The International Society on Hypertension in Blacks, Inc. (ISHIB) is a unique, nonprofit, professional medical membership organization devoted to improving the health and life expectancy of ethnic minority populations.

ISHIB was founded in Atlanta, Georgia in 1986 to respond to the problem of high blood pressure among ethnic minority populations. The organization’s scope includes diabetes, stroke, lipid disorders, renal disease, and other related cardiovascular disease risk factors.
The International Society on Hypertension in Blacks, Inc. (ISHIB) is a unique, nonprofit, professional medical membership organization devoted to improving the health and life expectancy of ethnic minority populations. ISHIB was founded in Atlanta, Georgia in 1986 to respond to the problem of high blood pressure among ethnic minority populations. The organization’s scope includes diabetes, stroke, lipid disorders, renal disease, and other related cardiovascular disease risk factors. The Society’s objectives follow:

• Promote public awareness of the harmful effects of hypertension and related risk factors, especially among ethnic populations;
• Develop health-related programs to improve the quality of life in ethnic populations worldwide;
• Educate the public on ways to prevent the complications of hypertension and other related risk factors;
• Stimulate research and clinical investigation; and
• Disseminate scientific findings to aid in the understanding of differences in hypertension and related risk factors.

ABOUT ISHIB

The Society’s peer-reviewed, referred medical journal is a highly respected source of information on disease patterns in ethnic populations throughout the world. Guided by a distinguished international editorial board, this publication offers original reports, reviews, and commentaries by physicians and scientists engaged in medical research. The journal is indexed in Index Medicus, MEDLINE, BIOSIS, and Cambridge Scientific. The online version of the journal is available at ishib.org/ED_edonline.asp.

INTERNATIONAL INTERDISCIPLINARY CONFERENCE

The Society sponsors an annual international conference. The conference attracts recognized lecturers and an audience of health professionals who want to learn the latest in clinical research and educational methodology.
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Care Coordination Institute  
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## FOR MORE INFORMATION

**Medical and Social Determinants of Cardiometabolic Health: From Concept to Focus on Constructive Action**  
**May 14-15, 2015**
THURSDAY, MAY 14, 2015

9:30 AM - 11:00 AM
OPENING CEREMONY/NEIL SHULMAN SYMPOSIUM
G. Scott, Morris, MD, MDIV - Holistic Healthcare for Medically Uninsured: The Church Health Center

11:15 AM - 12:15 PM
PLENARY SESSION I: Social and Medical Determinants of Cardiometabolic Health: The Big Picture
Co-Chairs: Shawna Nesbitt, MD, MS and Diane R. Brown, PhD
Speakers:
- Gary Puckrein, PhD - Health Disparities: Practical Implications of Geographic and Temporal Trends For Health Equity
- George Howard, DrPH - Medical & Social Factors Underlying Disparities: Insights and Potential Applications From REGARDS

1:30 PM - 3:00 PM
PLENARY SESSION II: Obesity Treatment: Interventions with Long-Term Benefit In Medically Underserved Populations
Chair: Erica Phillips-Caesar, MD
Speakers:
- F. Xavier Pi-Sunyer, MD - Lessons from Look Ahead and DPP/DPPOS
- Brent M. Egan, MD - The Pharmacology of Weight Loss with Emphasis on African Americans
- Blandine Laferrère, MD - Bariatric Surgery, Weight Loss, and Metabolic Outcomes in Minority Populations

4:00 PM - 6:00 PM
HYPERTENSION ACADEMY
Chair: John M. Flack, MD, MPH
Speakers:
- Brent M. Egan, MD - Resistant Hypertension Update
- Keith C. Ferdinand, MD - New Concepts in Treating Dyslipidemia
- Keith C. Norris, MD - Strategies for Controlling Blood Pressure and Cardiovascular Disease Risk Reduction in Chronic Kidney Disease
- John M. Flack, MD, MPH - Optimizing the Use of Diuretics in Hypertension Treatment

FRIDAY, MAY 15, 2015

8:00 AM - 9:30 AM
PLENARY SESSION III: Obesity, Diabetes and Metabolic Syndrome in African Americans
Chair: Kwame Osei, MD
Speakers:
- Kwame Osei, MD - Metabolic Syndrome in African Americans: What Are the Gaps And Paradoxes?
- Rita Louard, MD - Obesity and Type 2 Diabetes in African Americans: Major Obstacles in Patient Care
- Anthony J. Cannon, MD - Relevance of GLP-1 Analogues, DPP IV and SGLT2 Inhibitors in the Management of African American Patients With Type 2 Diabetes

9:30 AM - 11:00 AM
WORKSHOP: Cardiovascular Disease in Minority Women
Co-Chairs: Lawrence Y.C. Agodoa, MD and Renée Bullock-Palmer, MD
Speakers:
- Renée Bullock-Palmer, MD - Prevention, Detection and Management of Coronary Artery Disease in Minority Females
- Niya Jones, MD, MPH - The Management of Heart Failure in Minority Females

5:00 PM - 6:30 PM
ASH-SHIB JOINT SESSION: Improving Hypertension Control in Medically Underserved Patients: Practical, Scalable, Sustainable Models That Work
Co-Chairs: Angela L. Brown, MD and Elijah Saunders, MD
Speakers:
- Sonia Angell, MD, MPH - Meeting Million Hearts Hypertension Control Goals: Collaborative Success of the NYC Federally Qualified Health Centers and Department of Health
- Michael D. Nazar, MD - Adjusting for Diversity or Identifying the Variation that Drives Improvement: the Finger Lakes HBP Collaborative
- Jonathan N. Tobin, PhD - A Translational Research Approach to Improving Hypertension Control in Federally Qualified Health Centers: Focus on New York

6:30 PM—7:30 PM
TRI-SPONSORED RECEPTION: ISHIB-ASH-NYCDHOHMH/PCIP
MEETING FLOOR PLAN
CONFERENCE INFORMATION

REGISTRATION SCHEDULE

2ND FLOOR RHINELANDER GALLERY

Thursday, May 14th           8:30 AM –   6:00 PM
Friday, May 15th             7:30 AM – 12:00 PM

SPEAKER READY ROOM
WILL BE LOCATED IN CLINTON SUITE, 2ND FLOOR

ABSTRACT PRESENTATION

INSTALLATION:
Thursday, May 14th  8:00 AM

VIEWING HOURS:
Thursday, May 14th             10:45 AM –  11:30 AM
2:30 PM –    3:30 PM

ABSTRACT PRESENTATION

DISMANTLE:
Friday, May 15th  11:00 AM

ONSITE PAYMENT
Credit cards (American Express, Visa, MasterCard or Discover) or certified bank drafts in US funds will be accepted for on-site registration.

REGISTRATION FEE INCLUDES:

• One name badge
• Program syllabus and other meeting documentation
• Admission to all scientific programs and exhibit hall functions
• Eligibility to receive education credits

GUEST REGISTRATION

Onsite guests must register using the conference attendee’s form for an additional fee of $75. Guests are not allowed in the scientific halls during scientific events. Guests are welcome at Society-sponsored nonscientific conference programs.

Guests will NOT receive CME, CEU, or CE credits unless they have paid the conference registration fee.
CONFERENCE INFORMATION

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The copyright to all papers presented at ISHIB2015 is vested with ISHIB. If an author or his/her organization wishes to reprint the paper, applications should be made in writing beforehand to ISHIB’s Conference Manager, Ms. Terry Jackson. If written permission is given, the distribution of the paper shall not take place before the start of the conference.

PUBLICATION OF PROCEEDINGS
Authors have been asked to submit ready-to-be published papers of their presentations at ISHIB2015. A supplement to Ethnicity & Disease will feature these papers and research abstracts of the conference. Please submit your paper to terry-jackson@ishib.org by June 1, 2015.

DISCLAIMER
The information provided at this CME activity is for continuing education purposes only and is not meant to substitute for the independent medical judgment of a healthcare provider relative to diagnostic and treatment options of a specific patient’s medical condition.

ACCREDITATION
This activity has been planned and implemented in accordance with the Essential Areas and Policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint sponsorship of American Society of Hypertension and ISHIB. American Society of Hypertension is accredited by the ACCME to provide continuing medical education for physicians.

DESIGNATION
American Society of Hypertension designates this live activity for a maximum of 9.5 hours AMA PRA Category 1™ credits. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

CE credits for nurses, dietitians, and other health care professionals requiring continuing education credits will be provided by ISHIB. ISHIB has been reviewed and approved as an authorized provider by the International Association for Continuing Education and Training (IACET) and uses the criteria and guidelines designated by that organization as the basis for granting continuing education units (CEUs). Participants who successfully complete this activity can receive up to .95 CEUs.

DISCLOSURE POLICY
American Society of Hypertension adheres to ACCME Essential Areas, Standards, and Policies regarding industry support of continuing medical education. Disclosure of the planning committee and faculty’s commercial relationships will be made known at the activity. Speakers are required to openly disclose any limitations of data and/or any discussion of any off-label, experimental, or investigational uses of drugs or devices in their presentations.

RESOLUTION OF CONFLICTS OF INTEREST
In accordance with the ACCME Standards for Commercial Support of CME, the American Society of Hypertension has implemented mechanisms, prior to the planning and implementation of this CME activity, to identify and resolve conflicts of interest for all individuals in a position to control content of this CME activity.
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AMERICAN SOCIETY
OF HYPERTENSION

ISHIB
Devoted to Ethnicity and Health

ISHIB CORPORATE ROUNDTABLE PARTNERS

NOVARTIS
Welcome to the International Society on Hypertension in Blacks’ 30th Annual Scientific Meeting, “Medical and Social Determinants of Cardiometabolic Health: From Concept to Focus on Constructive Action,” which will address critically important issues in the quest for health equity in medically underserved populations. The Scientific Sessions are designed to provide practical cutting edge information on important modifiable medical and social factors impacting disparities in the prevalence and management of diabetes, obesity, hypertension and related clinical outcomes. The overarching objective is to provide conference participants with effective, low-cost, highly scalable, and rapidly actionable options for impacting key modifiable medical and social determinants of cardiometabolic health in the minority communities they serve.

At the completion of ISHIB2015, participants should be able to:

- Explore the medical and social determinants of cardiovascular health in a large bi-racial cohort study.
- Show how the faith community can objectively impact health outcomes.
- Explore current interventions and outcomes for obesity and diabetes treatment in underserved populations.
- Understand treatment strategies for blood pressure control and cardiovascular risk reduction in high-risk hypertensive patients.
- Discuss prevention, detection, and management of coronary artery disease in minority females.
ISHIB 2015 FACULTY INFORMATION

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Welcome and Conference Overview

Chair: David S. Kountz, MD

Introduction and Acknowledgement of ISHIB Founders

President: Brent A. Egan, MD

Introduction of the Keynote Speaker

Moderator: Jennifer Mieres, MD

KEYNOTE PRESENTATION: Holistic Healthcare for Medically Uninsured: The Church Health Center

Keynote Speaker: G. Scott Morris, MD, MDiv

G. Scott Morris, MD, MDiv is founder and Chief Executive Officer of the Church Health Center, which has as its mission to seek to reclaim the Church’s biblical commitment to care for our bodies and spirits. The Church Health Center opened in 1987 to provide primary health care to low-income, uninsured working people of Memphis. The CHC, a health care ministry supported by a broad base of the faith and medical communities, provides care to over 65,000 patients in its Clinic, which now includes primary care, dentistry, optometry, counseling and social work services. The CHC has also developed its Wellness and Faith Community Outreach ministries where the best disease prevention efforts of medicine are combined with the pastoral and spiritual care of the faith community.

Dr. Morris has an undergraduate degree from the University of Virginia, a Master of Divinity degree from Yale University, and M.D. from Emory University. He is a board certified family practice physician and an ordained United Methodist minister.

Dr. Morris writes a monthly column for the Memphis Commercial Appeal.

NO, I have no financial or other relationships to disclose

Upon completion of this topic, participants should be able to:

- Review the historic lines between faith and health.
- Present a brief case study of the work of the Church Health Center in Memphis, TN since 1987.
- Show how the faith community can objectively impact health outcomes.
- Present a role for nurses working in faith communities to impact transitions of care and improve health outcomes.
### PLENARY SESSION I: Social and Medical Determinants of Cardiometabolic Health: The Big Picture

**THURSDAY, MAY 14, 2015**

<table>
<thead>
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<th>Time</th>
<th>Session</th>
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<tr>
<td>11:15 AM – 12:15 PM</td>
<td>PLENARY SESSION I: Social and Medical Determinants of Cardiometabolic Health: The Big Picture</td>
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**Upon completion of this session:**
- Explore the medical and social determinants of cardiovascular health in a large bi-racial cohort study.

**Consultant:** AMGEN and Daiichi Sankyo Consultant

**Introduction Co-Chair:** Shawna D. Nesbitt, MD, MS

**CONSULTANT:** NO, I have no financial or other relationships to disclose

**Health Disparities: Practical Implications of Geographic and Temporal Trends for Health Equity**

**Speaker:** Gary A. Puckrein, PhD

**NO, I have no financial or other relationships to disclose**

**Upon completion of this topic, participants should be able to:**
- Introduce a method of measuring health disparities in small geographic areas using Medicare data.

**Medical & Social Factors Underlying Disparities:**

**Speaker:** George Howard, DrPH

**NO, I have no financial or other relationships to disclose**

**Upon completion of this topic, participants should be able to:**
- Describe the magnitude of black-white disparities in prevalent and incident cardiovascular risk factors
- Assess the extent to which social determinates mediate these disparities in cardiovascular risk factors
- Discuss next steps for intervention to reduce the magnitude of the disparities.
**PLENARY SESSION II: Obesity Treatment: Interventions with Long-Term Benefit In Medically Underserved Populations**

**THURSDAY, MAY 14, 2015**

1:30 PM – 3:00 PM

Upon completion of this session:
- Identify disparity in outcome after bariatric surgery
- Define the medical indications for pharmacotherapy of obesity

**Introduction Chair**

<table>
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<tr>
<th>Consultant: NovoNordisk; Eli Lilly, McNeil specialty products, Zafgen</th>
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**NO, I have no financial or other relationships to disclose**

**Lessons from Look Ahead and DPP/DPPOS Speaker**

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**The Pharmacology of Weight Loss with Emphasis on African Americans Speaker**

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<th>CONSULTANT: Medtronic</th>
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**Bariatric Surgery, Weight Loss, and Metabolic Outcomes in Minority Populations Speaker**

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<th>GRANT/RESEARCH SUPPORT: NIH</th>
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W. DALLAS HALL BLUE RIBBON SESSION:
Multi-Level Interventions to Improve Hypertension Control for African-Americans: Lessons Learned and Tools from NHLBI-Funded Cluster Randomized Trials

THURSDAY, MAY 14, 2015  3:15 PM – 3:45 PM

Upon completion of this session, participants should be able to:
- Review the NHLBI initiative to test multi-component interventions using a cluster randomized clinical trial design to improve blood pressure control in African American populations.
- Permit each grantee to briefly present/disseminate a single component of their intervention.
- Review composite results from meta-analysis of 3 linked cluster randomized clinical trials.
- Discuss promising multi-component approaches to improving blood pressure control for African American hypertensives.

Introduction  Chair  Jonathan N. Tobin, PhD

GRANT/RESEARCH SUPPORT: NIH, AHRQ, PCORI, CDC

Overview of RFA  Presenter  Paula Einhorn, MD

Baylor  Presenter  David Hyman, MD, MPH

NO, I have no financial or other relationships to disclose.

NYU/CDN  Presenter  Gbenga O. Ogedegbe, MD, MPH

VNS  Presenter  Penny H. Feldman, PhD

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Meta-Analysis Results  Speaker  Jonathan N. Tobin, PhD

Upcoming Dissemination on Webcast  Presenter  Jonathan N. Tobin, PhD

Question and Answer  Chair  Jonathan N. Tobin, PhD

Conclusion  Chair  Jonathan N. Tobin, PhD

THURSDAY, MAY 14, 2015  3:15 PM – 3:45 PM
Upon completion of this session, participants should be able to:

- Understand contemporary, evidence-based approaches to the evaluation and management of treatment resistant hypertension.
- Discuss unique aspects of dyslipidemia and potential benefits of PCSK9 inhibition in blacks.
- Understand treatment strategies for blood pressure control and cardiovascular risk reduction in high-risk hypertensive patients.

**Introduction and Overview**

**Moderator** | John M. Flack, MD, MPH

**GRANT/RESEARCH SUPPORT:** Medtronic and Novartis  
**CONSULTANT:** Back Beat Medical, Bayer, Forest, Medtronic, and Sanofi

**Resistant Hypertension Update**

**Speaker** | Brent M. Egan, MD

**GRANT/RESEARCH SUPPORT:** Medtronic, Quintiles  
**CONSULTANT:** Medtronic

Upon completion of this topic, participants should be able to:

- Describe an approach to distinguishing between apparent and true treatment resistant hypertension.
- Outline the steps and components of an effective management plan for patients with true treatment resistant hypertension.

**New Concepts in Treating Dyslipidemia**

**Speaker** | Keith C. Ferdinand, MD

**GRANT/RESEARCH SUPPORT:** Boehringer Ingelheim  
**CONSULTANT:** Amgen, AstraZeneca, Boehringer Ingelheim, Sanofi

Upon completion of this topic, participants should be able to:

- Discuss unique aspects of dyslipidemia, metabolic syndrome and CHD risk factors for African Americans.
- Highlight emerging concepts linking Lp(a) and CHD in blacks.
- Highlight potential benefits of PCSK9 inhibition in blacks.
Strategies for Controlling Blood Pressure and Cardiovascular Disease Risk Reduction in Chronic Kidney Disease

Speaker
Keith C. Norris, MD

NO, I have no financial or other relationships to disclose.

Upon completion of this topic, participants should be able to:
• Identify key strategies and supporting evidence for effectively treating BP in patients with CKD.
• Discuss key strategies and supporting evidence for effectively reducing CVD risk in patients with CKD.
• Explain new recommendation in JNC 8 BP control in patients with CKD.

Optimizing the Use of Diuretics in Hypertension Treatment

Speaker
John M. Flack, MD, MPH

GRANT/RESEARCH SUPPORT: Medtronic and Novartis
CONSULTANT: Back Beat Medical, Bayer, Forest, Medtronic, and Sanofi

Upon completion of this topic, participants should be able to:
• Understand the evidence-base for blood pressure lowering and cardiovascular risk reduction for commonly used diuretics.
• Identify patient characteristics that influence optimal diuretic selection.
• Explain common diuretic side effects and strategies to mitigate them.
THURSDAY, MAY 14, 2015

7:00 PM – 8:30 PM

DR. ELIJAH SAUNDERS MEMORIAL RECEPTION

SUPPORTED BY: ARBOR PHARMACEUTICALS, LLC
PLENARY SESSION III: Obesity, Diabetes and Metabolic Syndrome in African Americans

FRIDAY, MAY 15, 2015  8:00 AM – 9:30 AM

Upon completion of this session, participants will be able to:
• Understand the impact of health inequities on the burden of obesity and diabetes in the African American Community.
• Understand the ethnic and racial differences in metabolic syndrome.
• Discuss obstacles imposed by obesity in the management of African American patients with type 2 diabetes.
• Develop new therapeutic strategies in the management of African American patients with type 2 diabetes.

Introduction  Chair  Kwame Osei, MD

Metabolic Syndrome in African Americans: What Are The Gaps and Paradoxes?  Speaker  Kwame Osei, MD

GRANT/RESEARCH SUPPORT:  Merck
CONSULTANT:  AstraZeneca, Merck

Upon completion of this topic, participants should be able to:
• Discuss the prevalence of metabolic syndrome in US.
• Discuss the ethnic differences in insulin resistance and metabolic syndrome and its components in AA and WA.
• Discuss the paradox of insulin resistance and body composition, lipids and lipoproteins and hypertension in AA and WA.
• Discuss the significance of each component of metabolic syndrome in AA and WA.

Obesity and Type 2 Diabetes in African Americans: Major Obstacles in Patient Care  Speaker  Rita Louard, MD

SPEAKER BUREAU:  AstraZeneca

Upon completion of this topic, participants should be able to:
• Review the burden of obesity and diabetes on health care outcomes for African Americans.
• Evaluate strategies for improving health care outcomes for obesity and diabetes in African American Communities.
Relevance of GLP-1 Analogues, DPP IV and SGLT2 Inhibitors in the Management of African American Patients With Type 2 Diabetes

Speaker: Anthony Cannon, MD

SPEAKERS BUREAU: GSK, Janssen, Merck, Novo Nordisk

Upon completion of this topic, participants should be able to:

- Review the GLP agonist class for its ability to lower A1C values as well as measure their effects on hypoglycemic potential, weight, and overall safety profile. In addition, Exenatide (ExQW) will be reviewed with respect to these parameters.
- Review the DPP4 class for its ability to lower A1C values as well as measure their effects on hypoglycemic potential, weight, and overall safety profile. In addition, Linagliptin will be reviewed with respect to these parameters.
- Review the SGLT2 class for its ability to lower A1C values as well as measure their effects on hypoglycemic potential, weight, and overall safety profile. In addition, Canagliflozin will be reviewed with respect to these parameters.
WORKSHOP: Cardiovascular Disease in Minority Women

FRIDAY, MAY 15, 2015  9:30 AM – 11:00 AM

Upon completion of this session, participants will be able to:
- Discuss prevention, detection and management of coronary artery disease in minority females.
- Identify developing treatment strategies for women of color with heart failure.

Introduction  Co-Chair  Lawrence Y.C. Agodoa, MD

NO, I have no financial or other relationships to disclose.

Introduction  Co-Chair  Rene Bullock-Palmer, MD

NO, I have no financial or other relationships to disclose.

Prevention, Detection and Management of Coronary Artery Disease in Minority Females  Speaker  Rene Bullock-Palmer, MD

Upon completion of this topic, participants should be able to:
- Explain the important features in the prevention of coronary artery disease in minority females.
- Recognize early detection of coronary artery disease in minority females.
- Use management of coronary artery disease in minority females.

The Management of Heart Failure in Minority Females  Speaker  Niya Jones, MD, MPH

NO, I have no financial or other relationships to disclose.

Upon completion of this topic, participants should be able to:
- Identify causes of heart failure that disproportionately affect women of color.
- Explain developing treatment strategies for women of color with heart failure.
## ASH/ISHIB JOINT SESSION: Improving Hypertension Control in Medically Underserved Patients: Practical, Scalable, Sustainable Models That Work

**FRIDAY, MAY 15, 2015**

### 5:00 PM – 6:30 PM

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<th>Speaker</th>
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<td>Angela L. Brown, MD</td>
<td>Sonia Angell, MD, MPH</td>
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<td>Meeting Million Hearts Hypertension Control Goals: Collaborative Success of NYC Federally Qualified Health Centers and Department of Health</td>
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<td>Michael D. Nazar, MD</td>
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<td>Adjusting for Diversity or Identifying the Variation that Drives Improvement: the Finger Lakes HBP Collaborative</td>
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Sincerely,

Anne M. Dubois, APR, Fellow PRSA
Managing Editor, Ethnicity & Disease
corporatecommunications@EthnDis.org
ABSTRACTS

ABSTRACT REVIEW COMMITTEE

Lawrence Y.C. Agodoa, MD
Clarence E. Grim, MD, MS
German Hernandez, MD
Ike Solomon Okosun, MS, MPH, PhD
BASELINE CHARACTERISTICS OF HISPANICS IN THE SYSTOLIC BLOOD PRESSURE INTERVENTION TRIAL (SPRINT)


BACKGROUND: SPRINT is an ongoing clinical trial testing whether a systolic blood pressure (SBP) < 120 mmHg reduces adverse clinical outcomes compared to the treatment goal of < 140 mmHg. Here we describe the baseline characteristics of Hispanic participants in SPRINT.

METHODS: Non-diabetic hypertensives > 50 years old with SBP 130-180 mmHg on 0-4 BP medications were enrolled in the mainland US and Puerto Rico (PR). Multivariable logistic regression models restricted to Hispanics were used to identify factors associated with achieved BP control (SBP<140 mmHg and diastolic BP <90 mmHg) at baseline.

RESULTS: 11% (n=984) of SPRINT participants were Hispanic; 56% (n=550) of Hispanics were living in PR, the remainder on the US mainland. Hispanics overall were younger, female, less likely to live alone, more likely to have lower education and be uninsured, although just as likely to be employed compared to non-Hispanics. Hispanics on the US mainland were more likely to be older, male, have less than a HS degree, and be uninsured although just as likely to be employed as those in PR. (Table) BP control was not different between Hispanics vs. non-Hispanics at baseline. However, a significantly higher percentage of Hispanics on the US Mainland (compared to Hispanics in PR) were BP controlled. BP control was independently associated with cardiovascular disease history and functional status. Non-smoking and being on >3 anti-hypertensive medications were independently associated with BP control among PR Hispanics, whereas no independent predictors were identified among mainland Hispanics.

CONCLUSIONS: These findings highlight the diversity of the SPRINT population. It remains to be seen whether factors identified among Hispanics impact intervention goals and subsequent clinical outcomes.
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<tr>
<th>Baseline Characteristics</th>
<th>Hispanics (n = 984)</th>
<th>Non-Hispanics (n = 8377)</th>
<th>P-Value for Hispanic Difference Overall</th>
<th>Hispanics in Puerto Rico (n = 550)</th>
<th>US Mainland Hispanics (n = 434)</th>
<th>P-Value for Island vs Mainland Difference Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age: 50-64</td>
<td>508 (51.6)</td>
<td>3297 (39.4)</td>
<td>&lt;0.0001</td>
<td>295 (53.6)</td>
<td>213 (49.1)</td>
<td>0.0002</td>
</tr>
<tr>
<td>65-74</td>
<td>298 (30.3)</td>
<td>2610 (31.2)</td>
<td></td>
<td>180 (32.7)</td>
<td>118 (27.2)</td>
<td></td>
</tr>
<tr>
<td>&gt;75</td>
<td>178 (18.1)</td>
<td>2469 (29.5)</td>
<td>&lt;0.0001</td>
<td>75 (13.6)</td>
<td>103 (23.7)</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>454 (46.1)</td>
<td>2879 (34.4)</td>
<td>&lt;0.0001</td>
<td>298 (54.2)</td>
<td>156 (35.9)</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Lives alone</td>
<td>236 (24.0)</td>
<td>2477 (29.6)</td>
<td>0.0003</td>
<td>120 (21.9)</td>
<td>116 (26.8)</td>
<td>0.07</td>
</tr>
<tr>
<td>&lt;High School</td>
<td>231 (23.5)</td>
<td>646 (7.7)</td>
<td>&lt;0.0001</td>
<td>106 (19.3)</td>
<td>125 (28.9)</td>
<td>&lt;0.0001</td>
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<tr>
<td>Employed</td>
<td>346 (35.2)</td>
<td>2867 (34.3)</td>
<td>0.56</td>
<td>181 (33.0)</td>
<td>165 (38.1)</td>
<td>0.09</td>
</tr>
<tr>
<td>Uninsured</td>
<td>124 (12.6)</td>
<td>849 (10.2)</td>
<td>0.02</td>
<td>35 (6.38)</td>
<td>89 (20.6)</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>SBP, mmHg</td>
<td>140.7±0.5</td>
<td>139.6±0.2</td>
<td>0.02</td>
<td>143.0±0.6</td>
<td>137.8±0.7</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td># of BP Medications</td>
<td>1.75±0.03</td>
<td>1.84±0.01</td>
<td>0.003</td>
<td>1.68±0.04</td>
<td>1.83±0.05</td>
<td>0.02</td>
</tr>
<tr>
<td>BP Controlled</td>
<td>485 (49.4)</td>
<td>4211 (50.4)</td>
<td>0.5629</td>
<td>241 (43.9)</td>
<td>244 (56.4)</td>
<td>0.0001</td>
</tr>
<tr>
<td>BMI, kg/m²</td>
<td>29.5±0.2</td>
<td>29.6±0.1</td>
<td>0.05</td>
<td>29.7±0.23</td>
<td>29.27±0.23</td>
<td>0.14</td>
</tr>
<tr>
<td>Physical Activity</td>
<td>397 (40.5)</td>
<td>3879 (46.6)</td>
<td>0.0003</td>
<td>219 (39.9)</td>
<td>178 (41.2)</td>
<td>0.68</td>
</tr>
<tr>
<td>CVD History</td>
<td>184 (18.7)</td>
<td>1693 (20.2)</td>
<td>0.26</td>
<td>84 (15.3)</td>
<td>100 (23.0)</td>
<td>0.02</td>
</tr>
<tr>
<td>Smoking Status</td>
<td>113 (11.5)</td>
<td>1127 (13.5)</td>
<td>&lt;0.0001</td>
<td>60 (10.9)</td>
<td>53 (12.3)</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Cholesterol, total (mg/dL)</td>
<td>193.9±1.3</td>
<td>189.7±0.5</td>
<td>0.003</td>
<td>198.3±1.7</td>
<td>188.19±1.94</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Cholesterol, LDL (mg/dL)</td>
<td>114.6±1.1</td>
<td>112.4±0.4</td>
<td>0.04</td>
<td>118.3±1.5</td>
<td>109.7±1.7</td>
<td>0.0001</td>
</tr>
<tr>
<td>General Health Status Questionnaire</td>
<td>2.8±0.9</td>
<td>2.6±0.8</td>
<td>&lt;0.0001</td>
<td>2.7±0.8</td>
<td>3.0±0.9</td>
<td>&lt;0.0001</td>
</tr>
<tr>
<td>Depressive Symptoms</td>
<td>0.09±0.29</td>
<td>0.08±0.27</td>
<td>0.09</td>
<td>0.06±0.24</td>
<td>0.13±0.34</td>
<td>0.0001</td>
</tr>
<tr>
<td>Montreal Cognitive Assessment</td>
<td>20.9±4.89</td>
<td>23.12±3.94</td>
<td>&lt;0.0001</td>
<td>21.25±4.85</td>
<td>20.49±4.92</td>
<td>0.2</td>
</tr>
<tr>
<td>Functional Assessment (FAQ)</td>
<td>2.65±4.14</td>
<td>1.39±3.09</td>
<td>&lt;0.0001</td>
<td>2.88±4.06</td>
<td>2.35±4.23</td>
<td>0.19</td>
</tr>
<tr>
<td>Morisky Medication Adherence</td>
<td>6.9±1.4</td>
<td>7.0±1.3</td>
<td>0.25</td>
<td>7.0±1.3</td>
<td>6.8±1.4</td>
<td>0.02</td>
</tr>
</tbody>
</table>
ASSOCIATION OF WEIGHT MANAGEMENT TACTICS WITH CARDIOVASCULAR RISK AMONG OBESE ADULTS WITH HYPERTENSION: US NATIONAL HEALTH AND NUTRITION EXAMINATION SURVEY 1999-2011

JUNG HYE SUNG, Ji-Young Lee, Jae Eun Lee

Obese individuals are encouraged to lose their body weight to improve CVD risk, but strategies for weight management remain controversial, particularly for individuals with hypertension. This study aims to determine the association of weight management strategies with cardiovascular risk among obese adults with hypertension.

The analyses utilized the data of NHANES 1999-2011 which included a valid sample of 3,572 obese adults with hypertension. Weight change was measured by percent change between self-reported past year and current weights. Least square means adjusted for age, gender, race, BMI, and survey year were compared between those losing >=5% and those maintaining weight ±2%.

Majority of study samples (54.1%) maintained their weight within ±2% for a year. A higher level of HDL (p=0.0008), glucose (p=0.0524), CRP (p=0.078), triglyceride (p=0.0334), homocysteine (p=0.0344) was found among those losing >=5% than those who maintained their weight. Meanwhile, a significant lower level of apolipoprotein (p=0.0041) and insulin (p=0.072) was found among those losing weight. However, no significant difference was found in Fibrinogen, LDL, Ferritin, Folate, and Transferrin receptor. Those losing weight were more likely to be depressed (p<0.0001), to have worse physical health (p=0.0001), mental health (p=0.0028), overall health (p<0.0001) and physical function (p<0.0001), and to visit medical professional (p<0.0001).

Our study found that weight loss tactic for obese adults with hypertension may be helpful in improving lipoprotein but worse in inflammation markers, quality of life, physical function and depression. As in previous studies, the benefit of weight loss for obese adults with hypertension was not clear. Further study is needed to examine longitudinal change of vascular marker after weight loss.

This study is supported by grant number U54MD008149 from the National Institute on Minority Health and Health Disparities, National Institutes of Health.
OBJECTIVES: Mississippi leads the nation in cardiovascular disease (CVD) and prevalence of risk factors. Alarming trends among children and adolescents suggest the need for early interventions to address and prevent CVD. Jackson Heart Study and the Tougaloo College Undergraduate Training Program offer CVD risk factor assessments and education to high school students through the summer-long SLAM and “Know Your Numbers” initiatives. Our purpose was to assess the prevalence of certain CVD risk factors and impact of education among ninth grade 2014 participants.

METHODS: All participants completed pre- and post-surveys (“Know Your Numbers?” health awareness, CDC Y-BRFSS). Height and weight were determined without shoes (scale-mounted stadiometer, Tanita® Body Composition Analyzer/Scale); BMI was calculated. Blood pressures were measured according to American Heart Association standards using electronic sphygmomanometers and appropriate sized cuffs.

RESULTS: Participants (N=28) were 71% female, average age 15 years, and predominately African American (93%). The majority (61%) were overweight/obese and 32% were pre-hypertensive. Average total and itemized correct responses on the knowledge-based questions improved from a baseline of 52% to 70% on the post-survey (Paired t-test; p<0.0001) (T-test; p=0.30).

CONCLUSIONS: Assessments identified that overweight/obesity and pre-hypertension among SLAM participants are much higher than state and national rates. Participation appeared to increase knowledge, though scores were less than ideal. While previous reviews support the impact of participation on increasing knowledge and some self-reported healthy behaviors, these findings demonstrate the need for longitudinal evaluation of ongoing and consecutive years to determine effective methods of addressing risk factors in this vulnerable population.
AFFECTIVE RESPONSES TO APPRAISALS OF FAIRNESS BY UNDERGRADUATE AFRICAN AMERICAN STUDENTS AT AN HISTORICALLY BLACK UNIVERSITY (HBU)

JAMES FISHER, Clifton Addison

OBJECTIVES: Justice comprises distributive justice (the perceived fairness of outcomes) and procedural justice (the perceived fairness of the decision-making processes that generate outcomes). These types of justices have the power to differentially influence emotional state, with consequent positive and negative emotions broadly classifiable as inward-focused (e.g., shame, guilt, pride) or outward-focused (e.g., anger, hostility, respect). This study sought to examine empirical data about whether procedural justice mediates affective responses for African American populations.

METHODS: 60 undergraduate African American students at an historically black university in Jackson, Mississippi provided information about their affective states and their emotional responses to scenarios depicting varying conditions of procedural and distributive justice.

RESULTS: There were significantly higher ratings of positive inward- and outward-focused emotions from individuals who were exposed to a distributive justice-procedural justice condition than from those exposed to other conditions. No significant association has been uncovered between negative outward-focused emotional responses and exposure to a distributive justice-procedural injustice condition, suggesting that unfavorable procedures may not inform emotional responses when outcomes are deemed favorable. The results indicate the relative importance of procedural justice in determining the emotional responses of a minority population whose definition of fairness has been shaped by historic inequalities and extant socioeconomic disparities.

CONCLUSIONS: The research suggests that, when outcomes are viewed as favorable, procedural justice enhances positive emotion, while procedural injustice contributes to negative outward-focused affective responses.
RISK FACTORS FOR CARDIOVASCULAR DISEASE AMONG SOMALIS IN THE USA: IS THERE A “HEALTHY IMMIGRANT EFFECT”?
A. DALMAR, MD; D. Pryce, MD; A. Osman, MD; B. Martinson, PhD; S. Wewerka, MPH; D. Dubois, MPH; L. Ehrlich, MPH; B. Westgard, MD

BACKGROUND: Many migrants to the United States arrive with few cardiovascular disease (CVD) risk factors, i.e., “healthy immigrant effect,” only to adopt the diet and exercise patterns of the U.S. population and to eventually develop the CVD risk factors common to affluent societies. For 20 years, Somalis have been migrating to the U.S. The largest number resides in the Minneapolis-St. Paul metropolitan area of Minnesota. In 2000, the first systematic study of the CVD risk profile of Somali immigrants showed a relatively low prevalence of hypertension (10%), but substantial dyslipidemia (17%), tobacco use among men (44%), and obesity among women (60%). We have begun a follow-up study to reassess the CVD risk profile of this population 15 years later and determine if the healthy immigrant effect still persists.

We hypothesize (1) that lower social capital and increased acculturation without development of social capital are associated with higher prevalence of CVD risk factors. Through social network analysis (SNA), we also plan to test the hypotheses that (2) different participant characteristics are associated with willingness to accept health care interventions and proactively seek health care and that (3) individuals with high socioeconomic status and health literacy who are highly connected in the Somali community will be the best advocates for health policy interventions.

METHODS: This is a cross-sectional survey of a social-network-based, respondent-driven sampling (RDS) study. We intend to survey 1340 participants regarding demographics, anthropometrics (height, weight, waist circumference, and blood pressure), health and healthcare behaviors, diet and exercise, acculturation, social networks, and social capital. We are also using finger-stick blood testing to collect data on cholesterol, hemoglobin A1C, and C-reactive protein as a marker of inflammation.

RESULTS: To date, we have surveyed around 250 participants. Preliminary review of our data suggests high prevalence of hypertension. The results of our final data collection and SNA will be used to test the above hypotheses and to develop an agent-based model of healthcare interventions to modify CVD risk factors among Somalis.

CONCLUSION: Because of the tightly-knit and largely oral culture of the Somali community in Minneapolis-St. Paul, we have found that intensive community engagement has been necessary to achieve adequate recruitment of our respondent-driven sampling. Based on preliminary data review, we anticipate that we will see some decline in “the healthy immigrant effect” and that lower social capital and increased acculturation without development of social capital will be associated with a higher prevalence of CVD risk factors.
GOAL-STRIVING STRESS AND SELF-RATED HEALTH OF BLACK COLLEGE STUDENTS

MILTON R. DAWKINS JR., MS, Brenda Jenkins, PhD, Clifton Addison, PhD, Marinelle Payton, MD, PhD, MS, MPH

INTRODUCTION: Blacks living in the United States have a higher mortality rate from breast and lung cancer, and are more likely to develop cardiovascular disease. Blacks are also more likely to self-rate their health as either “fair” or “poor”. Some research has suggested that biological factors contribute to the health disparities between Blacks and Whites. However, a robust body of research investigating psychosocial factors as determinants of health is emerging and is providing conflicting opinions. One such variable of interest includes goal-striving stress (GSS).

OBJECTIVE: The objective of the current study was to examine the relationship between GSS and self-rated health of Black college students.

METHODS: It was hypothesized that participants who reported higher levels of GSS would self-rate their health lower. The study included Black college students living in the Deep South. Preliminary analyses revealed an inverse relationship between GSS and self-rated health among participants.

RESULTS: Participants who reported higher levels of GSS self-rated their health lower. The results of this investigation are fruitful, and suggest that psychosocial variables may play a major role in the vulnerability and development of disease.

CONCLUSION: To the best of our knowledge, no published research exists that examines the association between GSS and self-rated health of Black college students. Despite increased research efforts to improve the health of Blacks in the United States, large health disparities continue to exist.
ETHNIC DIFFERENCES IN SENSITIVITY TO ALDOSTERONE: AN EFFECT OF EXTRACELLULAR FLUID VOLUME (ECFV)?

Wanzhu Tu, PhD, George J. Eckert, MS, Brian S. Decker, PharmD, MD, and J. Howard Pratt, MD

Extracellular potassium (K) maintains membrane potential of cells and is vital to various cell functions. Aldosterone acting in kidney regulates extracellular K by increasing its urinary excretion. In turn, K stimulates secretion of aldosterone. In previous studies, the plasma aldosterone concentration (PAC) was lower in blacks than whites. How this affects K homeostasis was the question addressed in the present study. Subjects (1,116 samples from 161 blacks and 271 whites) were from a cohort of young (5-39 yr) and healthy individuals. We found that PAC was lower in blacks (by ~30%). The serum level of K, however, was the same in the two ethnic groups. Thus, it took less aldosterone to maintain the circulating K level in blacks. In earlier studies, we showed that BP was sensitive to PAC in blacks but not in whites. There was ‘aldosterone sensitivity’ of BP in blacks which was best explained by increased ECFV. The present findings with respect to K suggested that an increase in ECFV led to a precise decrease in aldosterone secretion from a combination of reduced angiotensin II exposure and appropriate feedback from K. In conclusion, ECFV appears to be increased in blacks in comparison to whites (based on indirect evidence) which sensitizes targets of aldosterone. In blacks, normal or even low levels of aldosterone may be excessive due to greater ECFV.
ABSTRACT

RASHIDA ALBEELY, MD, MPH, Cassandra Patrick, Xueyuan Wang, MS, Thia Walker, MPH, Jamela Alexander, MPH, Brenda Jenkins, MPH, PhD, Clifton Addison, PhD, Marinelle Payton, MD, PhD, MPH

OBJECTIVE: The aim of this study was to examine the social economic factors for obesity in the states of Mississippi and Colorado and to formulate a comparative analysis to determine the relationship of the prevalence of obesity between the two states.

METHODS: BRFSS 2009 data on adults from the state of Mississippi and Colorado were compared. A sample of 22,833 subjects was analyzed. Logistic Regression analyses for the two states were conducted to examine the correlates of being neither overweight nor obese, either overweight or obese. We investigated the relationship between age, gender, socioeconomic position (education and income) and the prevalence of obesity in each state.

RESULTS: Gender comparisons between Mississippi and Colorado yielded similar results with males having a higher percentage of being overweight (M=39.9% / F=30.2%) and (M=44.4% / F= 28.7%) respectively. Women in both states had slightly higher rates of obesity. Participants aged 34-54 had higher overweight and obesity rates. Those who had less than a High School education had the highest obesity rates in both states. Those with a college education had the lowest obesity rates in both states. Those averaging $15, 000 or less annually, had the highest percentages of obesity. Those averaging $50,000 or more annually had the lowest percentages of obesity.

CONCLUSION: Obesity is a disparity plaguing the poor and disadvantaged. Policies and interventions are needed to improve these statistics. Even all members of society are affected, immediate attention should be paid to the underprivileged.
MULTI-LEVEL INTERVENTIONS TO IMPROVE HYPERTENSION CONTROL FOR AFRICAN-AMERICANS: LESSONS LEARNED AND TOOLS FROM NHLBI-FUNDED CLUSTER RANDOMIZED TRIALS

JONATHAN N. TOBIN, PhD, Valory N. Pavlik, PhD, Gbenga Ogedegbe, MD, David J. Hyman, MD, MPH, Penny Feldman, PhD, Joseph E. Schwartz, PhD, Wenyaw Chan, PhD, Margaret McDonald, MSW, Bonnie L. Svarstadt, PhD, Andrea Cassells, MPH, Paula Einhorn, MD, MS

Hypertension is the most prevalent cardiovascular risk factor, in the USA and globally. While the hypertension prevalence rises after age 50, African-Americans (AAs) continue to have a 1.5-2x higher prevalence; among age >60, over 80% of AAs are hypertensive, and nearly 50% are uncontrolled on treatment. Thus, the majority of AAs who present for care require blood pressure (BP) management.

NHLBI (RFA HL-04-007) funded five separate cluster randomized clinical trials (RCTs) to examine multi-level interventions to improve BP control for hypertensive AAs in community-based clinical settings. Each RCT developed its approach to implementing BP control strategies, and reported results separately and in a combined analysis. Dissemination toolkits of methods used during the RCTs will be shared, including strategies for: recruitment, retention, intervention implementation, fidelity management, and sustainability.

The existing collaboration offers opportunities to identify intervention components most likely to improve BP control in AAs seen across diverse settings and by different types of clinicians, including large numbers of practices and patients in diverse geographic locations. These practice settings are representative of venues where most AA hypertensive patients receive care.

The panelists will: (1) review individual and combined study results; (2) identify intervention components that are most likely to improve BP control in AAs; and (3) disseminate intervention components to ensure the broadest reach and greatest public health impact. The experience of the projects represents a unique resource for developing and conducting comparative effectiveness research across a broad range of clinical practice settings with multiple health professionals.
**ABSTRACT**

EVALUATING THE SPENDING OF HEALTHCARE DOLLARS IN AMITE COUNTY, MISSISSIPPI AND ITS ECONOMIC IMPACT

ADRIANE VANN, MHSA., DrPH. (ABD), Brenda Jenkins, MPH, PhD, Clifton Addison, PhD, Marinelle Payton, MD, PhD, MPH

**OBJECTIVES:** In 2005, the mortality rate from heart disease in Amite County, Mississippi was almost 30% higher than the state average. Yet, despite its need for proper and sufficient health care coverage, patients must access treatment outside of the county making this area particularly weak in terms of healthcare dollars. This study examined the economic impact of healthcare to the local economy.

**METHODS:** In this study, the IMPLAN model was used to estimate the various economic impacts of the health care sector of Amite County in Mississippi. IMPLAN (an input/output model of transactions taking place between industries, businesses, and consumers in an economy) was used to estimate the economic impact of current policies that allow for forward and backward linkages in the economy. This methodology was used to obtain personal health care expenditures.

**RESULTS:** Health care contributed significantly to the economy of Amite County with a percentage of that contribution being made indirectly through purchasing made by suppliers to the health care sector.

**CONCLUSIONS:** A health sector economic impact analysis showed the interconnectedness of economic activity through examination of the county’s economic make-up, the roles of the health sector, and the interdependence of economies.
CONTRIBUTING FACTORS ASSOCIATED WITH OBESITY IN AFRICAN-AMERICAN WOMEN IN A RURAL COMMUNITY IN LEXINGTON, MISSISSIPPI

VANESSA BLAND, MS, Brenda Jenkins, MPH, PhD, Clifton Addison, PhD, Mario Azevedo, PhD, Marinelle Payton, MD, PhD, MPH

OBJECTIVE: Obesity is one of the leading causes of morbidity and mortality among African American women in the United States. Certain groups are more likely to be obese than others. Obesity increases the risk of major health concerns such as diabetes, heart disease, stroke, cancer, and breathing difficulties. The purpose of this study was to determine the contributing factors associated with obesity in African-American women in a rural community.

METHODS: Data were collected from 50 African-American women, ages 20-65, in rural Lexington, MS at community churches and a local clinic, using a survey of 20 questions. The questionnaire obtained information about: age, educational level, occupation, diet and physical lifestyle, type of insurance, access to supermarkets, access to healthcare assistance and healthcare regimen. A Chi-square analysis was conducted to determine the contributing factors associated with obesity in African American women in a rural community.

RESULTS: Lifestyle and health status, access to supermarkets and health care assistance are associated with increased obesity risk and adverse associated outcomes. Rural communities have an increased risk of obesity and obesity related risk factors, due to a lack of health education, inability to afford health insurance, limited access to healthcare, and the inability to obtain fresh fruits and vegetables.

CONCLUSION: Environmental and lifestyle factors as well as the access to healthcare and an individual’s health status play a major role in the increase risk of obesity and obesity associated risk factors among African American women in a rural community.
ABSTRACT

A COMPARISON OF GROUP VERSUS INDIVIDUAL HEALTH COACHING IN DECREASING CARDIOVASCULAR DISEASE RISK IN HIV-INFECTED INDIVIDUALS

Dominquie Guinn-Allen, Ngozi Agu, Melvin Roberts, Stephanie Walker, Dwalah Fisher, ADEBAYO OYEKAN

HIV-infected individuals are more likely to develop some type of cardiovascular disease (CVD) compared to the general population. Highly active antiretroviral therapy (HAART) may cause adverse lipid profile and increased insulin resistance, hence, those on HAART are more likely to develop CVD than those not on medication. However, only one in four people living with HIV/AIDS (PLWHA) is aware of the increased risk of CVD associated with HIV infection itself and HAART medications. The goal of the study was to increase knowledge and reduce CVD risk through group or individual coaching to determine the better intervention for PLWHA on HAART.

73 adults, aged 18-65, with documented HIV infection underwent a 12-week heart healthy intervention involving health education/activities and cooking sessions in a group session (GHC, n=50) or motivational interviewing through individual health coaching (IHC, n=23) via weekly phone calls. A 30-question survey of knowledge of CVD risk was administered at 0 and 3 months (Phase I). Health biometrics - blood pressure (systolic; SBP and diastolic; DBP), body mass index (BMI), full lipid panel, fasting blood glucose and A1C levels were recorded at 0, 6, and 12 (Phase II) months.

There was a significant increase in CVD knowledge at 3 months - higher (P<0.05) in the GHC group. During Phase I, SBP, DBP, BMI, total cholesterol and LDL were lower (P<0.05) in IHC suggesting short-term benefits. Comparing Phase I with Phase II, there were slight but significant reductions in DBP (9%), FBG (15%), and A1C (34%) but a surprisingly greater increase in LDL (34%) in the GHC group. There were no Phase II data to make the same longitudinal comparison for the IHC group.

The IHC group had better long time outcomes in minimizing CVD risk while the GHC group had better short term outcomes. Given the right interventions coupled with appropriate educational sessions, PWLHA are willing to learn more about how to improve their cardiovascular health with personalized health coaching being more effective.
RACIAL DIFFERENCES IN CARDIOMETABOLIC RISK FACTOR CONTROL AMONG OLDER ADULTS WITH DIABETES AND CONCORDANT CHRONIC CONDITIONS

KELLEE WHITE, PhD, MPH, Yueyao Li, BA, Tison Kidanie, BA

OBJECTIVES: Several prior studies have shown that concordant conditions are associated with improved diabetes management. However it is not clear whether these results extend to a multiethnic sample of older adults. The purpose of this study was to whether the association between concordant comorbidity and cardiometabolic risk factor control varied by race.

METHODS: The 2006 wave corresponding biomarker data from the Health and Retirement Study was used (n=1,351). Adults who self-reported as having diabetes and with complete biomarker information were included. Control of blood pressure, diabetes, and total cholesterol were the main outcome variables. Multiple chronic conditions were assessed as total number of concordant and discordant chronic conditions. Multivariate logistic regression analyses were used to estimate odds ratios and 95% confidence intervals. Analyses were adjusted for sociodemographic, lifestyle, clinical characteristics, and complex sampling design.

RESULTS: Number of concordant conditions was not associated with HbA1c control among whites or blacks. White respondents with higher numbers of concordant conditions were more likely to have total cholesterol controlled (OR: 1.39; 95% CI: 1.04, 1.86). Blacks with higher numbers of concordant conditions were less likely to have blood pressure controlled (OR: 0.46; 95% CI: 0.24-0.90).

CONCLUSIONS: In this sample of older adults concordant comorbidity conditions may complicate self-management goals. This issue was particular acute in older black adults. Strategies are needed to help older adults with multiple chronic conditions improve disease management.
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10% DISCOUNT (on/before March 31, 2016)

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