

 THE ABC DIGEST OF **URBAN**
CARDIOLOGY

A PUBLICATION OF THE ASSOCIATION OF BLACK CARDIOLOGISTS, INC.



A Response to the
Institute of Medicine
Report on Racial
Disparities (p. 12)

Community
Physicians Network®
(p. 25)

VOLUME 30, NUMBER 5

SEPTEMBER/OCTOBER 2004

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A PUBLICATION OF THE ASSOCIATION
OF BLACK CARDIOLOGISTS, INC.

6849 B-2 Peachtree Dunwoody Road
Atlanta, GA 30328

Urban Cardiology is a bimonthly publication of the Association of Black Cardiologists, Inc., a non-profit organization of medical professionals dedicated to the reduction of cardiovascular and related diseases in minority and underserved populations. The ideas and opinions expressed in this publication do not necessarily reflect those of the Association, editors, or publisher.

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ISSN# 1096-3863

Hilton Publishing, Inc.
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Roscoe, IL 61073

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OUR EDITORIAL MISSION

The *ABC Digest of Urban Cardiology*, published bimonthly, is an official publication of the Association of Black Cardiologists, Inc. (ABC). The ABC is a non-profit organization of health professionals dedicated to the reduction of cardiovascular and related diseases, especially in minority populations, wherein lies a burden of excessive morbidity and mortality. This publication is provided as an educational service to all health professionals who share this dedication.

The mission of this publication is to assist such clinicians to deliver the best of care to patients with cardiovascular and related diseases and to do so in a culturally competent and demographically appropriate manner. We do so by providing—in a compact, easily comprehensive journalistic style—up-to-date information of immediate applicability to the unique clinical setting of urban medicine. This information consists of:

- Original, evidence-based, clinical and research main articles (including CME self-assessment).
- "Tidbits"—a regular column of useful clinical knowledge gleaned from recent clinical research trials and other information drawn from the medical literature.
- "Developments"—a regular column covering newsworthy recent events such as new drug and device market introductions, new controversies in medicine, new trends in health care, new scientific insights, and new demographic, economic, and governmental activity affecting the practice of medicine.
- Commentary from the president of ABC, the publication's editor in chief, and the publisher.

We strive continually to improve upon the execution of our editorial mission and therefore encourage and welcome your suggestions on how we can serve you, our reader, better.

In this issue you will observe product advertisements from AstraZeneca, Bristol-Myers Squibb Medical Imaging, Fujisawa Healthcare, GlaxoSmithKline, McNeil-PPC, Pfizer Pharmaceuticals and Schwarz Pharma. These pharmaceutical firms are providing educational grant support to the Association of Black Cardiologists, Inc. to enable us, among other things, to provide you with this publication without a subscription charge to you.

We encourage you—as you deem appropriate—to acknowledge and show appreciation for this support, as well as for these supporters' recognition of the special health challenges faced by minority and underserved populations and by the clinicians who treat them.

SHINE THE LIGHT

While there is no doubt that racial disparities exist in this country, the extent of that disparity, and how it is measured, is open to different interpretations. From this standpoint, the key is to continue to “shine the light” into the abyss of research in order to continue to illuminate the problem. With research comes greater knowledge; and with greater knowledge, comes solutions.

We recommend that all ABC members read this issue with particular interest, as it directly impacts all of us who are minorities or who care for minority patients, and who have vested our lives in cardiovascular occupations and serving the minority communities. The ability to train future cardiologists is critical to our ability to serve our minority patients and the inability to access those training programs directly hinders that effort.

This issue sets forth important research on disparity and offers a response to it. This is, to say the least, an important matter for all of us.

From my heart to yours,
Hilton M. Hudson, II, M.D., FACS, FCCP
Chief of Cardiothoracic Surgery
Reid Hospital
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CEO, Hilton Publishing Co. Inc.

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Cover: Inset Illustration by Joel Gresham

The paintings used on the cover of the Digest of Urban Cardiology depict teachable moments between children and their grandparents. The dialogue here is:

Grams: I wonder who is having a birthday today?
Jay Jay: It's my B-day Grams!
Ivory: How old are you today Jay Jay?
Jay Jay: I'm six years old today. I've almost caught up with you Ivory.
Ivory: Not quite yet!
Jay Jay: Hey Grams, will you tell us a joke?
Ivory: Come on Grams tell us a good one!
Grams: Ok you two. Knock knock.
Ivory & Jay Jay: Who's There?
Grams: Wanda.
Ivory & Jay Jay: Wanda Who?
Grams: Wanda wish You a "HAPPY BIRTHDAY!"
Ivory: Grams that was a good one.
Jay Jay: You always tell the funniest joke. How did you become so funny?
Grams: It comes with age!

To "Talk Back" write to:
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WISDOM OF ABC'S INFLUENCE

We need dedicated advocates who are relentless in their resolve to promote the health and well being of our community.

There are different levels of dedication any member can confer to manifest their alignment with the goals ABC wishes to achieve. At the ULTIMATE level are those who have devoted themselves to the purpose of the Association. Whether in their work, their words or their worth they have firmly aligned themselves with the strategic plan of ABC. Committed members have provided our outstanding leadership. Those who have served as officers, as Directors to our Board, or Consulting Directors to our Centers have unselfishly given their time and talents to parcel our activities and promote our initiatives as they are developed. We have stalwart legends in Dr. Jay Brown, Dr. Dan Savage, Dr. Walter M. Booker, and Dr. Alphonzo Jordan whose lives personify the dedication to community that we as physicians feel.

Established leaders throughout the disciplines of Cardiology have molded our thoughts. Drs. Clyde Yancy, Keith Ferdinand, Janice Douglas, Ann Taylor, Luther Clark, Roosevelt Gilliam and Jackson Wright have world-wide recognition for carrying the banner as we strive to eliminate the gap as it exists in our community today.

The ABC has been blessed with a committed, active membership. Our 80 Life Members, 25 Board Members, and 24 Staff Members have been at the vanguard in promoting the ideals of our organization. Equally as important are our activists, organizers and operatives who perform the work that our organization is best known for. Our Committee heads and their

members, panelists, speaker's bureau, clinical investigators, community champions and cardiologists-in-training endeavor to keep the ABC at the forefront of

the struggle to achieve parity in the health and well-being that typifies America today.

We have developed a cadre of strong supporters throughout the pharmaceutical and device industry whose sponsorship underscores their faith in our ability to make a difference in health promotion. We have developed liaisons with agencies such as CDC, NHLBI, Robert Wood Johnson Foundation and the Kaiser Family Foundation. We stand prepared to forge relationships with any and everyone who shares our vision of optimal health for all Americans.

We are committed to achieving the best health in our community. Our Epicenter collects the data that guides us through the decision-making process. As we present the evidence we must have viable options in place that can be acted on. It is essential that we have strong programs in place to support and monitor cardiovascular health as we experience it in our community. Whatever your role, your efforts are appreciated and I am relying on your continued support.

Paul Underwood, M.D.
President



THE CARDIOLOGY WORKFORCE CRISIS A WAY FORWARD!

Dear Colleagues,

As summer winds down, and the fall schedule kicks in, I invite you to enjoy this issue of the Digest!

The much awaited Joint Committee report of the Association of Black Cardiologists, The American Heart Association, The American College of Cardiology, and the Consortium of Southeastern Hypertension Control titled "Response to the Institute of Medicine Report" has been approved for publication in the Digest, and is the feature article in this issue.

I encourage your thoughtful reading and analysis of this report.

Led by Dr. Julian Haywood (ABC), workshop authors including Dr. Augustus Grant (AHA), Dr. Alan Brown (ACC) and Carlos Ferrario (COSEHC) should be commended for this important contribution to the literature addressing the Cardiology workforce crisis.

The reports highlights key aspects of disparities in cardiovascular care, and quickly zeroes in on the impact of the cardiovascular manpower shortage, with regards to African American and Hispanic physicians. A key and measurable strategy that was put forth includes efforts to increase the number of board certified underrepresented minority cardiovascular specialists by over 50%, over the next 5 years!

The ongoing efforts of the ABC to promote new and non traditional strategies such as seeking new funding sources to fill approved GME fellowship slots, should be encouraged, and expanded to include collaborations with Historically Black and Hispanic serving Institutions.

Another important report that merits your careful review is the publication in the July 2004 issue of the

Journal of the American College of Cardiology of the 35th Bethesda Conference "Cardiology Workforce Crisis : A Pragmatic Approach to the Growing Shortage of Cardiovascular Specialists."

Working group three, chaired by ABC's own Dr. Charles Francis, with co authors Drs. Joseph Alpert, Luther Clark, Richard Wong, and myself, addressed the topic "How to encourage more minorities to choose a career in Cardiology" (JACC 2004; 44; 241-245).

The workgroup emphasized the importance of increasing "the pipeline" as a key strategy.

In 2001, the AAMC notes that, of the more than 127,574 total physicians in Internal Medicine, 2% were black, and 3.8% were Hispanics.

In 2002, of the 2,223 total trainees in Cardiology, 3.4% were black, and 5.7% were Hispanics.

AAMC trends also show that beginning in 1997, anti-affirmative action ballot initiatives and court decisions in California and Texas have had immediate and lingering effects on minority medical education throughout the nation.

The report emphasized the urgent need for a conscious effort to encourage and facilitate



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A RESPONSE TO THE INSTITUTE OF MEDICINE REPORT ON RACIAL DISPARITIES

A REPORT OF THE JOINT COMMITTEE FOR DISPARITY IN CARDIOLOGY

Co-Sponsored by the The Association of Black Cardiologists, The American Heart Association, The American College of Cardiology, and The Consortium for Southeastern Hypertension Control

According to the 2002 Institute of Medicine (IOM) report, racial and ethnic minorities receive a lower quality of healthcare than non-minorities, even after adjusting for socioeconomic differences and other healthcare access-related variables. Inasmuch as most of the evidence documenting this disparity cited cardiovascular care, four organizations constituted the “Joint Committee on Disparity in Cardiology” with the charge to:

- *Assess the extent of racial and ethnic differences in healthcare that are not otherwise attributable to known factors;*
- *Evaluate potential sources of racial and ethnic disparities in healthcare, including role of bias, discrimination, and stereotyping at the individual, institutional and health system levels;*
- *Provide recommendations regarding interventions to eliminate healthcare disparities.*

As result of this collaboration, the Joint Committee recommends that appropriate steps be taken by the medical and healthcare community at large to understand and eliminate disparities in the availability and access to cardiology and interventional cardiovascular serv-

ices. To the extent possible, efforts to implement interventions should build upon the rationale and evidence-based documentation summarized by the IOM report.

Multiple studies document that African Americans and Hispanics do not enjoy equal access to cardiovascular care which results in a significantly higher rate of cardiovascular related morbidity and mortality. Table 1 documents that, in part, the problem is aggravated by the observation that African-American and Hispanic physicians are more likely than white physicians to have trouble getting patients admitted to hospitals and referred to specialists, factors that will limit their accessibility to cardiovascular care.

The joint committee endorsed the following objectives:

1. Use the IOM report as a base from which to jointly address those issues that can facilitate the reduction of cardiovascular related health disparities.
2. Discuss the relevant issues from the IOM report and supplement those areas that require additional input from a cardiovascular perspective;
3. Developed strategies that could be supported by all four (4) organizations.

Participants

Dr. Julian Haywood chaired the session and represented the Association of Black Cardiologists, Inc. (ABC), Dr. Augustus Grant represented the American Heart Association, (AHA), Dr. Alan Brown represented the American College of Cardiology, (ACC) and Dr. Carlos Ferrario represented the Consortium for Southeastern Hypertension Control (COSEHC).

Strategy

After considering a myriad of strategies, the Joint Committee recommends that this joint effort focus on increasing the number of board

certified under-represented minority cardiovascular specialists by 50% over the next five (5) years. As the population of the United States approaches 300 million, the combined population of Hispanic and African Americans will constitute 25% or 75 million. Yet, there are less than 1,500 Hispanic and African American board certified cardiovascular specialists (cardiologists, cardiac and vascular surgeons) in the United States representing less than 7% of the pool of cardiovascular specialists, (see Figure 1.)

According to Dr. Malcolm Taylor, Immediate Past President of the ABC, "There are only 75 African American cardiologists-in-

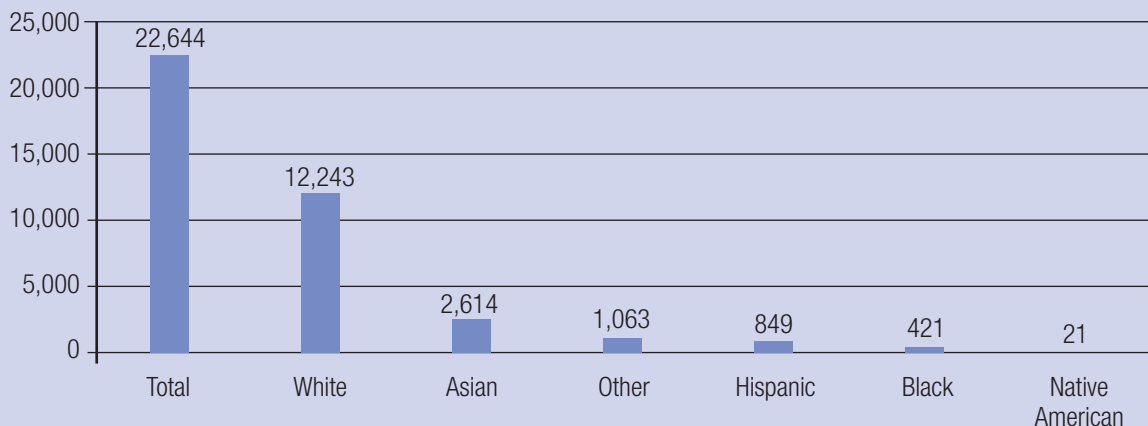
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TABLE 1

	African-Americans (%)	Hispanic (%)	White (%)
Physicians who reported difficulties obtaining hospital admissions for their patients	35.9	32.3	21.0
Physicians who reported difficulties getting their patients referrals to specialists	12.0	14.7	7.5

Source: Physician Survey, 1998-99, Center for Studying Health System Change

FIGURE 1: DISTRIBUTION OF CARDIOLOGISTS IN THE US BY RACE



training, yielding 25 graduates each year. At this rate, combined with the high rate of those leaving the field, the total number of African American cardiologists is not increasing. The ABC estimates that it will require approximately 50 African-Americans cardiologists matriculating each year to increase the number of African American cardiologists by 50% in five years. This will mean a 100% increase in admissions to cardiology training programs. Preliminary data from the ABC files reveal that 20% of the 185 training programs graduated 80% of the African-American cardiologists.

Duke University continues to lead the field in its recruitment, retention and graduation record of African American cardiologists as well as its unprecedented commitment to the black community through its recruitment efforts. Without changing its fellowship and medical school high admission standards, Duke has been able to ensure that twenty-five percent of its medical students and 25% of its cardiology fellows are African-Americans.”

On the other hand, 25 of our cardiology training programs have graduated no African American cardiologists and have no African Americans on their faculty. One hundred others have graduated fewer than three in over 40 years of training cardiologists! If all the cardiology training programs had admitted and graduated one cardiology fellow per year, instead of only 421 African-American cardiologists, there would be 5,000. If that objective is too aggressive, if current training programs admitted and graduated just one cardiology fellow every 10 years there would be twice the number we can presently account for. Currently, 75% of African Americans seek and receive care from cardiologists who are not African American.

The significance of this observation is the finding delineated in the IOM Report, that

when physician and patient are different with respect to race, ethnicity, language, religion and values, ensuring fair, equitable and culturally sensitive care is more challenging. The opportunity for miscommunication and resistance between minority patients and non-minority physicians abound and could be manifest in the way healthcare services are provided. Lack of training opportunities and difficulties in medical school admission reduce the potential pool of physicians that could care for under-represented minorities. In this context, it is important to emphasize that Under-represented Minorities are four times more likely to go to underserved areas to practice and are more likely to see minority patients regardless of where they practice.

The Association of American Medical Colleges (AAMC) reports that 40% of minority physicians choose underserved areas vs. 10% of majority physicians. Furthermore, the study by Komarony et al. (NEJM 1996;334:1305-1310) reported that communities with high proportion of African American and Hispanic residents, were four times as likely as others to have a shortage of physicians. In this California based study, care given by Hispanic physicians to Hispanic subjects was 21% higher than did other physicians. This study also revealed that even among under-represented minorities, cultural and economic factors continue to play a role as black physicians care for more patients covered by Medicaid (P = 0.001), whereas, Hispanic physicians provided care for a disproportionate number of uninsured patients (P = 0.03) than did other physicians.

By 2005, Hispanics will become the largest ethnic minority in the United States. One out of every three Hispanics has no health insurance. Hispanics are 65% Mexican American, 11% Puerto Rican, 8% Cuban, and 16% Central and South American and from other Spanish-speaking countries. They are subjected to a health system with limited knowledge of the Hispanic culture and language. Hispanic

physicians number about 4% of the physician workforce in the United States. Hispanic physicians serve as the safety net, along with community based clinics, for their communities in urban, rural, and U.S.A.-Mexico border areas of the nation. In addition, Hispanic medical faculty is beginning to engage themselves in the study of health issues and their impact on this segment of the population.

According to the AAMC African American and Hispanic physicians constitute less than 6% of the physician workforce, with Hispanic physicians in the cardiovascular specialties at twice as much as African Americans. The AAMC further asserts that increasing minority admissions to medical schools would achieve parity with the proportion of under-represented minorities, rectify inequities in educational opportunities, and a growing appreciation that minority doctors are more likely to work in underserved communities.

Not to address the workforce issue could lead to perpetuation of the on-going health disparities, especially in African American populations that were documented in the IOM report. Access related factors (insurance status, ability to pay and clinical setting) will certainly continue to act as contributors to observed differences in CVD care as well as other chronic diseases. However, racial differences persist even after these factors are accounted for.

The data reflecting examples of health disparity are consistent and robust.

- *Schulman et al.* Physicians were less likely to refer black women for appropriate catheterization.
- *Weiss et al.* Male physicians prescribed twice the level of analgesic medication for white patients while female physicians prescribed higher doses to black patients.
- *National Hospital Discharge Survey.* Blacks are less likely to undergo CABG or angiography.
- *Escarce et al.* Black Medicare patients were

one half to one third less likely to receive appropriate CVD procedures.

- *Goldberg et al.* Whites are four times more likely to receive CABG.
- *Ayanian et al.* Whites are 78% more likely to receive re-vascularization.
- *Weitzman et al.* Blacks admitted to either teaching or non-teaching hospitals were less likely to receive PTCA, CABG or thrombolytic therapy.
- *Oddone et al.* Black stroke victims are half as likely to receive appropriate carotid imaging.
- *Mitchell et al.* Blacks were 83% less likely to receive non-invasive cerebrovascular testing.
- *Chin et al.* Black diabetics are less likely to undergo a measurement of glycosylated hemoglobin, lipid testing, ophthalmologic visits, more likely to be treated with insulin and have poorer glycemic control.
- *Laouri et al. (RAND/UCLA)* Blacks were half as likely to undergo necessary CABG and one fifth as likely to receive PTCA

Having reviewed not only the IOM Report but also the relevant literature, the Joint Committee will support initiatives to reduce the disparity in the availability of African American and Hispanic physicians in the workforce by promoting the following outcome objectives. The taskforce asserts that purposefully placed manpower not only to give patients more options in their choice of providers but also with a recognition that as more minority physicians join the workforce, the dynamics of the workplace will change and individuals and institutions will become more sensitive to the needs of minorities.

Outcome Objectives

1. For cardiology training programs that are unable to support additional fellowships, we will seek non-traditional sources of funds to

continued on the next page

train additional cardiovascular specialists that are representative of both African American and Hispanics.

- *Foundations*—Robert Wood Johnson, Kellogg, Ford and Kaiser Family Foundations
- *Government (PHS Grants)*
- *Industry*

2. For those physicians able to complete, cardiovascular fellowships with these new sources of funding, a formal pay-back commitment should be delineated where these recipients will serve in under-represented communities for a period equal to the training support they received.

3. Identify those training programs that have graduated less than five African American and/or Hispanic cardiovascular specialists and offer assistance to identify qualified candidates for cardiovascular fellowships.

4. Publicize and monitor training opportunities that are part of the grant-award portfolio sponsored by the National Heart, Lung, and Blood Institute of the NIH and encourage medical school admission committees to increase their awareness regarding their mission to train physicians that can be devoid of a the state of “normative blindness.” That is to say, what we are born into and accept as normal.

5. Initiate a Joint Work Group to design an overall program to increase awareness of the need to train underrepresented minority cardiovascular specialists.

6. Training directors and deans from institutions that have graduated less than five underrepresented minority fellows should receive special emphasis in recruitment effort program planning.

7. Advocate the inclusion of specific cultural competence training in all cardiovascular fellowship programs.

8. Look at the feasibility of regularly scheduled meetings of all four organizations to institutionalize efforts to increase the number of under-represented minority cardiovascular specialists.

9. Evaluate the feasibility of using NIH Guidelines to ensure that all training programs receiving federal funds are held to a standard that under-represented minorities are included for all research grants.

10. Approach hospitals in rural and under-served areas for salary support for minority cardiovascular specialists. As an added benefit, organize existing cardiovascular specialists in a “virtual” locum tenets network to offer coverage relief so that cardiovascular specialists working in rural areas can leave their practices in good hands when they are on vacation, studying or for personal emergencies. This should increase the likelihood that more cardiologists will locate in rural underserved areas.

11. Organize state specific lobbying efforts to address those factors that prevent the procurement of affordable malpractice insurance coverage for cardiologists.

12. Inasmuch as most cardiology training programs report that they are able to accommodate two additional fellows per year if they could afford to pay these salaries, a marvelous opportunity is presented to fill these positions with under-represented minorities with funds specifically identified to support this effort.

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COMMUNITY PHYSICIANS NETWORK[®]

A PRACTICE BASED CONSORTIUM TO ELIMINATE HEALTHCARE DISPARITIES

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Introduction

Multiple factors interact to promote and maintain disparities in health care:

- a) *Patient factors include risk factor prevalence, and poor adherence to lifestyle or pharmacologic intervention*
- b) *Health care practitioner factors include inconsistent application of clinical practice guidelines*
- c) *Health care delivery systems barriers such as access to care and limited evidence base for effective therapies in African Americans and other underserved populations.*

The influence of race, ethnicity, and socioeconomic status (SES) is recognizably profound, but difficult to measure, due to the complex interactions of human behavior and health outcomes.^{1,2}

Indeed race, culture, and SES interact at all levels of the health care delivery process beginning with patients' trust, knowledge of and access to the health care system, to patient-provider interactions, and adherence to treatment recommendations.^{3,1}

Further compounding these interactions are the historic evolution of human experimentation on ethnic minorities, and the systemization of race and racial bias in America.^{4,5}

Only recently, a report from the Institute of Medicine confirmed that racial bias plays a major role in the diagnosis and treatment of patients.⁶

The history and economics of medicine also contribute to disparities, given the segmentation of the current health care delivery model, such that ethnic minorities and the poor (sometimes indistinguishable) are generally served by large urban inner city health centers. These centers generally serve as the teaching hospitals for research-intensive institutions. Therefore, much of the research and knowledge base on health disparities have relied on data from the teaching centers, the VA hospitals or administrative databases such as Medicare.^{7,8}

Such data are central to the formulation of National practice guidelines and treatment recommendations.

However practicing physicians are often faced with conflicting recommendations on treatment strategies in minority and under represented populations, due to limitations of these data.⁹ Therefore, further research as well as potential solutions must shift to the community, where a broad spectrum and diverse patient population (socioeconomic, ethnic and cultural) receive care.

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Although community practitioners are starting to participate in multi-center clinical protocols, these data usually remain with the sponsoring agency, most often pharmaceutical companies, and therefore are generally not accessible for analysis. Additionally, there is no incentive for longitudinal follow-up beyond the confines of the clinical trial.

Most importantly however, ethnic minorities including patients and physicians remain severely underrepresented in these clinical protocols.

Strategies to improve health care disparities must therefore, involve a fundamental paradigm shift to a process that not only 'speaks' to the inclusion of ethnic minorities but encourages and tests systems that will facilitate such inclusion.

The Morehouse Community Physicians' Network[®] (CPN) is a consortium of primary care and multi-specialty community based health care practitioners in partnership with Morehouse School of Medicine to eliminate health disparities through innovative educational programs, clinical research participation and practice based interventions. The consortium will promote equity in health care by expanding the African American Practitioner base in clinical research, increasing participation of African Americans and other ethnic minority patients in clinical trials, and supporting "best practices". By bringing together the science of Academic Medicine with the real world practice of the community, where most patients receive their health care, CPN[®] has a tremendous opportunity to positively influence health care outcomes.

Two recent developments lend support to the critical need for such a consortium, as an important mechanism to eliminate health disparities:

1. New Federal mandates on medical records privacy, and the National Institute of Health (NIH) certification requirements for human subjects protection.

3. Increasing expense of the drug discovery driving a more rapid and streamlined clinical trial recruitment process.

Both developments are likely to reduce the participation of African Americans and other minority physicians because of the limited infrastructure in these largely solo or small practices.

The framework and structure of CPN[®] will facilitate participation of such practices (see figure 1)

The Community Physicians Network[®] has partnered with National Professional Organizations including the National Medical Association (NMA), and its regional affiliates, the Association of Black Cardiologists (ABC), and the Consortium of Southeastern Hypertension Control (COSEHC) thus ensuring a broad base of support from physicians who treat a large majority of African American and other underserved minority populations.

CPN[®] has 2 primary strategies:

1. A regional educational strategy which focuses on practice based disease specific registries. Through initial pilot funds from the National Center for Minority Health to the Morehouse School Of Medicine's Center of Health Disparities, and a subsequent award from the Medtronic Foundation, CPN[®] has initiated Hypertension and Heart Failure registries.

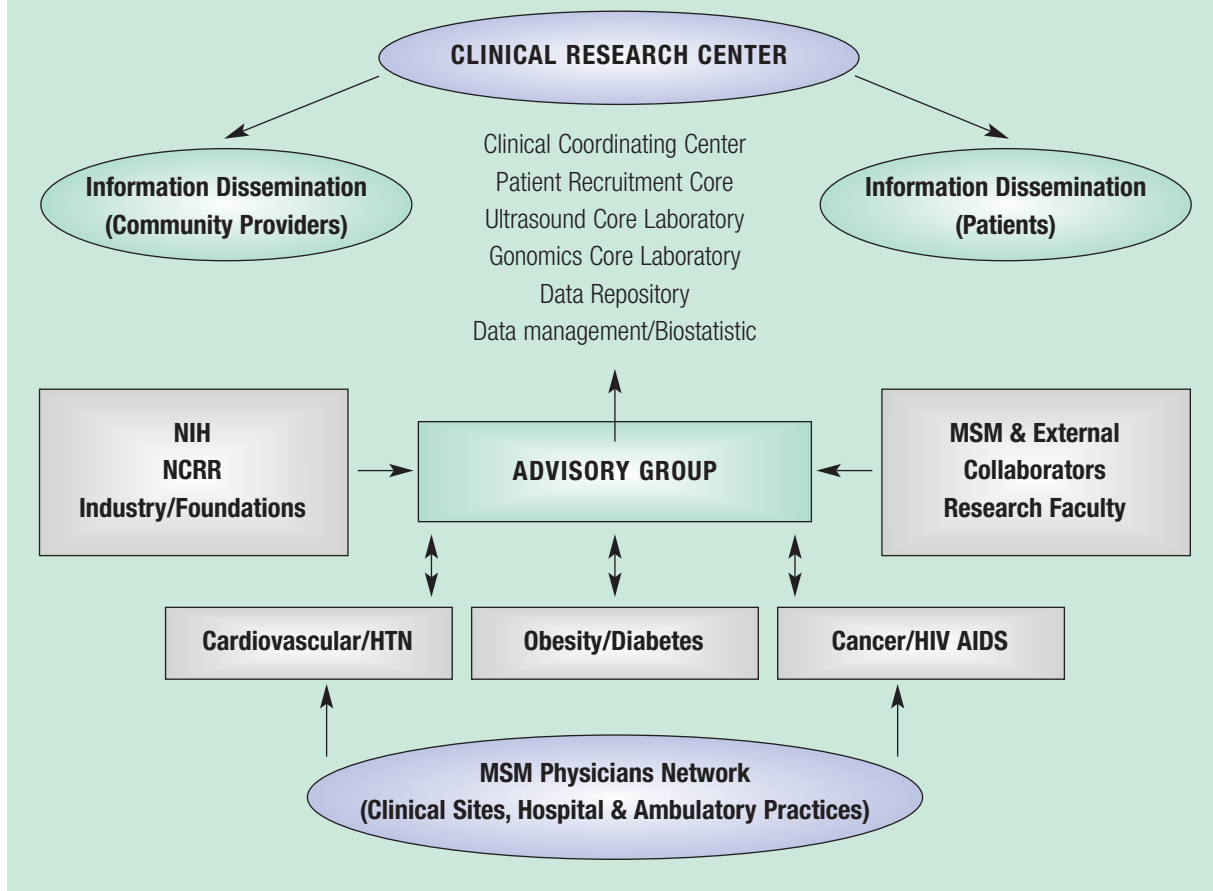
Such regional registries will inform practice specific educational efforts, as well as drive further regional or national educational initiatives, in collaboration with CPN[®] organizational partners. (see figure 2)

3. A national clinical research strategy that focuses on training and certification of CPN[®] physicians and other study coordinators for participation in pharmaceutically sponsored as well as NIH clinical protocols.

CPN[®] membership is open to physicians whose practices provide care to at least 30% minority patients (includes African Americans, Hispanics, Asians, Native Americans, Pacific Islanders and Alaskan Natives).

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FIGURE 1: MOREHOUSE COMMUNITY PHYSICIANS NETWORK®: AN ACADEMIC-COMMUNITY PARTNERSHIP TO ELIMINATE HEALTH DISPARITIES



*Community Physicians Network®
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Acknowledgements

The Morehouse Community Physicians Network® is supported by:

*grant # NIH NCRR- RCMI grant#
5P20RR11104 to the Clinical Research Center*

*grant# 5P20MD00272 Healthcare Disparities
Center.*

The Medtronic Foundation

*Sanofi Synthelabo Inc. has provided an unre-
stricted educational grant toward partial
support of CPN© physicians' training and
certification.*

CPN© also acknowledges its organizational partners and hospitals:

*The Association of Black Cardiologists, the
National Medical Association, the Georgia
State Medical Association, the Atlanta
Medical Association the Consortium of
Southeastern Hypertension Control and
Grady Memorial Hospital.*

*CPN© thanks the many practices that have
completed practice demographics for inclu-
sion in the registries.*

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minority students' enrollment throughout the medical career pipeline, from elementary school on through to Cardiology fellowship training. Medical institutions and private establishments from Academic Medical Centers to the National Institute of Health, undergraduate, post baccalaureate programs, as well as physicians in private practice must work to create, and serve as positive role models or mentors to future Cardiologists!

Best Regards,
Elizabeth Ofili, MD, MPH, FACC

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