and Control from the
4 New York City Department of Health and Mental
5 Hygiene and Dr. Melissa Schori, Medical Director,
6 Lincoln Medical and Mental Health Centers, New
7 York City Health and Hospitals Corporation.

8 [Pause]

9 Thank you very much for joining us,
10 ladies, just state your name and title for the
11 record and if you have any testimony, please
12 provide it to the Sergeant-of-Arms, he'll
13 distribute it to us and you may proceed.

14 DR. LYNN SILVER: Good morning,
15 Chairperson Rivera, Chairperson Sears, Councilman
16 Stewart, Councilwoman Arroyo.

17 My name is Dr. Lynn Silver, I am
18 Assistant Commissioner for Chronic Disease
19 Prevention and Control at the New York City
20 Department of Health. On behalf of the
21 department, I thank you for this opportunity to
22 provide testimony and to discuss the state of
23 heart disease among women in New York City.

24 My testimony today will provide an
25 overview of the state of cardiovascular disease

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2 among New York City women, describe initiatives of
3 the department and partnering agencies to address
4 cardiovascular disease, many of which have been
5 made possible with the support of the City
6 Council, and to discuss challenges the city faces
7 in reducing death and illness from cardiovascular
8 disease.

9 As you stated, cardiovascular
10 disease is the leading cause of death for both men
11 and women in the United States. The term
12 cardiovascular disease refers to a number of
13 conditions that affect heart and blood vessels,
14 these include heart attacks, stroke, heart
15 failure, and hypertension, amongst others. Nearly
16 80 million adults over the age of 20 in the United
17 States have one or more forms of cardiovascular
18 disease. In New York City, heart disease and
19 stroke account for 40% of all of our deaths every
20 year. Much of this burden of death and illness
21 could be prevented or postponed through further
22 reductions in smoking, preventing high blood
23 pressure and assuring its effective treatment.

24 In 2007, just over 24,000 New
25 Yorkers died from cardiovascular disease. While

1
2 people often think of heart disease often as a
3 disease of men, in reality, more than half, 55%,
4 of the people dying from cardiovascular disease
5 are women. Over 4,000 of these deaths occurred in
6 people under 65--deaths that we define as
7 premature. One-third of premature cardiovascular
8 deaths were in women. Such deaths are largely
9 preventable. While deaths from cardiovascular
10 disease have been declining over the past 25 years
11 similarly for men and for women, this decline has
12 been most marked in whites and has been slower in
13 blacks, Hispanics and Asians.

14 Heart disease is the leading cause
15 of adult death, affecting both sexes and New
16 Yorkers of all incomes, races, and ethnicities.
17 However, there are significant inequities in
18 disease distribution. Black women are twice as
19 likely as white women to die from cardiovascular
20 disease before the age of 65. Poverty is also bad
21 for your heart. The highest rates of early death
22 from cardiovascular disease among women in New
23 York City are clustered in our low-income
24 neighborhoods and communities of color. Rates are
25 especially high in the South Bronx, East and

1
2 Central Harlem and North Central Brooklyn. The
3 black-white gap in early cardiovascular disease
4 death rates has been widening more rapidly between
5 women than it has been between men in the last few
6 years.

7 The major risk factors for
8 cardiovascular disease are high blood pressure,
9 high cholesterol, diabetes, smoking, obesity, and
10 a family history of early heart attack or stroke.
11 Being male is also a major risk factor for
12 cardiovascular disease because rates are higher in
13 men compared to women, although more women die
14 from heart disease than men. The observation that
15 blacks are at higher risk for hypertension than
16 whites is also longstanding and not fully
17 understood.

18 Many of these risk factors have
19 high prevalence rates among women. In New York
20 City, one out of four adults, male and female, has
21 high blood pressure. And whether male or female,
22 only about half of these people with high blood
23 pressure have it adequately controlled--the rates
24 are quite similar. One out of four male and
25 female New Yorkers also has high cholesterol.

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2 Women make up the majority of New Yorkers with
3 diabetes, they are also slightly more likely than
4 men to be obese and, while they are less likely
5 than men to smoke, there are still about 440,000
6 women in New York city who are current smokers.

7 The racial disparities in
8 cardiovascular disease deaths among women are
9 likely the result of disparities in both social
10 and biological risk factors. Black women are two
11 times more likely than white women to be obese, to
12 report ever having hypertension, and/or report
13 ever having diabetes. Hispanic women are also two
14 times more likely than white women to be obese or
15 to have self-reported diabetes. Income is also an
16 important correlate of obesity. The highest rates
17 of obesity are found among women in neighborhoods
18 where more than 30% of the population lives in
19 poverty, such as our DPHO neighborhoods. When
20 compared to other groups, low-income black women
21 have the highest rates of obesity--an important
22 risk factor for heart disease.

23 Also, risk for heart disease can
24 start very early in life. A recent study
25 demonstrated that average blood pressure is

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2 increasing among children and adolescents in the
3 United States, including girls. This is a
4 particularly troubling development when
5 considering the rising rates of childhood obesity,
6 which is associated with elevated blood pressure,
7 and the potential future impact of these trends on
8 cardiovascular disease in adults and in women in
9 particular.

10 Let me turn now to some of our
11 efforts in the department to reduce heart disease
12 and stroke-related illness and death, and to
13 reduce these health disparities. These efforts
14 focus on two levels. The first is keeping people
15 healthy and, secondly, improving care for those
16 who are ill. Prevention is clearly our first
17 priority. We focus on the major risk factors,
18 such as high blood pressure, cholesterol, smoking,
19 obesity, and diabetes. Many of our programs aim
20 to reduce the occurrence of high blood pressure
21 and cholesterol by promoting exercise, healthy
22 eating, and salt reduction. We also work to
23 reduce overall cardiovascular disease risk by
24 identifying and treating those with high blood
25 pressure and/or high cholesterol and getting

1
2 smokers to quit.

3 Although our programs do not
4 exclusively target women, they do reach women in
5 numbers proportionally higher than men. I would
6 also like to acknowledge the importance of the
7 Council's leadership and funding, as well as the
8 strong support of individual Council Members in
9 making these initiatives possible.

10 While individuals can and should
11 make personal choices that reduce their likelihood
12 of getting heart disease or having a stroke, our
13 social, food, and built environments are major
14 determinants of heart disease and stroke risk
15 factors in our community. We therefore prioritize
16 changes in our City's environment that can make
17 staying healthy easier for New Yorkers. This is
18 achieved both through city-wide initiatives, as
19 well as neighborhood-targeted programs that
20 address the disproportionate burden of
21 cardiovascular disease in areas, such as our DPHO
22 neighborhoods. I'll highlight some of these
23 initiatives briefly and would be pleased to
24 explain in greater detail after the testimony at
25 your request.

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2 Much of our preventive work, as
3 you're aware, focuses on improving the food New
4 Yorkers eat. New Yorkers like to eat out.
5 Restaurants and take-away meals are a common
6 convenience in our busy lives. In the past three
7 years, the New York City Board of Health approved
8 two important Health Code amendments that will
9 help protect our hearts.

10 In 2006, the Board amended the
11 Health Code to phase out artificial trans fat in
12 NYC restaurants. Trans fat increases the risk of
13 heart disease by elevating LDL, or bad
14 cholesterol, and lowering HDL or good cholesterol.
15 By reducing the intake of this dangerous substance
16 in restaurants, we reduce our risk for heart
17 attack. The measure has proved highly successful
18 and over 94% of restaurants are now in compliance
19 with the City's restrictions on trans fat use.
20 Most of the remaining violations are simply
21 problems with documentation at this point.

22 The Board also recently adopted a
23 requirement for posting of calorie information on
24 menu boards, menus, item tags in restaurants,
25 which I presume all of you have seen sometime over

1
2 the last year. Our baseline studies show that
3 people purchase too many calories when they eat at
4 chain restaurants. The excessive caloric intake
5 in restaurants contributes to obesity and places
6 women and men at higher risk for heart disease.

7 Calorie posting allows people to
8 make informed choices on the amount of calories
9 they consume when eating out. The number of
10 people who see and use calorie information has
11 increased dramatically as a result.

12 Both of these measures became fully
13 effective this year and have been widely
14 replicated across the country.

15 Last September, Mayor Bloomberg
16 announced the launch of the City's first formal
17 food procurement standard, ensuring that over 225
18 million meals and snacks served each year at
19 schools, day care centers, senior centers,
20 homeless shelters, and other locations are
21 healthier than ever. Led by the Mayor's Food
22 Policy Task Force, an initiative begun at the
23 request of Speaker Quinn, and with representation
24 of the Council, the Department participated
25 actively in this collaborative effort to set

standards requiring City agencies to serve only healthier beverages, phase out deep frying, include two servings of fruits and vegetables in every lunch and dinner, lower salt content, and increase the amount of fiber in meals.

Americans currently eat almost twice the recommended limit of salt each day, thereby increasing our blood pressure and putting us at risk for heart attack and stroke. Almost 80% of the salt that we consume comes not from our salt shakers, but from processed and restaurant foods. If salt levels are reduced in these foods by half over the next decade, as proposed, the American Medical Association estimates that 150,000 deaths in the United States will be prevented each year. The Department, convening a national coalition of health organizations and public agencies, has begun to work with food industry leaders on a voluntary framework to cut the salt in their products. This may be the single most effective preventive action to reduce the burden of high blood pressure and cardiovascular disease.

We are also working on increasing

1
2 access to healthful foods in areas where such
3 options have not been available. The department
4 has partnered with local bodega owners to expand
5 the availability of healthier food choices in DPHO
6 neighborhoods. Through the Health Bucks program,
7 the department works with HRA to subsidize the
8 purchase of fresh fruits and vegetables from
9 farmers markets, primarily for families using food
10 stamps. And, thanks to a measure recently
11 approved by the Council, the Green Carts program
12 will be able to introduce 1,000 more mobile food
13 carts that sell fresh fruits and vegetables on
14 street corners in neighborhoods where New Yorkers
15 previously had little access.

16 Obesity and high blood pressure
17 must also be addressed by increasing physical
18 activity levels. With the support of the Council,
19 Sports, Play and Active Recreation for Kids, the
20 SPARK program, has trained over 9,000 early
21 childhood educators at daycare centers, schools
22 and after school programs citywide, as well as
23 equipping them. Increasing numbers of schools are
24 incorporating Physical Best, a curriculum focused
25 on promoting physical fitness, and the New York

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2 City Fitnessgram assessment, a health related
3 fitness assessment, into their physical education
4 programs across the school system. The department
5 and the Department of Education are also working
6 with after school programs to promote both
7 traditional and non-traditional sports activity
8 through the CHAMPS program and, with Council
9 support, through Road Runners as well. The
10 department is also collaborating with other city
11 agencies through its Fit City initiative and
12 PlaNYC to increase walking, biking, and stair use
13 by building more opportunities for physical
14 activity into our built environment.

15 Women who smoke are about twice as
16 likely to suffer coronary heart disease as non-
17 smoking women. In New York City, about 440,000
18 women are current smokers, reflecting a nearly 30%
19 decline in smoking prevalence since the
20 implementation of the city's innovative tobacco
21 control program in 2002. This significant public
22 health achievement has been driven by a
23 combination of legislative and public education
24 efforts. Most notably, the Smoke-Free Air Act of
25 2002 prohibited smoking in nearly every indoor

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2 area where people work, a series of excise tax
3 increases have brought New York City's combined
4 cigarette excise tax to the highest in the
5 country--taxes now comprise more than 60 percent
6 of our pack price. Aggressive anti-tobacco media
7 campaigns have been a hallmark of the Health
8 Department's efforts and continue to encourage
9 smokers to quit and to prevent youth from ever
10 starting.

11 Resources that support cessation,
12 such as annual free nicotine patch giveaways, are
13 also integral to the City's efforts to help New
14 Yorkers quit smoking and stay tobacco-free.

15 Despite these efforts, many New
16 Yorkers still develop high blood pressure.
17 Undiagnosed or uncontrolled blood pressure can be
18 addressed by increasing people's participation in
19 checking and tracking their own blood pressure
20 outside the doctor's office, as well as by
21 improving access to, and the quality of, clinical
22 care. Checking blood pressure measurements at
23 home has been shown to help people control their
24 blood pressure. The department is scaling up a
25 pilot project that distributes and evaluates the

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2 use of self-blood pressure monitors to patients
3 with poorly controlled blood pressure in select
4 clinics in communities with marked disparities in
5 cardiovascular disease. The majority of the
6 participants in this program, 65% are women and
7 more than half are black. In addition to
8 encouraging clinicians to use out-of-office
9 checking to help their patients, we are working to
10 improve insurance coverage of these automated
11 monitors. To make out-of-office checks easier,
12 the department has placed blood pressure kiosks in
13 community pharmacies at no cost to the pharmacists
14 in our District Public Health Office
15 neighborhoods. Just in the last eight months,
16 over 76,000 blood pressure measurements have been
17 taken from these city-placed kiosks.

18 The department also works with over
19 40 faith and community-based institutions to run
20 blood pressure monitoring programs. Three-
21 quarters of the participants in these programs are
22 women, and approximately 40% of them had
23 uncontrolled blood pressure. Healthy hearts is
24 also a focus of our Primary Care Information
25 Project, which now covers over one million

1 patients. PCIP is helping doctors to track blood
2 pressure and to deliver appropriate care for high
3 blood pressure and other heart disease risk
4 factors, whether to a man or to a woman, in
5 response to Councilwoman Sears' concerns. Public
6 Health detailing, City Health Information
7 bulletins and other department programs help
8 support and educate clinicians and their staff on
9 current recommendations for optimal care for high
10 blood pressure, cholesterol, diabetes, and
11 obesity. We work closely with our partners at the
12 Health and Hospitals Corporation as well to
13 support their efforts to continuously improve care
14 for heart disease and its risk factors.

16 To increase awareness of
17 cardiovascular disease as the leading cause of
18 death among women, the department has teamed up
19 with the American Heart Association to help
20 promote AHA's annual Go Red for Women campaign in
21 New York City. Our collaboration includes, co-
22 branding a New York City specific "Love your
23 Heart. Control your blood pressure" campaign
24 poster which will be distributed throughout the
25 community; developing messaging together for the

1
2 New York City Go Red transit media and billboard
3 campaign; developing a shared website that
4 contains both AHA and Health Department resources;
5 and participating in a press event.

6 In summary, New York has a number
7 of innovate initiatives that will improve the
8 cardiovascular health of women, yet much remains
9 to be done. Furthermore, the rising poverty and
10 unemployment during this economic crisis will tend
11 to aggravate existing risks and health
12 disparities. Premature illness and death from
13 cardiovascular disease will be most effectively
14 addressed with comprehensive multi-pronged and
15 sustained approaches that address not only its
16 environmental determinants and the immediate
17 health needs of people suffering from
18 cardiovascular disease, but also the social and
19 economic needs of the community. While we may be
20 yet far from our goal, city programs and our
21 community partners are working harder than ever to
22 meet the increased needs with leaner funding. We
23 look forward to continued partnership with our
24 fellow city agencies, with the American Heart
25 Association, the Health and Hospitals Corporation,

1
2 community partners, as well as ongoing
3 collaboration with the Council to further
4 strengthen our efforts to prevent and control
5 cardiovascular disease in both women and men.

6 In closing, let me reiterate our
7 appreciation of the Council's support for
8 cardiovascular disease prevention and control.

9 Many of the key initiatives discussed today
10 received Council funding and we thank you for your
11 commitment to addressing the City's leading cause
12 of death. I am happy to answer any questions that
13 you have.

14 CHAIRPERSON RIVERA: Thank you very
15 much. We'll just move on to the next testifying--
16 just to introduce the colleagues who joined us, we
17 have Council Member Sara Gonzalez, Council Member
18 Charles Barron, and then we also have Council
19 Member Melissa Mark-Viverito, Council Member
20 Darlene Mealy, Council Member Inez Dickens,
21 Council Member John Liu, and Council Member Rosie
22 Mendez who have joined us. Okay?

23 [Pause]

24 DR. MELISSA SCHORI: ...person
25 Rivera and Chairperson Sears and Members of the

1
2 Health and Women's Issues Committees. On behalf
3 of HHC, thank you for the opportunity to discuss
4 the state of heart disease among women in New York
5 City. Thank you for your support of our goal to
6 improve health care and outcomes in the city of
7 New York.

8 Heart disease in women. As has
9 been noted, cardiovascular disease is the most
10 common cause of death and disability in women.
11 Deaths due to coronary heart disease have
12 decreased by more than 10% in the past decade,
13 however, coronary heart disease still accounts for
14 35% of all causes of mortality in women. For
15 women between the ages of 45 and 64, one in nine
16 women will develop symptoms of coronary heart
17 disease; for women over 65, that climbs to one in
18 three.

19 Sudden cardiac death. Women have a
20 lower sudden cardiac death rate than men at all
21 ages, however, a higher fraction of those sudden
22 deaths occurred in the absence of prior overt
23 coronary heart disease--63% versus 44%, this means
24 no warning. The presence of heart failure
25 increased overall mortality in the instance of

1 sudden cardiac death.

2
3 Disparities in adult African-
4 American women's knowledge of heart attack and
5 stroke symptoms, something studies have shown.
6 Heart disease and stroke, as we've mentioned, are
7 the first and third leading causes of death in
8 American women. African-American women experience
9 a disproportionate burden of these diseases
10 compared to white women. They are more likely to
11 delay seeking treatment for acute symptoms.
12 Knowledge is the first step in seeking care, and,
13 in some cases, the knowledge is not as extensive
14 as it should be. Racial and ethnic gaps in
15 awareness remain. Educational efforts to increase
16 heart disease awareness should be targeted to
17 racial/ethnic minorities to improve both
18 prevention and recognition.

19 African-American, Hispanic, and
20 white women's perception of early disease. Why do
21 women in general delay seeking treatment for
22 symptoms of an acute heart attack--this applies
23 now to all women. Again, by age and race, there's
24 low perception of heart disease risk, they don't
25 recognize the initial symptoms because the

1
2 symptoms are atypical for a man's symptoms, we
3 tend to get more generalized sense of fatigue and
4 neck pain than the typical crushing chest pain.
5 We're the caretakers so we don't want to bother
6 others, so when we don't feel well, we really have
7 to not feel well before we pursue things. The
8 presentation of symptoms is atypical. The
9 barriers to access to care, such as insurance
10 issues, language, and availability. We associate
11 heart disease with men--women can correctly
12 identify the symptoms, but they don't recognize
13 them at the time they are occurring. And there's
14 a disconnect between personal risk and known risk
15 factors, so somebody who has hypertension can tell
16 you I know that's a risk factor, but they don't
17 consider it a risk factor for themselves.

18 Some racial, ethnic, and
19 socioeconomic differences in multiple risk factors
20 for heart disease and stroke in women. More than
21 a third of all women had multiple risk factors.
22 The prevalence of multiple risk factors was lowest
23 in whites and Asians; the odds for having multiple
24 risk factors were greater in African-American and
25 Native American women and lower for Hispanic women

1
2 compared with white women. The prevalence and
3 odds estimates increased with age and decreased
4 with education, income, and employment. Smoking
5 was more common in younger women. Older women
6 were more likely to have more medical conditions
7 and to be physically inactive.

8 Just to review the cardiovascular
9 risk factors, the assessment of these risk factors
10 are very important and they are a component of--or
11 should be a component of everybody's periodic
12 health examination. First is the personal history
13 of coronary heart disease--is there a family
14 history of premature coronary heart disease? Is
15 there high cholesterol, either high LDL or low
16 HDL? Smoking is associated with 50% of all
17 coronary events, so that's critical to assess
18 smoking risk and try to emphasize smoking
19 cessation. Hypertension, African-American and
20 Hispanic New Yorkers have higher rates of
21 hypertension--a major risk factor. Diabetes, 1 in
22 10 adults in the South Bronx have diabetes another
23 major risk factor. The presidents of peripheral
24 vascular disease, meaning that you have arterial
25 disease in your legs or potentially your neck, is

1
2 associated with coronary heart disease. Chronic
3 kidney disease is associated with coronary heart
4 disease; obesity, another association in the
5 Bronx, one in four adults in the South Bronx is
6 obese and a sedentary lifestyle. More than half
7 of South Bronx residents in general report no
8 physical activity.

9 What are the clinical features of
10 coronary heart disease in women? Women with
11 coronary heart disease are usually about 10 years
12 older than men at the time of presentation. Chest
13 pain, as I mentioned before, women are less likely
14 than men to have typical angina, the crushing
15 chest pain radiating to your left arm--they're
16 more likely to have pain and other sensations in
17 the neck and throat. Women who present to an
18 emergency department with a nuance of chest pain
19 are less likely to undergo an EKG, which tells us
20 whether or not you have abnormalities, cardiac
21 monitoring, and cardiac enzymes to receive a
22 cardiology consult, or to be admitted to a
23 coronary care or step-down unit because women
24 don't have as much heart disease as men.

25 Management of heart disease. The

1
2 benefit of aspirin, beta-blockers, ACE inhibitors,
3 statins and aspirin in women. Hormone replacement
4 therapy is no longer recommended for cardiac
5 protection. There is conflicting data on some of
6 the therapies between men and women, what's better
7 to do. Thrombolytics, which is the clot-busting
8 drug if you have a block in the artery, women are
9 much less likely to receive it and they're likely
10 to have more complications if they do. Some of
11 the angioplasties, if a woman has an angioplasty,
12 we have a higher rate of in hospital and a longer-
13 term mortality than men. And for coronary artery
14 bypass grafts, we also have a higher mortality
15 than men.

16 Outcome of heart disease in women.
17 Women with a heart attack have a higher long-term
18 mortality, as I mentioned. African-American women
19 have higher mortality than white women. Cardiac
20 mortality is also higher in women as compared to
21 men who have diabetes; women with heart disease
22 develop symptomatic heart failure more often than
23 men; and the six-month survival after first heart
24 attack is lower for women than men.

25 The recommendations to alter this

1
2 is to increase your physical activity; avoid and
3 stop cigarette smoking, and avoid environmental
4 smoke; maintain weight at a proper level; maintain
5 a heart healthy diet, as Dr. Silver discussed;
6 treat your high cholesterol, treat your high blood
7 pressure, treat your diabetes. If you smoke,
8 don't take oral contraceptives--shouldn't smoke--
9 guess you can choose which one you want to do
10 there; aspirin if you're 65; and it's not
11 recommended hormone replacement or antioxidant
12 vitamins have not shown to be beneficial.

13 What are some of the cardiac
14 services offered by HHC? We have very
15 comprehensive services, and we have very, very
16 large volumes of patients to provide these
17 services to, which is always a challenge. Our
18 cardiology clinics have been redesigned with the
19 goal of improved patient flow, greater cost
20 effectiveness, and ability to manage a greater
21 volume of patients. One of the keys is having a
22 patient actually seen by the cardiologist. We
23 have expanded to include mid-level providers,
24 nurse practitioners, physician's assistants so
25 that we can expand our cardiology services,

1
2 increase capacity, improve access--no matter what
3 you do, if the patient doesn't have access, you've
4 missed the first part of improving the outcome.

5 We've enhanced our noninvasive services,
6 echocardiograms, other studies, and we have
7 specialty clinics for diabetes management and
8 obesity management.

9 We offer smoking cessation
10 services, we screen patients who come into our
11 emergency room for smoking cessation, as well as
12 all our primary care clinics. For the facilities
13 that do not have cardiac cath onsite, we have
14 referral systems in place. We've leveraged our
15 information systems so that our results are all
16 part of our electronic medical record and we can
17 see the results of our tests, as well as all the
18 clinical information, and this is available across
19 our networks. We've interfaced our EKGs with our
20 electronic records, so you can actually pull up
21 the tracing and review it and compared to old
22 ones, which improves outcome. We have diabetes
23 registries where all our patients who have
24 diabetes are in a registry and we can focus on
25 approving the population base control--I'll tell

1
2 you more about that in a few minutes. We have a
3 cardiovascular risk registry, again, to improve
4 the management of risk factors. We have chronic
5 disease management programs with case management
6 of patients at high risk by staff, and we have
7 continuous targeted training and updates for the
8 medical staff and all the patient care staff.

9 Our blood pressure initiatives.

10 Again, enhancing care is the goal. The goal is to
11 have blood pressures less than 140 over 90 and the
12 target is to reach that in 70% of the adult
13 patients we take care of. The initiative was to
14 develop and implement guidelines for blood
15 pressure management, to instruct the staff how to
16 accurately measure blood pressure--you should be
17 sitting after you've had a chance, not the minute
18 you rush into the exam room, otherwise we're going
19 to get an artificially elevated blood pressure.
20 We've disseminated treatment algorithms to the
21 clinicians based on best practice studies. We
22 have the hypertension patient registry so we can
23 put extra efforts into the patients who are not
24 controlled, despite management and efforts. We
25 have a more active recall process, again, for the

1
2 poorly controlled patients. We have patient
3 education materials in all languages. These
4 additional efforts build upon recent achievements
5 to increase the rate of blood pressure control
6 among our patient population.

7 To enhance diabetes control had a
8 task force, again, HHC-wide that developed and
9 implemented guidelines for diabetes care. We
10 updated our corporate formulary to promote
11 diabetes disease management and we targeted our
12 goals of keeping your hemoglobin A1c, which is a
13 long-term measurement of diabetic control, less
14 than seven; to maintain blood pressure less than
15 130 over 80, and to maintain the LDL bad
16 cholesterol less than a hundred.

17 Take Care New York goals, which
18 also focus on improving heart disease risk
19 factors. I would say number one might be the most
20 important goal, that all patients should have a
21 primary care physician, these are the providers
22 who initiate preventive health and screening and
23 coordinate care.

24 Goal two of Take Care New York, be
25 tobacco free. Again, as has been mentioned,

1
2 smoking is the leading cause of preventable death
3 in New York City and the cause of heart disease,
4 stroke, emphysema, and lung cancer.

5 Goal three, keep your heart
6 healthy. While the heart disease death rate has
7 decreased over the last decade, the heart disease
8 hospitalization rate in the South Bronx is higher
9 than New York City overall. The focus of this
10 goal is to focus on smoking cessation, high blood
11 pressure and high cholesterol control, encourage
12 physical activity and prevent obesity. Obesity is
13 increasing rapidly, this has contributed to the
14 diabetes epidemic. Poorly controlled diabetes
15 worsens the harmful effects of high blood pressure
16 and dramatically increases the risk of
17 cardiovascular disease.

18 I have to brag a little, I'm sorry,
19 national recognition of Health and Hospital
20 Corporation facilities efforts. Lincoln Hospital
21 received the Gold Performance Achievement Award
22 for sustained performance by achieving more than
23 85% in all the Get with the Guidelines recommended
24 secondary prevention measures for coronary heart
25 disease from the American Heart Association, with

1
2 our range being 96 to 100% compliance. This is a
3 national achievement award and we see a tremendous
4 amount of patients and all their data comes out in
5 those numbers. HHC facilities perform above
6 national benchmark on these core measures for
7 acute myocardial infarction. And, another new
8 initiative, again, Jacobi Hospital, the Director
9 of Cardiology is collaborating with Yale for an
10 NIH funded study reviewing heart disease in women.

11 So our system's approach to
12 reducing heart disease: access to care, access to
13 care, access to care, risk factor prevention, risk
14 factor reduction, promote healthy lifestyles,
15 address the psychosocial issues and concerns and
16 barriers to care, early intervention, and
17 education and patient empowerment, and patient
18 empowerment and knowledge is critical.

19 At HHC, we're proud of our role to
20 improve the health care of New York City
21 residents.

22 Thank you for your time.

23 CHAIRPERSON RIVERA: Thank you very
24 much. At this point in time, I'm pretty sure my
25 committee members and I have a couple of

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questions.

The information you provided highlights a lot of the stuff that we're doing and I think that we have made a real strong effort on many levels, whether it's anti-smoking campaigns or if it's the trans fat reduction elimination in the city of New York, and menu labeling. But it seems that the primary issue that we have is that, from what I hear today, is that women don't see how impacted they may be or how it affects them. So I understand that it in part of the testimony, you stated that you do reach out to a significant amount in the community and it doesn't target women particularly, but that women do get the information. Why don't we specifically target women per se, since we know that they need an extra nudge to get help? Is there reason or...?

COUNCIL MEMBER SEARS: It's a good question.

[Pause]

Press the button please.

DR. SILVER: I'd have to say that most of our programs have gone into the community with a take-all-comers approach so that we

1
2 organize an activity in a church and anyone from
3 that congregation who wants to participate comes.
4 In certain venues we have a much heavier
5 participation of women, typically, for example, in
6 community activities and faith-based organizations
7 and senior centers we have very heavily weighted
8 towards women, other activities that we carry out,
9 perhaps less so.

10 We have had limited resources for
11 our community-based activities in terms of
12 personnel and staff to build programs and I think
13 that's placed limitations on our ability to roll
14 out community-based programs that would target
15 specific subpopulations even within the larger
16 high-risk communities that we've targeted and I
17 think that's probably the key limiting factor.

18 CHAIRPERSON RIVERA: Okay. Part of
19 your healthy hearts Primary Care Information
20 Project in the City Health Information Bulletins,
21 what type of information do they distribute and
22 how does it target the individual groups?

23 DR. SILVER: Just to give you an
24 idea, the primary care information project is now
25 covering over a thousand providers, primarily in

1
2 our high-risk communities and over a million
3 patients. It assures that basic cardiovascular
4 issues that the patient has are highlighted to the
5 providers, so if a patient's blood pressure is too
6 high, they'll get an alert, they'll be taken
7 directly to an order set that facilitates
8 prescribing the most evidence-based medications
9 for that problem. When patients have a history,
10 for example, of a cardiovascular event that
11 requires a special medication or other treatment
12 to prevent recurrences, the electronic medical
13 record will call attention to that and I think
14 part of that can help reduce the disparities
15 between men and women in treatment because even if
16 a provider's mindset is to be less conscious of
17 women's risk for cardiovascular disease, the
18 electronic medical record is not and it will alert
19 the provider the same way for a man and a woman
20 and provide those sort of extra nudges to make
21 sure that both men and women receive appropriate
22 care. So I think it can play a positive role in
23 reducing the disparities in care for
24 cardiovascular issues between men and women.

25 CHAIRPERSON RIVERA: Okay.

1
2 DR. SILVER: And will be tracking a
3 series of indicators to look at how that evolves.

4 CHAIRPERSON RIVERA: Okay. And you
5 also mentioned the fact that you highlight in
6 certain communities the risk is higher, such as
7 South Bronx and other neighborhoods. Have you
8 reached out to the local elected officials to do a
9 workshop in the district and to collaborate with
10 the Council Members in those high-risk
11 communities?

12 DR. SILVER: No, we have not.

13 CHAIRPERSON RIVERA: Okay. If you
14 have any informational packets that we can
15 distribute in our district offices that'll be
16 helpful and if some of the members would want to
17 put something together, I'm pretty sure you'll be
18 more than willing to do so, right?

19 DR. SILVER: We'd be delighted to
20 send you all of our materials, or some of our best
21 ones on cardiovascular disease to the Council.

22 CHAIRPERSON RIVERA: Okay. Thank
23 you. I think Council Member Charles Barron has a
24 question.

25 COUNCIL MEMBER BARRON: Yeah, I just

1
2 wanted to--that our communities are suffering
3 higher than most and you can sit here and say you
4 have not reached out. Why? I go through a lot of
5 workshops and we see all of the how bad it is, the
6 statistics, but then when it comes to the care
7 providing, it's just like no, we haven't and our
8 primary caretaker in most of our communities is
9 the emergency room, it's not a primary care
10 doctor.

11 So I think that in addition to
12 showing us these slides and letting us see how bad
13 we're doing, I'd like to see slides just on how
14 well you and other agencies in the city is going
15 to do to protect the communities and people that
16 are most vulnerable. And it's been a real
17 challenge in our communities to get good health
18 care services and we've even done studies on a
19 disproportionate or disparity of healthcare
20 services and information and targeted stuff, and
21 when money comes in, whether it's from a stimulus
22 package or whether it's from other sources,
23 there's not an appropriation of those funds based
24 upon the ones who are in greatest need and danger,
25 it doesn't come to the black and Latino

1
2 communities in particular and sometimes the Asian
3 community as well. So I just think that there's a
4 thing--I was reading some study on racism and
5 health and how we do these wonderful studies and
6 say how bad the South Bronx and Latino women and
7 black women are doing, but then we don't have the
8 appropriate response and care to match the
9 statistics you're showing us and I just want to
10 know why.

11 DR. SILVER: First, I said we hadn't
12 met with elected officials, but we have very much
13 targeted all of our activities to the communities
14 that are suffering the highest disparities. All
15 of our community work, and I can especially speak
16 for the community work in my bureau, absolutely
17 targets our highest risk communities pretty much
18 every cent that goes--

19 COUNCIL MEMBER BARRON:

20 [Interposing] I'm from East New--

21 DR. SILVER: --towards programs--

22 COUNCIL MEMBER BARRON: --I'm from
23 East New York and Brownsville and I don't see a
24 whole lot of it and East New York and Brownsville-

25 -

1
2 DR. SILVER: Let me give you an--

3 COUNCIL MEMBER BARRON: --and I'm
4 from--I mean, you may have done a workshop here
5 and there, but I'm saying the kind of targeting
6 that's going to have a measured result, not the
7 kind of targets that we've done a workshop, we
8 gave out some information, but actually has
9 measured results.

10 And I know we're not flooded with
11 it in East New York.

12 DR. SILVER: Many of our programs--
13 there's a limited number of programs that we've
14 been able to take to full scale, but just to give
15 one example, SPARK, for example, the funding that
16 we've received from the City Council we used first
17 to cover every single group day care in the
18 district public health office neighborhoods. Only
19 after having covered the highest risk neighborhood
20 day cares did we then try and expand citywide to a
21 wider range of communities.

22 Our efforts on blood pressure
23 monitoring, for example, or the kiosk or the
24 pharmacy program have all been targeted
25 specifically to those high-risk communities so

1
2 100% of the resources that we have, which are not
3 massive, have gone to our high-risk communities
4 for our other community interventions, maybe self-
5 blood pressure [off mic] it's 80 or 90% we've had
6 occasional HHC sites that weren't in the DPHO
7 neighborhoods [crosstalk]--

8 COUNCIL MEMBER BARRON:

9 [Interposing] You know what even happens sometimes
10 we have community health clinics being shut down
11 in areas that are high-risk and even TB centers
12 sometimes are closed down like they tried in our
13 area, we had to fight it to keep it open and then
14 still it was reduced, although the effects, the
15 disease itself wasn't reduced, so I just see some
16 problems here.

17 I wanted to just ask you and I'll
18 stop here, I just want to ask you a more of a--I
19 read a book that was talking about heart disease
20 has a lot to do with the fact that people don't
21 really know when to eat, they have a body cycle
22 and a combination of foods, how you combine foods,
23 whether you should have vegetables or
24 carbohydrates with fats, the different combination
25 of foods. But they say that we have a body cycle

1
2 from like four in the morning, I think, to 12 noon
3 is more of your--that's the time for waste or
4 releasing, and then from 12 noon to eight you're
5 supposed to eat, and then from eight to 4 a.m.
6 your body is digesting that which you've eaten.
7 And, unless you really know the cycle that you're
8 eating when you should be allowing for waste to
9 release and you're--or eating when you're supposed
10 to be digesting food and sometimes that could
11 contribute to bad health, and it contributes to
12 heart disease. Do you know anything about that?

13 DR. SILVER: I confess that I have
14 not reviewed the literature on that issue, the
15 strongest evidence is on overall dietary patterns
16 and intake types of food, total caloric intake.
17 The best patterns of dietary intake have been the
18 subject of a great deal of debate and I think
19 there's not a definitive word out on that yet, but
20 I--

21 COUNCIL MEMBER BARRON: And do you
22 have anything--

23 DR. SILVER: --I have not
24 specifically [crosstalk] issue--

25 COUNCIL MEMBER BARRON:

1 [Interposing] All right. Do you have anything on
2 what foods--'cause there's even debates on what
3 foods are good and bad, like some people say milk
4 is bad and especially for black people if you have
5 a lactose deficiency, and cows milk is not fit for
6 human consumption. Do you have anything on that?
7 What is healthy food? I don't know what to eat
8 anymore, you know.

10 DR. SILVER: It's pretty confusing
11 the word out there. In relation to heart disease,
12 there's some things that we do know, we know that
13 high salt consumption is not good for you and that
14 reducing salt consumption can significantly reduce
15 cardiovascular events. But most people don't get
16 their salt from the salt shaker, they get it--

17 COUNCIL MEMBER BARRON: Right, it's
18 from the content in the food.

19 DR. SILVER: --in the boxes of food
20 and--

21 COUNCIL MEMBER BARRON: Exactly.

22 DR. SILVER: --what they buy at
23 McDonald's or--

24 COUNCIL MEMBER BARRON: [Crosstalk]
25 label reading.

1
2 DR. SILVER: --other processed food.
3 So salt is a clear one, reduction of saturated fat
4 intake, which also is associated with bad or
5 unhealthy cholesterol levels in the body is also
6 something that we clearly need to reduce. Whole
7 milk and cheeses have a fair amount of saturated
8 fat and so we promote people using lower fat milk
9 products.

10 The other questions that have been
11 raised about milk, primarily in the black
12 community also have to do with milk intolerance
13 and--

14 COUNCIL MEMBER BARRON: Right.

15 DR. SILVER: --allergies. Milk is a
16 good source of protein and calcium, but not for
17 everybody, there's a significant number of
18 children who and that also have reactions to it.

19 COUNCIL MEMBER BARRON:

20 [Interposing] And milk is not a natural, huh?
21 It's not like got to get that glass of--

22 DR. SILVER: Yeah, my--

23 COUNCIL MEMBER BARRON: The other
24 thing, what--

25 DR. SILVER: [Interposing] My

1
2 professor of pediatrics at Hopkins had written a
3 book called Don't Drink Your Milk. I'm not
4 exactly from that school, but there are health
5 issues for many people, it's a good nutrient for
6 others.

7 COUNCIL MEMBER BARRON: And then the
8 last question, how is obesity defined?

9 DR. SILVER: Obesity is generally
10 defined as having something called a body mass
11 index, which is a measure of weight in relation to
12 your height. Over 30, overweight is considered an
13 index over 25 and obesity over 30.

14 COUNCIL MEMBER BARRON: Over 30% of
15 what...

16 DR. SILVER: A body mass index which
17 the absolute number is 30, it's really a sort of
18 population distribution of weight in relation to
19 height and how that plays out and then there's a
20 [crosstalk]--

21 COUNCIL MEMBER BARRON:
22 [Interposing] Because I was told that if you're,
23 whatever your normal weight's supposed to be for
24 your height, if you're 5 or 10, 10, 15 pounds over
25 that, you're obese.

1
2 DR. SILVER: For example, for a
3 woman my height 5 foot 3, I'm really short, it's
4 about 30 pounds, being about 30 pounds overweight--
5 -

6 COUNCIL MEMBER BARRON: Over the--

7 DR. SILVER: --puts you over the
8 threshold into obese.

9 COUNCIL MEMBER BARRON: It's about
10 30? Just wanted to--

11 DR. SILVER: Not 130--

12 COUNCIL MEMBER BARRON: --'cause I
13 was checking--

14 DR. SILVER: --30 pounds above your
15 ideal weight.

16 COUNCIL MEMBER BARRON: Thirty
17 pounds above your ideal weight.

18 DR. SILVER: Ideal weights would--

19 COUNCIL MEMBER BARRON: Oh.

20 DR. SILVER: --would put you over
21 the threshold into obesity.

22 COUNCIL MEMBER BARRON: I think
23 we're all in trouble around here.

24 DR. SILVER: Well, about 56% of New
25 Yorkers are overweight or obese.

1
2 COUNCIL MEMBER BARRON: Thank you
3 very much.

4 DR. SILVER: A lot of us.

5 CHAIRPERSON RIVERA: Thank you. I
6 think Council Member Barron the nail on the head,
7 he said people are confused and people are
8 concerned, I think the number one killer above
9 everything is stress. I think people stress so
10 much about what's good to do, what's bad to do,
11 and all the misinformation and the conflicting
12 information out there. I think that if people get
13 to the gym, they'll burn off the stress, so
14 that'll definitely [crosstalk]--

15 COUNCIL MEMBER BARRON:
16 [Interposing] And the Mayor's budget contributes
17 to that stress too, which is--

18 CHAIRPERSON RIVERA: Yeah, the whole
19 [crosstalk]--

20 DR. SILVER: Excellent advice.

21 CHAIRPERSON RIVERA: --economy
22 contributes to that, I think [crosstalk]--

23 DR. SILVER: We should exercise and
24 fix the budget.

25 COUNCIL MEMBER BARRON: There you

1
2 go.

3 CHAIRPERSON RIVERA: We were
4 actually at Lincoln Hospital on Friday and there
5 was a lot of stress in the hospital because of the
6 budget cuts coming from the state and how it's
7 going to impact IHHC here in the city, so there's
8 stress all over the place.

9 Thank you, Council Member. Thank
10 you. I'm going to turn it over to my co-chair,
11 Council Member Helen Sears.

12 CHAIRPERSON SEARS: Thank you very
13 much.

14 I think considering that we sit a
15 lot, and I have to agree with Councilman Barron,
16 that our lack of exercise and, I find the longer
17 you wait to eat--I think that you had a very good
18 point about when is it time to feed to eat because
19 I know like all of us, we go around to the
20 schools, there's Career Day and I can tell you
21 some of those kids, of course, because of the
22 overcrowding, are having their lunch at 10 o'clock
23 in the morning, certainly in my district they do
24 that. Then they're allowed to have a snack late
25 in the afternoon and it's all when you're hungry,

1
2 it seems that fat seems to soothe that. So it
3 seems to me that we should be able to begin to
4 tackle the problem in a different way, maybe in a
5 way--and I was just discussing that with my co-
6 chair, and I think we need to look at how we can
7 address and educating in a way a directory of
8 exactly really just advising what are the foods to
9 eat maybe that are better in the a.m., what's
10 better in the afternoon, and what's better in the
11 p.m.

12 And I think we need to do that
13 because with the myriad of the different foods,
14 fast foods, everything like that and people--I
15 know we eat so irregular, when we do eat, we're
16 famished and then we just chew down everything at
17 three in the afternoon, because we haven't had
18 breakfast or lunch. That's bad to do that and I
19 think many people do and we don't really pay
20 attention to the consequences of what that does to
21 us by doing that. Which leads me to the question
22 that because there's the uniqueness of women's
23 symptoms for heart attack, does HHC train their
24 professional staff to identify what those symptoms
25 are because they're separate and apart from men

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experiencing heart attacks?

DR. SCHORI: Yes, that was part of the training medical staff and providers that I mentioned as part of the initiatives. And they've even started training medical students now to look at--which they should've done a while ago--men and women are not the same, the symptoms for many things, not just this, are not the same, the outcomes aren't the same, the risk factors aren't the same, and the response to treatment is not the same, and I think one of the issues with some of the research we have available to us is if you look at who's in any study just about, it's always way more men than women and it's always not racially diverse. So there's a huge influence now to have so-called translational research, which is focusing on racial and ethnic and gender and look at things the way they should be looked at to make appropriate evidence-based recommendations for what's best.

CHAIRPERSON SEARS: That's good, because I think, particularly as Chair of the Women's Committee that more and more of these health indices seem to be rising in women and I

1
2 think that Chair Joel Rivera really has a point
3 when he's talking about really isolating women
4 from men when it comes to certain health indices
5 and we don't do that, and it seems like it's about
6 time that we should because the symptoms are
7 different for almost anything, the treatment is
8 different, the bodies are different. Would that
9 be a problem to do that? And I'm not talking
10 about financially, but is that a problem for the
11 medical community to do that? Because I know you
12 deal globally with hearts and you're dealing just
13 with all of the issues, it's a very global picture
14 in dealing with it, but if some of these issues
15 were to be separated and directed directly at
16 women's issues, is that a problem for the medical-
17 -

18 DR. SCHORI: [Interposing] That does
19 happen within the individual clinics and there
20 actually are some facilities that have clinic just
21 for women with risk of heart disease, that's not
22 the preponderance of them, and the way that
23 becomes a problem is let's say you're at risk for
24 heart disease, well I don't want to focus on the
25 heart disease and forget about that I should be

1
2 bringing in breast cancer screening, colon cancer
3 screening, smoking cessation, and any other risk
4 factors you may have. That's why when I talked
5 about the Take Care New York goals, the number one
6 of importance is the primary care provider who
7 coordinates the care and focuses on all the
8 preventive health and screening that apply to you
9 the individual, whether by gender, ethnicity, what
10 is it you the individual are at risk for and
11 should be screened for and have discussed with
12 you.

13 CHAIRPERSON SEARS: All right. And
14 just one other question, for salt and the fact
15 that there's so much of it in food, is it
16 possible--and one of the reasons salt is used, not
17 only to preserve something, but it also makes the
18 food taste better, there seems to be, particularly
19 in certain groups, they need a lot of salt--is it
20 possible that the Health Department looks at what
21 might be alternatives to that salt reduction, that
22 somehow we would be able to give out to our local
23 restaurants? And I think that the Council is a
24 great resource for that.

25 DR. SCHORI: I'll let Dr. Silver

1
2 answer that, but first, again, I want to brag a
3 little bit. One of the things we do at Lincoln is
4 for, again, you hit the nail right on the head,
5 different ethnic groups in different countries of
6 origin have different ways of cooking and
7 different things they like to eat and if I give
8 you the diet that's appropriate for the average
9 blah, blah, blah American, that's got nothing to
10 do with the diet you're really eating so what did
11 I do for you, I just confused you. So we actually
12 have ethnic-related cooking classes and diets
13 related to what you are used to eating and how we
14 can adapt that to what's in your best interest for
15 health and we've started doing that sometime back
16 'cause otherwise I'm really not communicating
17 again to the individual needs of that individual,
18 which is key to change outcomes. And I'll let Dr.
19 Silver answer the rest.

20 [Pause]

21 CHAIRPERSON SEARS: Press the
22 button.

23 DR. SILVER: Certainly salt affects
24 taste, although it's one of many, many options for
25 conferring good taste on food and one thing we're

1
2 doing is encouraging a wider use of alternative
3 flavorings to salt, but at least the experience
4 from the United Kingdom where they've been working
5 with salt reduction across the industry for a
6 number of years is that if you reduced salt
7 gradually in products and across a wide range of
8 products, people's palates adjust and they don't
9 perceive it. If you change it suddenly, things
10 taste tasteless, but if you come down gradually,
11 what you would've considered normal yesterday,
12 starts tasting very salty to you and what you're
13 eating today tastes fine. So part of it is just
14 gradual adaptation of palates.

15 Some manufacturers have used salt
16 substitutes and other products, we're not
17 recommending any of those specific products and I
18 don't think we'd be supplying alternatives,
19 particularly in general, it's more of an
20 adjustment of recipe issue. Also many restaurants
21 get their supplies from large national
22 manufacturers.

23 CHAIRPERSON SEARS: Thank you.

24 Thank you, Mr. Chair.

25 CHAIRPERSON RIVERA: Thank you very

1
2 much.

3 [Off mic]

4 CHAIRPERSON RIVERA: Okay. One of
5 the things it's tough to kick the habit of salt
6 and a lot of these different things that we add
7 into our recipes. One of the remedies to that
8 I've found is train for a marathon because when I
9 was training for the New York City Marathon, they
10 said you have to increase your carbohydrate diet
11 and you have to increase your salt intake because
12 you can get a sodium deficiency and you could
13 actually die. So the way I found a way to
14 actually have all the stuff I like to eat is train
15 for a marathon. So anyone who doesn't want to
16 give up salt or doesn't want to give pasta or rice
17 or things of that nature, the New York City
18 Marathon's a good way to not have to kick that
19 habit.

20 I know Council Member Gonzalez and
21 then Council Member Inez Dickens have questions.

22 COUNCIL MEMBER GONZALEZ: Thank you,
23 Chair. I just want to go back to the issue here,
24 heart disease among women and the question I have
25 is, in listening to your testimony, all the

1
2 recommendations, it seems to me that we have a lot
3 of the answers, yet you're saying that the way you
4 disseminate this information or you have brought
5 this information out to the communities is through
6 senior centers you stated and what other method?
7 Because I can think of other methods where I'm
8 immediately, just by having this information, that
9 we can sort of bring it around to the community.
10 Especially in my community where a lot of the
11 women don't always attend senior centers, or
12 perhaps even in the congregations, perhaps
13 community board meetings, perhaps even just
14 training people in CBOs or bringing information to
15 community-based organizations that they can go out
16 and disseminate and the work they do, because you
17 spoke a lot about a lot of other issues, which are
18 important that you're going out there as well
19 speaking about in respect to health. So along
20 with that, it sounds to me that there are barriers
21 just for women to understand that they can get
22 heart disease, just understanding that seems to be
23 an issue.

24 So what are the methods and what
25 can we do as a Council and as a Council Member to

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assist you to bring that message forward?

DR. SCHORI: Well just to give you an idea of when I started in 2004 we didn't even have a heart disease program, so the heart disease program was created in late 2004 initially with two people, we're considerably larger at this point. Because it was such a small program, we concentrated on trying to work on environmental changes that we thought would benefit large number of residents and reduce risk factors, such as trans fat, food procurement, that had a large multiplicative effect, but our ability to provide grassroots on the ground campaigns in the community specific to heart disease has been somewhat limited by staff. We really have just one full-time community person right now and then we have some people that are working full-time on specific campaigns in the high-risk communities, like blood pressure monitoring.

So whether at senior centers or other venues, we don't have a huge capacity because of the very limited budget of the program to do a large amount of grassroots organizing and education. So the funding issue has been critical

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on that.

We agree with you that there are many places where you could work to help educate women, but we would also say that a lot of the behavioral risk factors for cardiovascular disease are influenced by fixed characteristics of our environment--what kinds of foods are out there, what kind of ability to exercise is out there--and if we can shift the balance on some of those, we may be able to provide long-term benefit for reducing cardiovascular disease.

COUNCIL MEMBER GONZALEZ: I strongly agree, but I also think that information is vital and I mean even though these are tough economic times, I believe that if we stay together on this, even if it meant that you would have some type of a forum where community-based individuals, whomever they designate, could be there where you could give them the information, you wouldn't have to go to them, they could come to you, that sort of things.

I remember years ago, we did a lot of work with Department of Health and HIV/AIDS and there was a lot of training that when on where it

1
2 wasn't that they were coming to the organizations
3 in the neighborhoods, but that the neighborhoods
4 were coming seeking information to the Department
5 of Health, so that we in turn could bring it back
6 to the community. So I think that could still be
7 a method of reaching people. I mean I have some
8 ideas already and I'd like to maybe reach out to
9 you after--

10 DR. SCHORI: [Interposing] We'd love
11 that, we need do do some work, we've trained, for
12 examples, 460 or 70 people in faith-based
13 organizations and centers and set up volunteer
14 blood pressure monitoring programs, we've been
15 working particularly with the ecumenical councils
16 in several of the boroughs to try and train people
17 from health ministries, we have the Brooklyn
18 Hypertension Task Force, which has been working
19 also to provide education, but still not on the
20 scale we'd like, and if you have ideas we'd be
21 delighted to [crosstalk]--

22 COUNCIL MEMBER GONZALEZ:

23 [Interposing] Definitely and I know that a lot of
24 us Council Members, we sent out a lot of
25 literature and mail outs in respect to heart

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2 disease and sort of small in comparison, but
3 enough to send the message, so I think that that's
4 the way to go. We do have the information, so I
5 think it's important to reach those communities
6 that don't make it to those senior centers and
7 those people that, for whatever reason, they're
8 still--the other thing is, I wanted to ask you
9 linguistically, is there anything that says
10 exactly what you're telling me here in respect to
11 signs and barriers and all this in language that
12 would be appropriate, for example, in my
13 communities that are Mandarin, Cantonese, Spanish,
14 so on and so forth? Do you have that material
15 that I may be able to duplicate or...?

16 DR. SCHORI: Pretty much all of our
17 materials are at least translated into Spanish
18 and, whenever possible, we translate them,
19 depending on budget constraints, into additional
20 languages including Russian, Chinese, and Urdu,
21 but that tends to be funding dependent, but
22 Spanish is--

23 COUNCIL MEMBER GONZALEZ:

24 [Interposing] Again, right, exactly, it always
25 goes back to money, but--

1
2 DR. SCHORI: --Spanish is a basic
3 one.

4 COUNCIL MEMBER GONZALEZ: Right, but
5 I think we need to look at that, especially in my
6 community, I know that we're like 28% and counting
7 in respect to Asian and it's Cantonese, Mandarin,
8 and so I think that's something that I will look
9 at it as an elected official and maybe try to work
10 with you.

11 But I thank you, Chairs.

12 COUNCIL MEMBER DICKENS: Thank you
13 so much, Chairs. And thank you for your
14 testimony.

15 And I congratulate Lincoln Hospital
16 for the Gold Performance Achievement Award, but I
17 was very interested in something you said, and
18 that's because food preparation impacts upon the
19 health of a woman and the entire family. And if
20 the woman is reeducated in food preparation and
21 other available food products that would be
22 nutritious, yet more healthy for us, then I'm
23 interested in that because ethnic cooking
24 certainly does affect our health and Harlem
25 Hospital has a women's heart disease program, but

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2 I have not heard about the food preparation as a
3 part of that.

4 That's one, and, two, since you
5 have already done a lot of outreach within our
6 religious institutions and our churches, in Latino
7 and black communities on Sundays frequently we
8 serve dinner after service and on Fridays we have
9 fish fries. And maybe if you made that education
10 that you're doing with the religious institutions
11 a part and made the culinary education, the food
12 preparation a part of that, maybe come in, one
13 Sunday after--if you could get several of the
14 churches together and teach those that cook within
15 our churches about a way to prepare our ethnic
16 food in a way that does not have so much salt
17 added. So have you thought about something like
18 that? Because I was listening to you and I said
19 it's excellent that you're reaching out to our
20 churches, but we prepare--as hardly a church I can
21 think of that doesn't prepare food on Sunday.

22 So have you thought about something
23 like that?

24 DR. SCHORI: We maintain that
25 education within the patient population in the

1
2 hospital through our nutritionist, etc., but not
3 out in the community. They give the education,
4 but we don't have anybody who's, for example,
5 would go to a church setting, but that doesn't
6 mean that can't be done.

7 COUNCIL MEMBER DICKENS: But yeah,
8 because the reason I said that because I know the
9 budget is tight, however, if maybe the person that
10 does it at the hospital or Mondays through
11 Fridays, if they took off Thursday and they went
12 Sunday instead to--if you could do something like
13 that, get several churches together to educate us
14 in how to prepare food that would be tasty,
15 nutritious, and yet without so much salt. For
16 instance, fried chicken, I love fried chicken, my
17 body mass index is thick ,I'm sure, and I love it
18 with a lot of salt, unfortunately. But if you
19 could educate--and I eat dinner after service on
20 Sunday at church, the same fried chicken.

21 So if you could help to maybe find
22 a different way of doing outreach, particularly in
23 the food preparation area, I think that would go a
24 long way to helping--because it's mostly women who
25 attend churches by the way--it would go a long way

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2 in doing further outreach, other than just within
3 a acute care hospital setting.

4 DR. SILVER: We love that idea as
5 well and it had been our plans for our community
6 work to do trainings with people who cook for the
7 churches, we've done a little bit of it, but we
8 haven't been able to do as much as we wanted
9 because our small number of community staff, we
10 actually just got one more person on heart
11 disease, so I hope we'll be able to increase that
12 work at least in Brooklyn, but we think it's a
13 great idea as well.

14 The other area that we've worked
15 with has been trying to train health providers to
16 talk to their patients about nutrition, hoping to
17 have sort of more of a multiplicative effect. So
18 we have trained over 2,000 primary care providers
19 and their staff in how to talk to patients about
20 nutrition and giving them plate planners and
21 bottles that show how much sugar soda has in it
22 and other kind of simple tools that help them talk
23 to people about nutrition and we hope also to
24 reach women through that mechanism as well. But
25 we love the church cooks idea as well.

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2 COUNCIL MEMBER DICKENS: I think
3 that's great, but you know in the Latino and
4 African-American communities, frequently we don't
5 have a primary health care provider and
6 frequently, as was stated in the slide, we don't
7 even seek medical treatment or access until we're
8 feeling so terribly bad that we're already in
9 trouble, and that's why I'm so concerned about
10 finding other ways of doing outreach to educate
11 our communities.

12 So I'd be willing to help you and
13 work with you in any way possible on something
14 like that, so please call my office, any way that
15 I can help with that because this is so very, very
16 important.

17 Lastly, you mentioned that the
18 Bronx, the residents from what you have been able
19 to ascertain, have indicated that they do no
20 exercise and since the Bronx has left the house
21 except for my Chair, and I thought I would be
22 slightly competitive in this, does that mean that
23 the Harlem residents are more active and in better
24 health?

25 DR. SILVER: Well I know there's at

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least one--

COUNCIL MEMBER DICKENS: That's unfair, Chairman.

DR. SILVER: --I know there's at least one Bronx resident who runs the marathon.

I actually don't have with me the comparative data on physical activity levels between the Bronx and Harlem, but I can get those and send them to you.

COUNCIL MEMBER DICKENS: [Off mic] Referring really to the slide show that indicated that activity exercise was down in the Bronx and so I was just wondering, what does that mean as it relates to maybe some of the other boroughs. Thank you so much.

[Pause]

CHAIRPERSON RIVERA: Member James Sanders from Queens.

Ladies, thank you very much.

The next panel will be Mary Ann McLaughlin, M.D., from the American Heart Association. We have Holly S Andersen from the Ronald O. Perelman Heart Institute, we have Hannah Lipman, M.D., from Montefiore Medical Center and

also from Montefiore Medical Center, Cynthia Taub.

[Pause]

Okay. So whichever one wants to begin, just state your name for the record and proceed with your testimony.

DR. MARY ANN MCLAUGHLIN: Hi, I'm Dr. Mary Ann McLaughlin.

Good afternoon, Chairperson Rivera, Chairperson Sears, Members of the Council, my friends and colleagues here, and especially the students, it's great to see you coming downtown for this.

I'm Dr. Mary Ann McLaughlin, I am a cardiologist and associate professor from Mt. Sinai School of Medicine. I'm a member of the board of directors from the American Heart Association and I'm here on behalf of the American Heart Association today. I would like to thank you for holding today's oversight hearing and giving us the opportunity to discuss the issue of women and cardiovascular disease.

The American Heart Association is the largest voluntary organization in the world dedicated to the reduction of disability and death

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2 due to heart disease and stroke--the number one
3 and three causes of death and disability. To
4 achieve this mission, we fund research, develop
5 benchmark treatment guidelines, implement
6 educational and awareness programs, and advocate
7 for policies that will reduce the incidence of
8 cardiovascular disease.

9 As the Association looks at ways to
10 have the greatest impact in reducing the number of
11 those affected by cardiovascular disease, we have
12 targeted our efforts to focus on population where
13 improvements are most needed. That, in turn, has
14 led us to focus on raising awareness of women's
15 risk for heart disease and stroke.

16 As we've already heard, more women
17 die of cardiovascular disease each year. In the
18 United States, 450,000 women die as a result of
19 cardiovascular disease, and in New York City, an
20 average of 32 women are lost every day--killing
21 more women than the next five causes of death
22 combined.

23 Despite these facts, there
24 continues to be a lack of awareness that women are
25 at risk. A 2006 survey conducted by the American

1
2 Heart Association found that 43% of women were
3 unaware that heart disease was the leading cause
4 of death for their gender. The level of awareness
5 was lowest among black and Hispanic women, who are
6 also disproportionately afflicted with heart
7 disease. Only 31% of black women and 29% of
8 Hispanic women knew that heart disease was their
9 greatest health risk. Given the diversity of New
10 York City's population and the prevalence of risk
11 factors for coronary vascular disease, this is
12 particularly troubling.

13 There is also a lack of awareness
14 among health care providers. A 2005 study found
15 that fewer than one in five physicians knew that
16 more women die as a result of cardiovascular
17 disease each year. Studies have shown that
18 physicians' perception that women are at lower
19 risk results in suboptimal preventive care and
20 worse outcomes. We know that physicians are less
21 likely to address cardiovascular prevention
22 therapies, such as diet and exercise with women,
23 that women are at risk for CVD are often not
24 referred for the same diagnosing testing that men
25 receive. The cumulative effect of this lack of

1
2 awareness is that women with acute coronary
3 syndromes are more likely to have adverse
4 outcomes, including death, heart attack, stroke,
5 or re-hospitalization, even after adjusting for
6 age differences.

7 To address this disparity in care
8 and reduce the overall burden of cardiovascular
9 disease, the American Heart Association is
10 implementing public awareness and education
11 campaigns with the help of our partners like the
12 New York City Department of Health, and we are
13 advocating for policy changes and I'm happy to
14 describe more of those in detail at the end of my
15 testimony if you'd like.

16 At the federal level, we are
17 working for passage of the HEART for Women Act,
18 which would raise awareness among women and health
19 care providers, provide gender and race-specific
20 data for researchers and clinicians, and expand
21 screening for low-income women.

22 In New York City, we urge you to
23 continue with the great work you have done around
24 prevention policies. Initiatives like the Smoke-
25 Free Air Act, the trans fat ban, and the Green

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2 Carts have made New York City a leader in
3 prevention and have set the standard for other
4 jurisdictions.

5 To continue with that success, it's
6 vital that the City maintain funding for the
7 Department of Health and Mental Hygiene,
8 particularly the cardiovascular disease and
9 tobacco control programs. We also need to
10 continue working to expand access to quality
11 health care and prevention services and maintain
12 our commitment to community-wide nutrition and
13 physical activity initiatives. Of particular
14 importance is the need to ensure that all New York
15 City children are receiving quality physical
16 education instruction at school.

17 Unfortunately, we know that there
18 is currently a widespread failure to do so and we
19 know that especially in the Bronx.

20 The American Heart Association
21 would also urge you to examine New York City's
22 emergency chain of survival. It is critical that
23 those already suffering from cardiovascular
24 disease will recognize their signs and symptoms in
25 an emergency, contact 9-1-1, receive quick

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2 assistance from emergency medical services, and be
3 routed to the appropriate care center. There is
4 room for improvement in New York City. Our
5 cardiac arrest survival rate is just 3%, compared
6 with 6% nationally. We need to examine why that is
7 and take action to improve it. We urge the
8 Council to take a look at the Introductions 667
9 and 76, which would both make improvements to the
10 EMS link in the chain of survival by improving the
11 accuracy of reported response times.

12 Working together, we can help to
13 eliminate health disparities and improve the
14 health of all New Yorkers.

15 Earlier, we talked about ways we
16 could reach women in other settings and I have
17 three suggestions. One is partnering with
18 gynecologists. We know that women in their 20s,
19 30s, and 40s, that's their primary care provider,
20 they just go to the gynecologist for their care
21 and I think that those physicians need to partner
22 with a cardiologist to really improve their
23 recognition and discussion of cardiac risk factors
24 there because by the time they get into their 50s
25 and they're going through menopause and they go to

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2 a primary care provider and internist, it's too
3 late. That's number one.

4 Number two, is to educate the
5 family members of the men that are undergoing
6 cardiac procedures, right? So the spouses that
7 are in the waiting room. There was a study done
8 by Dr. Monsey at Columbia recently where she went
9 and targeted everyone in the waiting rooms and
10 checked their blood pressures and their
11 cholesterols and found them to be at risk, and I
12 think that's a great idea that should be more
13 widespread.

14 And third, educating the children.
15 We know it's the children in the early, early ages
16 in third grade to fifth grade that we can make an
17 impact with diet--even in the first grade. My
18 kindergartner tells me not to drink soda because
19 it's bad for me and if we can teach the children
20 to cook correctly and they can bring it home and
21 cook for their parents and show them in the
22 teenage years, I think that's the way to change
23 the patterns longitudinally.

24 So thank you again for this
25 opportunity to testify and I look forward to our

1
2 further discussion. Thank you.

3 DR. HOLLY ANDERSEN: Hi, thank you,
4 Councilmen, Chairmen Rivera and the Council.

5 I'm Dr. Holly Andersen, I'm a
6 practicing cardiologist and I am the Director of
7 Education and Outreach for the Ronald O. Perelman
8 Heart Institute at the New York Presbyterian
9 Hospital-Weill-Cornell Medical Center.

10 This past week, I was at the third
11 annual conference for Women and Heart Disease
12 sponsored by the American College of Cardiology
13 and I assure you the information I have is up-to-
14 date and I would love to comment on some of the
15 great questions that you spoke about earlier--
16 salt, milk, and outreach.

17 But you've heard a lot of
18 statistics and I want to just kind of paint this
19 visual, more personal one. Today, in the United
20 States and in New York City, a woman who is having
21 a heart attack will wait longer before presenting
22 to an emergency room; she will be less likely to
23 have the classic symptom of crushing chest pain;
24 she will be less likely to have a diagnostic
25 electrocardiogram; not surprisingly, she will be

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2 less likely to be diagnosed correctly. But even
3 if she is diagnosed correctly, she will be less
4 likely to receive all the life-saving therapies we
5 have today to treat heart disease and if the
6 decision is actually made to give her these
7 therapies, they will be given on average at a
8 significant time delay compared to a man.

9 And for those of us who treat heart
10 attacks, we have a saying that time is muscle.
11 And even if you control for all of these
12 variables, a woman will still be more likely to
13 die from her heart attack than a man and it is the
14 youngest women who have the greatest death
15 discrepancy rates compared to the youngest men and
16 we don't know why.

17 If this woman is fortunate enough
18 to survive her heart attack, upon discharge she
19 will be less likely to be referred to a
20 cardiologist, she will be less likely to attend
21 cardiac rehab, and she will be less likely to
22 receive all the life-extending medicines we have
23 today, and if they are given to her, they will be
24 given, more likely, at suboptimal dosages.

25 You've heard that heart disease is

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2 our number one killer, but what you also need to
3 hear is this is not just a disease of older women.
4 Nine thousand heart attacks occurred in the United
5 States last year in women under the age of 45,
6 16,000 heart-related deaths occurred, and 40,000
7 heart-related hospitalizations occurred in women
8 younger than the age of 55. And once--and this is
9 always true--once a woman is diagnosed with heart
10 disease, she will do worse and will be more likely
11 to die from it than a man.

12 I have provided you statistics
13 about sudden cardiac death and the use of
14 implantable defibrillators and I could give you
15 statistics about patients with congestive heart
16 failure and acute coronary syndrome and you will
17 find the same thing--that even today, women are
18 understudied, treated less aggressively and fare
19 worse than men.

20 It is 2009, I started speaking
21 about women and heart disease in 1995 and not too
22 many people were speaking about it then and very
23 few people were interested. When I spoke to
24 groups of women, they were outraged, no one had
25 ever told them that they could die of heart

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2 disease. Today, awareness is much better. As
3 you've heard, 57% of American women understand
4 that heart disease is the number one cause of
5 death among American women, but these women don't
6 personalize that risk. Eighty-three percent of
7 those who know it, don't think that it applies to
8 them.

9 So has our increased awareness
10 translated into better outcomes? Yes, death rates
11 due to heart disease have been declining for
12 decades in men and, yes, just more recently in
13 women and just a little bit, but there's a very
14 alarming statistic emerging and that is death
15 rates due to heart disease in our youngest adults
16 is increasing and has been increasing since the
17 year 2000 and it's increasing faster among our
18 young women.

19 We need to do a better job. We
20 need to educate our women, we need to educate
21 girls, we need to educate health care providers--
22 cardiologists, internists, gynecologists that we
23 talked about, emergency medicine personnel. In
24 fact, there's a report--I think you caught it--two
25 weeks ago from our colleagues in Boston that said

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2 after women called 9-1-1, they were 52% more
3 likely to experience delay getting back to the
4 hospital. And we need to educate men because it's
5 their number one killer too and increasing
6 awareness is critical.

7 I'm excited about being involved
8 with the Ronald O. Perelman Heart Institute. The
9 establishment of this institute really confirms
10 our commitment to provide the best cardiovascular
11 care in the world. Currently, New York Hospital
12 is ranked number one in the city by US News &
13 World Report and number six in the nation. This
14 Institute will allow us to expand on our cardiac
15 care expertise, to do translational and clinical
16 research, and to advance minimally invasive
17 procedures that can quicken hospitalizations and
18 quicken recoveries.

19 And a core part of this institution
20 is outreach and education because we know that
21 improving education and understanding of this
22 disease in our society will save lives. It will
23 also save money because it's much, much better to
24 prevent disease and much more cost-effective than
25 to treat it.

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2 I will tell you that a fundamental
3 focus of this institute will be to advance the
4 understanding, prevention and heart disease in
5 women and I look forward to working with you to
6 make New York City a leader in this campaign and
7 to make this city a healthier one. Thank you.

8 DR. HANNAH LIPMAN: Hi, thank you,
9 Chairperson Rivera and Members of the Council.

10 My name is Hannah Lipman, I am a
11 Geriatric Cardiologist at Montefiore in the Bronx.
12 And I wanted to come today just to give a
13 different perspective as a geriatrician who
14 primarily practices with old people with heart
15 disease.

16 I just wanted to highlight two
17 statistics that stood out to me from the previous
18 presentations. One, on one of the slides it said
19 that the incidents of symptoms from heart disease
20 rises in those women over 65 to one in three and
21 also in her comments, one of the previous speakers
22 mentioned that in order to reach women with our
23 targeted education campaigns, there were more
24 women participating in the activities in senior
25 centers. We know that most heart diseases are

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2 diseases of aging and women outlive men, so I
3 wanted to give a flavor of what it means to me to
4 take care of old women with heart disease. And I
5 thought of three patients that I've treated
6 recently that I'll just tell you two sentences
7 about each one and they're not the typical face of
8 heart disease that we think about, but one is an
9 88-year-old woman who came to see me in my office
10 who values most her ability to read for pleasure
11 and her independence above anything else. She has
12 what's called severe aortic stenosis, which is a
13 valvular disease that has no medical treatment,
14 only surgical treatment, but, because of her
15 frailty, she does not want to undergo heart
16 surgery--too big of risk, too strenuous a recovery
17 for her. And she wants to live as well as she can
18 as long as she can.

19 So I see my job as her cardiologist
20 to help her understand how to live with her
21 disease and plan for the symptoms that will
22 inevitably arise from it and to see her through
23 her illness even though there is no cure.

24 There are also women in nursing
25 homes. An 82-year-old woman I recently treated

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2 from a nursing home who had three admissions to
3 the hospital for a refractory angina chest pain.
4 We debated back and forth with her family about
5 whether she was strong enough to undergo the
6 current best medical practice, which is to do a
7 cardiac cath and hopefully an angioplasty and,
8 after enormous amount of considered discussion, we
9 decided to undertake that risk on her behalf and
10 she did well.

11 And the third is a 76-year-old
12 woman who has a very long history of coronary
13 disease, who has already undergone bypass, but has
14 now congestive heart failure and multiple
15 recurrent, monthly almost, admissions to the
16 hospital even in the intensive care unit with
17 intubation and mechanical ventilation and she's
18 wondering, what do I do next if I don't want to
19 come to the hospital monthly.

20 I just tell you about these women
21 because, of course, the targeting young people,
22 education, outreach, prevention of heart disease
23 is obviously the number one priority, but there
24 are enormous number of older women who are coping
25 with multiple medical problems, multiple family

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2 responsibilities who are in our communities trying
3 to live with the heart disease that they already
4 have and I wanted to represent their voice here.

5 For these women, we already know
6 that women like these three women are not in our
7 evidence base. As a physician I can't turn to a
8 randomized control trial to say what do I need to
9 do to treat this person, she doesn't match any of
10 the people in the trials, so each decision must be
11 individualized based on what I know from the
12 evidence extrapolated to her particular situation
13 after careful consideration of her other diseases,
14 her quality of life, and her goals.

15 And I just wanted to say that the
16 theme of education that Chairperson Sears raised,
17 I think is equally important for these older women
18 who already have heart disease. Senior centers
19 are an amazing network for education, support, and
20 chronic disease management, as well as the home
21 attendant services that are provided that take
22 care of these women in their community.

23 And I think that's about what I
24 wanted to say.

25 DR. CYNTHIA TAUB: My name is

1
2 Cynthia Taub, I'm a cardiologist from Montefiore
3 Medical Center, I'm the director of non-invasive
4 cardiology at the Weiler campus of Montefiore.

5 I would like to take this
6 opportunity to make three points on the issue of
7 young women and heart disease. Number one, as we
8 all know, the risk for death after heart attacks
9 is substantially higher in women than men, but
10 only among the younger age groups. Based on a
11 study performed by researchers from Yale
12 University, women aged 50 or younger had a nearly
13 50% higher risk of death within two years of
14 discharge than men did. While the basis for sex
15 disparities in mortality among young patients is
16 unclear, the implication of this issue is
17 significant. Sex differences in access to care
18 and quality of care in this patient population are
19 relatively unknown. Obstacles to higher quality
20 of care for women may relate to many factors,
21 including personal preferences, differences in the
22 perception and reporting of their symptoms, and
23 lack of coordination with diverse healthcare
24 givers, for example, internists, cardiologists,
25 and gynecologists.

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2 Number two, data on minority women
3 with heart disease are very limited. However, it
4 is suggested that minority women carry an even
5 greater burden of heart disease than white women.
6 Biological and socioeconomic factors related to
7 racial disparity are poorly understood.

8 Number three, the role of
9 demographic, clinical, and psychosocial factors on
10 the excess mortality risk in young women,
11 particularly minority women, is not clear. It has
12 been suggested that low socioeconomic class, low
13 education level, double work loads of employment
14 and family responsibilities are more powerful risk
15 factors for post-heart attack adverse outcomes.
16 Women often work outside the home, in addition to
17 their roles as household managers, mothers, wives,
18 and caregivers to elderly parents, and the impact
19 of these roles on outcomes after heart attack has
20 not been investigated.

21 So the bottom line is the society
22 needs to be aware that there is gender disparity
23 in heart disease outcome, and we, as physicians,
24 need support to pursue science behind this.
25 That's it.

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2 CHAIRPERSON RIVERA: Thank you very
3 much. I think your testimonies have been very
4 enlightening, especially the one about reaching
5 out to gynecologists and dealing directly with
6 them since they are the frontline for women's
7 health. I think that's a great idea, we'll take
8 that concept and we'll bring it to the Department
9 of Health, see if they can implement that.

10 Also, it's a trend that has been
11 increasing and it's troubling the fact that women
12 are not getting adequate care in a timely fashion
13 and how do end that. I think that it's going to
14 be an ongoing discussion because obviously it's
15 something that takes time, it's something that we
16 have to do by reaching out to women within the
17 city of New York, like you just stated. Women are
18 not only mothers, they are also bosses at a lot of
19 companies, they're also hard working employees and
20 they are the frontline support in the house and
21 breadwinners for most households as well, so it's
22 a double duty and we got to make sure that they
23 understand that their health is impacted by high
24 stress levels and poor diet and lack of exercise
25 and how can we implement programs that'll reduce

1
2 stress, have better diet, and increase physical
3 activity.

4 So I want to thank you definitely
5 for coming here and joining us here today.

6 Does anybody have any questions?
7 Council Member [off mic] James Sanders.

8 COUNCIL MEMBER SANDERS: Thank you,
9 Mr. Chair.

10 To the panel, you gave an excellent
11 presentation, although the facts were depressing
12 and outrageous. I was sitting and just--I thought
13 I knew the subject well and was just growing more
14 stunned as the facts accumulated and, of course,
15 the thought went to me imagine if we, as a society
16 would just take the money for the Iraq war for one
17 day and put it into this type of research, imagine
18 what we could have done. There I go thinking
19 again, it gets me in trouble.

20 What do you suggest that the
21 Council do about this issue? Now it's one thing
22 to present these facts, it's another thing to
23 marshal our forces, bully pulpit or otherwise, to
24 do something about it. What would you give us as
25 marching orders? Anyone?

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2 DR. ANDERSEN: Well I think the City
3 Council has a great opportunity to talk with so
4 many different cross sections of this city, so
5 many Department of Education, the Department of
6 Transport, Department of Sanitation--every single
7 part of this city which you come in contact with,
8 you can help us increase their awareness. And it
9 may be something little, it may be something we
10 can get to you and come up with some kind of
11 healthy tips, but if you can start talking to the
12 heads of all these other organizations that you
13 meet with and communicate with in New York and you
14 start making them understand how important it is,
15 days missed, the health care cost that we have by
16 just trying to increase awareness in all of New
17 York City's employees, that will be--I mean a few
18 moments of you to them and a few moments of them
19 to all their employees could really make a
20 difference.

21 DR. MCLAUGHLIN: Yeah, I agree with
22 Dr. Andersen that you have widespread influence
23 and I think another issue is the working mother,
24 right? So that's the population that they're such
25 at high risk and there's no time for them to

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2 exercise or to eat as healthy, right? So I work
3 with these women, they work for me, with me, they
4 work all day, they come home, they get the kids
5 home from school, do their homework. If we can
6 ensure that there's a place in the workplace, if
7 you can influence more employers to have even
8 small, little exercise rooms or gyms with one or
9 two treadmills that people could do in their lunch
10 hour and then ways to provide maybe healthier
11 meals that they could take home, something near--
12 if you could talk to employers of big
13 organizations that way and reach out to them.
14 Because I think that I mean everyone I work with
15 it's the same thing, the medical systems, the
16 registrars, they come in, they work hard, they eat
17 a pizza for lunch, then they run home to take care
18 of their kids, and if we can build it into the
19 daily life more through your influence, I think
20 that's another option.

21 DR. ANDERSEN: I was thinking maybe
22 there could be a car on the subway trains, that
23 there's one just a workout club because the people
24 that commute back and forth every day, they like
25 there's no way I have time to exercise, I'm on the

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2 train an hour in the morning, I'm on the train the
3 hour afternoon, I'm like there should be a car on
4 these trains for you to go exercise. I'm sure the
5 city could make a lot of money on it.

6 Anyway, it's a bit facetious, but
7 it is hard in today's world for people to fit
8 everything in and physical activity in the
9 workplace and physical activity in the schools
10 really matters for concentration and productivity
11 and that is a great selling point.

12 DR. LIPMAN: I think that all the
13 education and outreach programs that have been
14 mentioned targeted at younger people will help the
15 patient population that I'm most concerned about
16 because they are the caregivers for my older
17 patients.

18 As far as I understand it, Council
19 has purview over senior centers, Meals on Wheels,
20 and some home attendant services, which could be--
21 they are untapped--well senior centers are tapped,
22 but home attendant services and Meals on Wheels
23 could be forums for delivery of patient education,
24 caregiver education, materials as well.

25 DR. TAUB: Agree with all of the

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above.

COUNCIL MEMBER DICKENS: Thank you very much. You know you talk about physical exercise, it's always been a thorn in my side that we're building schools today that have no gyms and it's just amazing, particularly in my district where we are so short of space, very overcrowded and our schools are very highly over-utilized, we literally have no gyms. We don't have any small area to exercise and there's no outdoors in which to do it. I have an intermediate and an elementary and when they were built, they didn't even thought enough to put a little recreation area on the roof and construct that building so that it could hold that.

Seems to me somehow we need to get the Department of Education and the Department of Health and the Council to come together for a hearing because I know that they're addressing the overcrowding of schools, but at the same time, it seems we try and do one thing and then we're creating another, because when I get into the schools and, particularly in the schools that do not have this space, at quarter to nine they're

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2 falling asleep, 'cause we're guest speakers
3 sometimes quite early, their lunch is served at 10
4 o'clock, then they have to do something to eat by
5 two o'clock. When they are picked up, they're put
6 into a car, they go back home and, literally,
7 literally we are creating an environment
8 completely opposed as to what you're talking
9 about.

10 So I think we need to look at how
11 we don't speak with a forked tongue in this city
12 and identify these things and then we do
13 otherwise. I think it's a major problem and it's
14 a growing problem, because we just do not have
15 space.

16 DR. ANDERSEN: I was just in
17 Atlanta, and I believe it was the Mayor of
18 Atlanta, I saw this program and it was a black
19 woman with hypertension and diabetes and she had
20 her own health scare and she decided to make a
21 difference in her own schools that didn't have a
22 lot of funding or space and she implemented a
23 program where all the children in her schools did
24 calisthenics, she called them physical exercise in
25 the morning in the classroom. They got up and did

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2 things right in the morning in the classroom, a
3 lot of them did them with music and they
4 implemented changes in their cafeteria and the
5 costs in the cafeteria went down remarkably well,
6 and the performance on these tests went up like
7 27% because kids were learning more and paying
8 attention just by doing physical activity next to
9 their desk or in front of the room. So that's
10 something that maybe you could push a little bit
11 too.

12 COUNCIL MEMBER DICKENS: That's a
13 thought. I really have to check if my schools do
14 that.

15 Just one other question, that with
16 your patients, do you recommend or advise
17 sometimes if there is a research program going on
18 that they join that program? 'Cause women seem to
19 be very reluctant to participate in research, do
20 you find that to be the case with your female
21 patients?

22 DR. MCLAUGHLIN: I just have to say
23 that Dr. Andersen trained me and I trained Dr.
24 Lipman, so I think that--and Dr. Lipman and I did
25 research together too, so it's interesting that we

1
2 all did not know each other would be here today
3 too. So that's our--

4 CHAIRPERSON RIVERA: Small world.

5 COUNCIL MEMBER DICKENS: Yes indeed.

6 DR. MCLAUGHLIN: --so that's how
7 small of a female community [crosstalk]--

8 DR. ANDERSEN: [Interposing] That
9 makes me the oldest.

10 DR. MCLAUGHLIN: Yes. But you know
11 what's interesting about research, yes, I
12 encourage my patients to go into research programs
13 and what I think is happening is the retired
14 women, the older women are maybe a little more
15 likely to do it, but everyone else is too busy
16 taking care of people, they're the caretakers and
17 they say I don't have time to even get on the
18 telephone and answer surveys and things.

19 But I have been more successful, we
20 did some hypertension studies and heart failure
21 studies in East and Central Harlem and there we
22 were able to have the women that were over 60 were
23 able to--they were interested in complying and
24 they actually did a hypertension project, and we
25 reduced blood pressure in Latinos and blacks in

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2 that community, we're about to publish it and what
3 was interesting is we had a nurse who called them
4 very frequently on the phone and asked them to
5 check their blood pressures and made sure they
6 were taking their medications and after the trial
7 was over, we held little focus groups and said
8 what was it that made a difference in how you took
9 care of yourself, was it how you talked to your
10 doctor? Was it how you did this, took your
11 medicines? And they said no, it was that they
12 took care of themselves first, like they finally
13 realized that in order to have a healthy family,
14 they needed to be healthy, and so then they
15 learned from our nurses to take care of themselves
16 to make their health a priority, and that was over
17 and over again, that women would say that.

18 DR. ANDERSEN: I have two quick
19 points and one is, we've known that it's very
20 difficult to enroll women in studies, but I don't
21 want to leave here with all these kind of
22 negative--I have some very optimistic news. One
23 is that we know that if the woman is the primary
24 investigator in the trial that trial will enroll
25 more women than if there is a man whose a primary

1
2 investigator in the trial. We are attracting more
3 women into cardiology, although it's very slow,
4 only 6% of adult practicing cardiologists are
5 women and what I think is really perhaps
6 optimistic and perhaps, Dr. McLaughlin, you found
7 this, women like, once they're in a study, they
8 like being in studies, they ask for the next one,
9 and we completed the biggest trial of women and
10 heart disease, the women's health initiative and
11 that is a huge population of women now that were
12 enrolled in trials in this country and they're
13 starting to tell their friends and their mothers
14 and their daughters, it's fun, it's good, do it.
15 So I think that this is an exciting time for
16 cardiology and really changing the direction here
17 of women and heart disease.

18 COUNCIL MEMBER DICKENS: Thank you.
19 That's very encouraging. And thank you very much,
20 because you've really been very informative.
21 Thank you.

22 CHAIRPERSON RIVERA: Do you get paid
23 to be in these studies? I know that some studies
24 and research groups they actually get like a
25 stipend or something?

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2 DR. MCLAUGHLIN: What happens is
3 depends on who's funding the study, right? So if
4 it's a federally funded study, sometimes they get
5 reimbursed for their transportation costs or their
6 time. So what the value of their time can vary on
7 who's funding it, so if the pharmaceutical company
8 is funding a study will often give more money for
9 their patient's time. And if it's something
10 that's an investigation like a new drug, they'll
11 be more likely to pay them more because it's
12 something--if it's something like a study we did,
13 we gave them transportation, five dollar metro
14 cards or something like that to get to and from
15 their visits.

16 But I do think that sometimes
17 that's an incentive, I do have some patients who
18 come to me and say do you have any studies 'cause
19 they do get--they like the ones that they get
20 reimbursed hundreds of dollars for, but those do
21 exist.

22 CHAIRPERSON RIVERA: I was going to
23 say 'cause the economy being what it is, you may
24 see an uptick in people taking part in studies to
25 make ends meet.

1
2 DR. MCLAUGHLIN: Right, but you
3 don't want to coerce them either and just--

4 CHAIRPERSON RIVERA: Yeah.

5 DR. MCLAUGHLIN: --so it's a fine
6 line we try not to--but we do acknowledge that
7 they're taking time out of their day, they're
8 coming to us, and going back home, and we
9 definitely should try to reimburse them fairly.

10 CHAIRPERSON RIVERA: I mean, I would
11 tend to--I've done this--there was a steady about
12 studies that came out a while ago and it said that
13 there are people who pharmaceutical companies they
14 target people who have done studies in the past
15 and had positive feedback for particular things,
16 so I tend to trust more the ones that are
17 federally funded that don't have that particular
18 type of rewards that pharmaceutical ones have.

19 So have you seen a difference in
20 the types of studies that have been done? Whether
21 it's done by a federal funded organization or done
22 by a privately funded organization?

23 DR. MCLAUGHLIN: It probably should
24 be pharmaceutical versus non-pharmaceutical study-

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CHAIRPERSON RIVERA: Okay.

DR. MCLAUGHLIN: --I would guess. I would say that, certainly of the federally funded studies that I'm aware of, one of the really emerging sentiments for women in these trials because we've really started trying to study our population of women, is that they want to do it for their daughters and their granddaughters, and that's something that's I think really emerging now, it's really important, because they understand that we need to understand women better.

CHAIRPERSON SEARS: Well, just one other, I would imagine that the length of the study determines just how many you do get to get into a study. What is approximately the shortest and longest of studies that you're familiar with?

DR. MCLAUGHLIN: So that's interesting, I mean, I think it's more the invasive miss of the study that can influence people. We've done studies that are a month-long where we take a blood sample and give them a drug overnight and see if it changes their blood and watch them for a month and we've done studies for

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2 the Framingham [phonetic] study goes on for 20
3 years. Once a year, they're asked to come in and
4 do a physical exam and give a blood sample and
5 give a hair sample and things like that. But I
6 think those patients get committed to those long-
7 term studies after the first year, it's like once
8 a year, and I think they're interested 'cause they
9 get to see all the results coming out about that.

10 But I think that what I've seen is
11 that patients, if we want to put them in a MRI
12 machine, forget it, like half of them don't even
13 want to go there, no matter how much money you
14 want to give them. Things like that may scare
15 people or drugs that really are in an early stage
16 of being investigated, they are much more with
17 leery about, something like that.

18 CHAIRPERSON SEARS: I would also
19 think that with the younger women and those who
20 are raising children, the length of the study
21 would have a lot to do with it. I mean, I--

22 DR. MCLAUGHLIN: You're right, the
23 actual time of the visits to, yes.

24 CHAIRPERSON SEARS: --I've raised
25 three children, and I've got six grandchildren and

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I don't think that I would think of a long --

DR. ANDERSEN: [Interposing] We're terrible--

CHAIRPERSON SEARS: --term study--

DR. ANDERSEN: --we're terrible at enrolling young women for all the obvious reasons you're saying and that's why, that's really where the mystery is, why are they dying more often and we don't know.

CHAIRPERSON SEARS: Thank you.

Councilwoman Dickens I think has a question.

COUNCIL MEMBER DICKENS: Thank you.

And thank you to the entire panel for all your suggestions and your information.

Dr. Andersen, in answer to my colleague's question--Council Member James Sanders--you gave us some very interesting suggestions, one quite nouveau, and that's the exercise in the subway.

But having said that, you did give a lot of interesting suggestions, one of which I'm going to ask my Chairs, if they can talk to the Department of Ed to ascertain what would be the cost, which I would think would be very minimal

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2 for our youth, particularly in light of the fact
3 that we don't have gyms in our schools and many of
4 our schools to do exercise for 15 minutes or 10
5 minutes beside their desk, because when I was a
6 kid, that's what we did we did exercise right in
7 the classroom beside our desk. So that's
8 something that maybe we need to resurrect,
9 particularly since we don't have gyms in many of
10 our schools and I'm going to ask my Chairs if that
11 is something that they would be interested in
12 bringing in DOE to see if there's something we can
13 do about that.

14 CHAIRPERSON RIVERA: Actually, what
15 we do in the Council, we fund a couple of programs
16 called Health Corp and one of them is done by Dr.
17 Oz [phonetic], who is a cardiologist here in the
18 city of New York and he actually goes into schools
19 with premed students and they get kids physically
20 active and more information about nutrition.

21 We also do something with the Road
22 Runners, which also goes into high-risk
23 communities and gets kids to simulate a marathon.
24 They do one mile a day for 26 days and [off mic]
25 goes to get them physically active. So we

1
2 actually do have, you know, get them out there, we
3 already do, so what we'll do is we'll forward the
4 information on.

5 And interesting stat is that the
6 Department of Education is in violation of state
7 law when it comes to the amount of physical
8 activity a child is supposed to receive on a daily
9 basis. And what even makes it even more
10 interesting is that the city of New York has
11 received awards for its curriculum on physical
12 education that we are in violation of not
13 implementing, so it's an ongoing battle. We
14 actually attempted to introduce legislation to
15 mandate that DOE implement the physical ed that's
16 required, but we're preempted by state law, so we
17 had to pass the buck to them.

18 COUNCIL MEMBER DICKENS: Yeah, I
19 wasn't finished, though.

20 CHAIRPERSON RIVERA: Oh [off mic]

21 COUNCIL MEMBER DICKENS: Thank you.
22 In addition, Dr. Andersen, or any of our
23 panelists, do you have information pamphlets that
24 you could disseminate to all the electeds on all
25 three levels that maybe we can begin to put in our

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2 newsletters, and every newsletter we might be able
3 to put something about what our families can do to
4 stem the tide of what is going on with the cardiac
5 rates that you're now finding with these various
6 studies.

7 And in all the levels of
8 government, we're phenomenally known for a lot of
9 studies and a lot of hearings and sometimes we
10 don't get a lot out of it. So I would like to
11 having listened to you and sat through this, I
12 would like to know if I can get from you, not just
13 for my office, but for all of our offices,
14 information pamphlets that we can put into our
15 mailings that we can put information in about, not
16 just the disparities that occur, but things that
17 they can do, suggestions that we can make to help
18 them make changes in their life. Do you have
19 anything like that that you and that's published
20 that you could give to us?

21 DR. MCLAUGHLIN: I'm representing
22 the American Heart Association today and we do
23 have great informational pamphlets, both in
24 English and in Spanish, that we can give to you.
25 We have pamphlets on hypertension control, smoking

1
2 reduction, cholesterol, etc.

3 And I wanted to point out I had
4 mentioned that this past year the American Heart
5 Association granted five grants in the community,
6 education grants in New York City to target
7 promoting education for women and heart disease
8 and one of them, which I think you would
9 appreciate, was in beauty salons. Like you said,
10 the women spend a lot of Sundays in church and
11 there's a group of them who spend hours in the
12 beauty salon on Saturday. So this grant went out
13 to educate the salon owners of cardiovascular and
14 to have cardiovascular disease awareness materials
15 there and to target them for screenings for
16 cholesterol and blood pressure there while they're
17 all in the beauty parlor. So I thought that was a
18 great grant that the American Heart Association
19 gave out this year.

20 DR. ANDERSEN: And just, again, to
21 address outreach here, we know that the most
22 trusted source of medical information in this
23 country right now comes from population surveys,
24 comes from, number one, doctors; number two,
25 nurses. However, we're doing a terrible job of

1
2 reaching people, okay. The most common source of
3 where people get their medical information is,
4 depends on the age group, but, number one,
5 television, okay? Probably for the older
6 population, two, magazines, newspapers are getting
7 smaller and smaller. And for the young, the
8 Internet.

9 So I really want to spend energies
10 to marry doctors and nurses who want to speak
11 about prevention to the Internet and the
12 television media to get the word out because young
13 people don't even look at pamphlets anymore.
14 They're just looking at their telephones or the
15 Internet, they don't even look at television
16 anymore and I think that's a really important part
17 of outreach.

18 [Pause]

19 CHAIRPERSON RIVERA: We'll call up
20 the last panel, Safiya Addison from New York
21 Methodist Hospital and the greater New York
22 Hospital Association.

23 [Pause]

24 DR. SAFIYA ADDISON: Good afternoon,
25 Councilperson Rivera and the rest of the Council.

1
2 Thank you for this opportunity to talk about New
3 York Methodist Hospital's program for educating
4 women about heart disease and heart disease
5 prevention. My name is Safiya Addison and, as
6 director of the community health outreach program,
7 I am pleased to represent New York Methodist
8 Hospital.

9 In 2004, in conjunction with the
10 initiation of Brooklyn's newest cardiac surgery
11 program, New York Methodist Hospital established
12 the Community Health Outreach Department to
13 address the cardiovascular needs of underserved
14 populations in Brooklyn and to assist the
15 prevention of heart disease. The goal of the
16 program is to increase the number of people who
17 are educated about cardiovascular risk factors,
18 increase the number of people engaged in risk
19 reduction behavior, and increase the number of
20 people able to access cardiac diagnosis and
21 treatment.

22 The department targets communities
23 identified as having populations with high rates
24 of cardiovascular disease, morbidity and
25 mortality. Its program works with the community-

1 based organizations to bridge gaps in health
2 services and cardiovascular health education by
3 offering screenings, lectures, and workshops.

4 Nearly all of the participants in our programs are
5 women, and since women are not only the health
6 moderators in families, but also the most at risk
7 for undetected heart disease and unrecognized
8 symptoms of heart attacks, we are very glad to
9 play to this audience.

10
11 During the past five years, New
12 York Methodist Hospital has broadened its
13 cardiovascular health outreach to include faith-
14 based organizations, head start Early Learning
15 programs, the New York Public Library Adult
16 Learning Center, and Brooklyn YWCAs, as well as
17 other community groups where medically underserved
18 populations are already accessing services. These
19 collaborations involved promoting screenings and
20 lectures, distributing educational material, and,
21 when possible, hosting events. Since the
22 commencement of the program, relationships have
23 been established and maintained with 122 community
24 organizations and their constituents.

25 A 2007 assessment of the program's

1
2 outreach activities determined that most at-risk
3 populations need additional and enhanced support.
4 Therefore, New York Methodist developed and pilot
5 tested an eight-week series of didactic
6 cardiovascular discussions that provided
7 information and opportunities for participants to
8 start to engage in risk reduction behavior. The
9 pilot program has successfully led to significant
10 improvements in the participants' knowledge, as
11 well as their intent to engage in desired
12 behaviors related to risk factors.

13 In several studies that examined
14 the relationship between low literacy and adverse
15 health outcomes, it was found that patients with
16 low literacy had poorer health outcomes, including
17 knowledge, intermediate disease markers, measures
18 of morbidity, general health status, and use of
19 health resources. Therefore, a major initiative
20 has been to establish relationships with the
21 Brooklyn Public Library's Adult Learning Center,
22 to facilitate the eight-session cardiovascular
23 disease program. In addition to the
24 cardiovascular curriculum, the workshops provide
25 culturally relevant, literacy-level-appropriate

1 health material on heart disease and its related
2 conditions. During the eight-session
3 cardiovascular disease workshop, participants are
4 educated on symptoms of heart attack and risk
5 factors for heart disease, as well as the
6 importance of prompt response. The topics include
7 the relationship between heart disease and
8 diabetes, hypertension, and cholesterol, as well
9 as the anatomy of the heart. In addition, and
10 most important, participants learn skills that
11 empower them to make better health choices and
12 teach them how to live healthier lives through
13 diet, exercise, and stress management.
14

15 Thank you for this opportunity to
16 share the highlights of New York Methodist
17 Hospital's experience in combating heart disease
18 among women of this group. Do you have any
19 questions?

20 CHAIRPERSON RIVERA: No. Thank you
21 very much.

22 DR. ADDISON: Thank you.

23 CHAIRPERSON RIVERA: Appreciate it.
24 Seeing no one else, we're going to conclude this
25 meeting.

I want to thank everybody for joining us here today and we know that there has to be great collaboration between the City Council, Department of Health, and the entire city to make sure we can combat this issue.

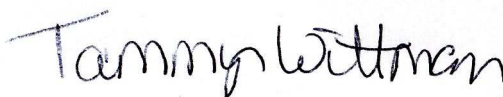
Thank you for joining us here today. Meeting is adjourned.

FEMALE VOICE: Thank you.

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C E R T I F I C A T E

I, Tammy Wittman, certify that the foregoing transcript is a true and accurate record of the proceedings. I further certify that I am not related to any of the parties to this action by blood or marriage, and that I am in no way interested in the outcome of this matter.

A handwritten signature in black ink that reads "Tammy Wittman". The signature is written in a cursive style and is positioned above a horizontal line.

Signature _____

Date February 19, 2009