High Value Cardiovascular Care In Underserved Populations

Disparities in Healthcare

- Race/ Ethnicity
- Gender
- Insurance Status
- Wealth

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Intercountry Differences in Guideline Directed Medical Therapy and Outcomes Among Patients With Heart Failure
JACC: HEART FAILURE VOL. - , NO. - , 2021 Fuery et al. - 2021:

- **Patients with HFrEF in the United States were twice as likely to be hospitalized for HF compared with patients in Canada.**
- **The differences in outcomes was driven by increased heart failure hospitalization among U.S. Black patients.**

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Racial, Ethnic, and Sex Disparities in Patients With STEMI and Cardiogenic Shock.
JACC: CARDIOVASCULAR INTERVENTIONS VOL. 14, NO. 6, 2021

- Queried the National (Nationwide) Inpatient Sample database from January 2006 to September 2015.
- Women are less likely to undergo invasive cardiac procedures, including revascularization and Mechanical Circulatory support.
- Women as well as Black and Hispanic patients have a higher likelihood of death compared with White men.

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Cardiovascular events in percutaneous coronary intervention related to insurance status

American Journal of Cardiology January 2011

In Hospital deaths

- No insurance = 5.1%
- Medicaid = 6.2%
- Medicare = 4.5%
- Private Insurance = 1.5%

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Association of Dual Eligibility for Medicare and Medicaid With Heart Failure Quality and Outcomes Among Get With The Guidelines–Heart Failure Hospitals. JAMA Cardiology:10.1001/jamacardio.2021.0611

1. **Dual eligibility for Medicare and Medicaid, is an indicator of low socioeconomic status, higher rates of comorbidities, and high health care spending.**

2. **Dual eligible patients have lower performance on HF care measures, who were less likely to have left ventricular function measured, to have a post discharge HF appointment, to receive aldosterone antagonists, to receive anticoagulation for atrial fibrillation, and to have an ICD placed or prescribed at discharge.**

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Sex and Race/Ethnicity Differences in Implantable Cardioverter-Defibrillator Counseling and Use Among Patients Hospitalized With Heart Failure

Circulation. Volume 134, Issue 7, 16 August 2016, Pages 517-526

- The GWTG-HF program.
- AICD resulted in a 31% and 23% reduction in the hazard of death in comparison with conventional medical therapy.
- Eligible race/ethnic minority group patients were less commonly counseled than their white counterparts (white patients 24.3%): black patients 22.6%, Hispanic patients 18.6%, and other race/ethnic minority patients 14.4%
- Race/ethnic minority group patients received or were prescribed an ICD less commonly than white patients (white patients 65.3%): black patients 58.0%, Hispanic patients 56.3%

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Racial and Ethnic Disparities among Enrollees in Medicare Advantage Plans John Z. Ayanian, M.D., M.P.P., Bruce E. Landon, M.D., M.B.A., Joseph P. Newhouse, Ph.D., and Alan M. Zaslavsky, Ph.D. n engl j med 371;24 nejm.org December 11, 2014.

- Black enrollees were substantially less likely than white enrollees to have adequate control of blood pressure, cholesterol, and glycated hemoglobin.
- Despite overall improvements in risk-factor control for black enrollees and white enrollees, substantial disparities between these groups persisted nationally.
- The enrollment of blacks in lower-performing health plans accounted for about half the disparity in each case.
- There were substantial disparities in intermediate outcomes that continued to persist in Medicare Advantage health plans nationally for blacks as compared with whites with hypertension, cardiovascular disease, or diabetes in 2011.
- **Disparities in risk-factor control for blacks was eliminated in the West among Kaiser health plans.**

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Achieving High Value/Quality Care

Remove Financial Barriers to Health Care.

Provide access to Everyone

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- All patients ≤ 200% Federal Poverty Level Pay nothing
- Reached out to Federal Qualified Clinics, Addiction Centers, Halfway houses, Homeless Shelters, Refugee Centers and other Non for-profit clinics. Provided direct access for their patients.

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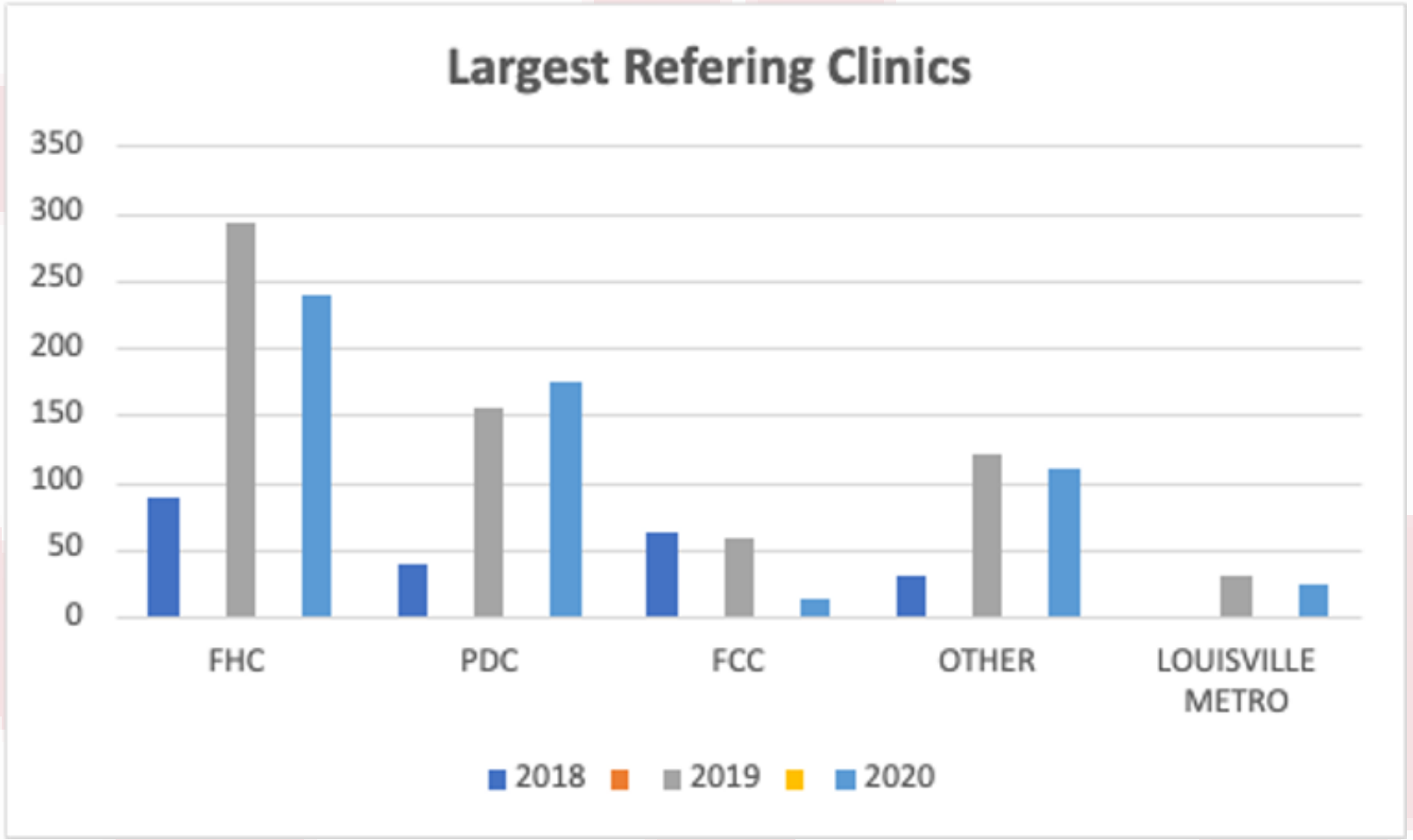

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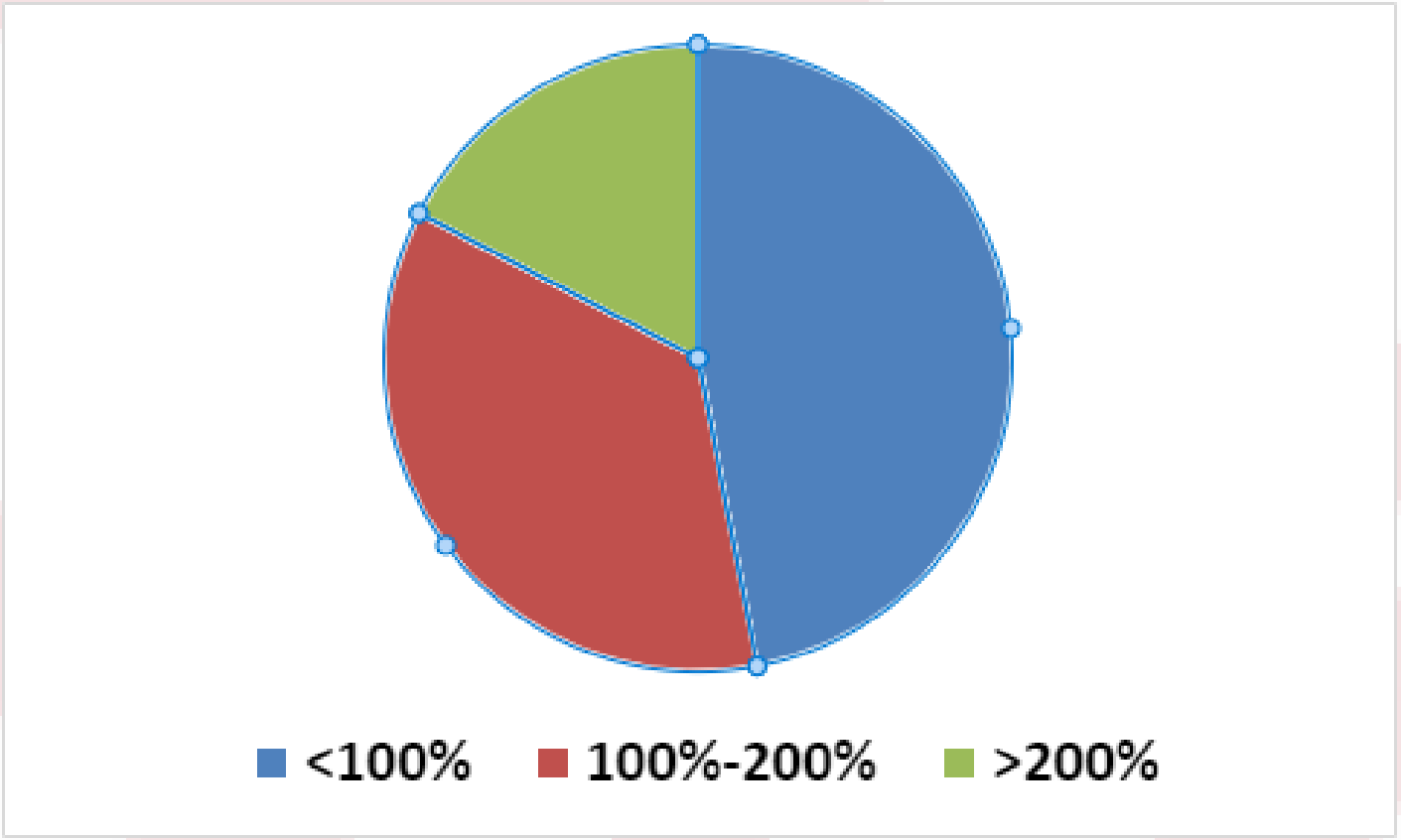
Federal Poverty Level

83% ≤ 200% FPL



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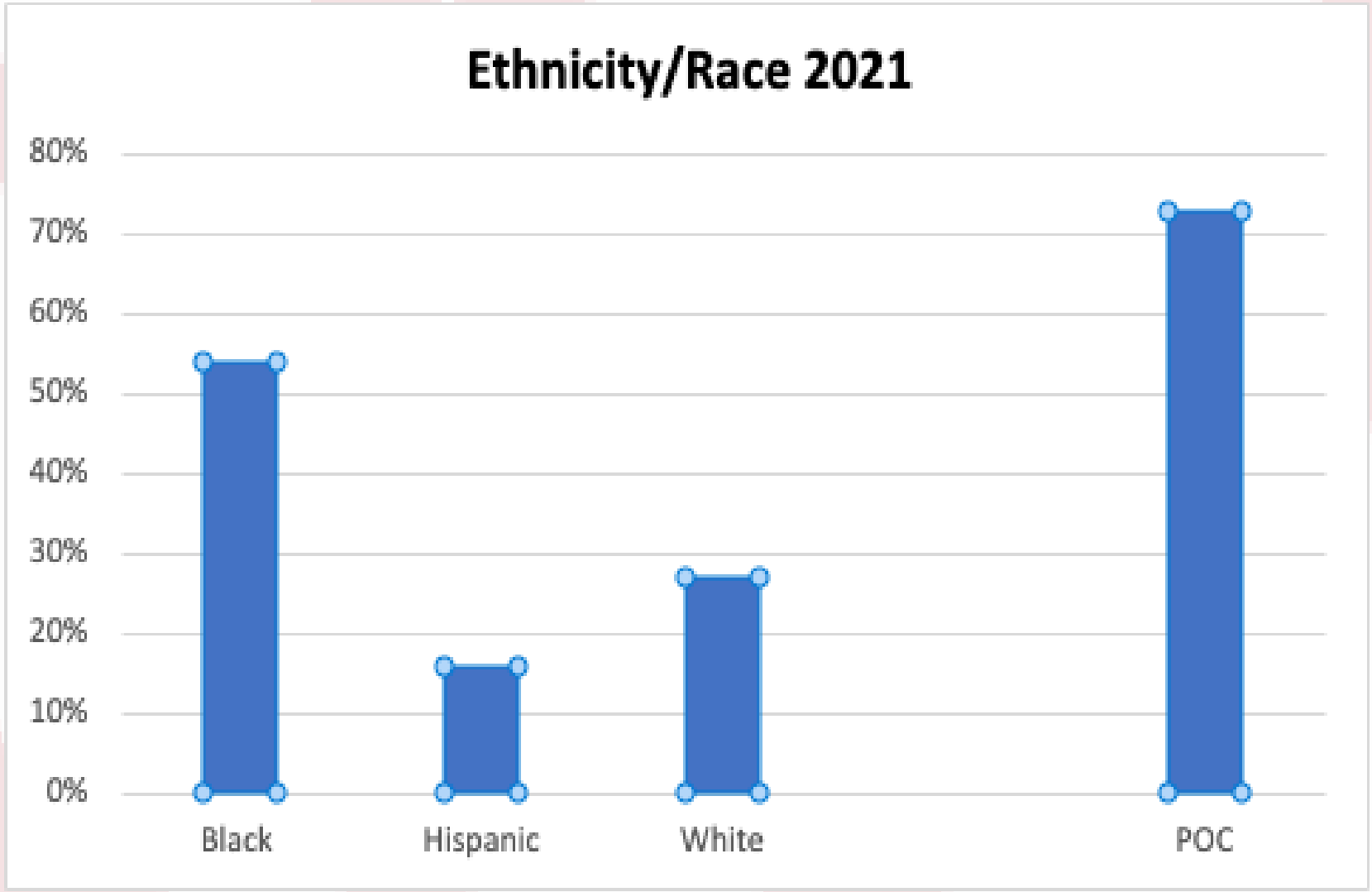
2018 – 2020:
62% People of color

2021 :
72% People of color



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Expand the Collection, Reporting, and Analysis of Standardized Data

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Quality Data

CHF ACE/ARB	Prescribed	Not Prescribed	Percent
Black	21	3	88%
White	25	2	93%
LA	7	1	88%

Black		Prescribed	Not Prescribed	Percent
Total	**33**			
eligible	**31**	**29**	**2**	**93%**
White				
Total	**32**			
Eligible	**30**	**28**	**2**	**93%**
LA				
Total	**8**			
Eligible	**8**	**6**	**2**	**75%**

CHF AICD		Percent	Prescribed	Not Prescribed
	Black	100%	10	0
	LA	**100%**	3	0
	White	**100%**	14	0

CAD B Blocker	Prescribed	No Prescribed	Percent
LA	14	2	88%
Black	42	5	89%
White	96	6	94%
Total	164	12	88%

CAD anti platelets	**Prescribed**	**No Prescribed**	**Percent**
LA	16	0	100%
Black	43	3	93%
White	99	2	98%
All	166	5	97%

	Statin	No	Percent on
Black	19	1	95%
White	29	2	93%
LA	4	1	80%

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Barriers to Quality Healthcare

- Multiple Medical conditions
- No Shows
- Income
- Transportation
- Safety/Walkability
- Language
- Insurance Status
- Communication

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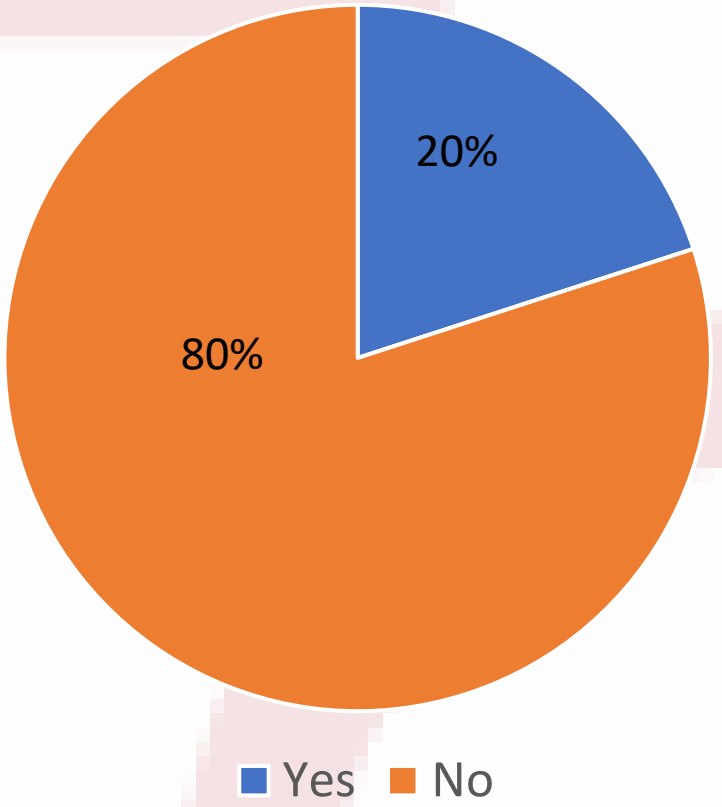
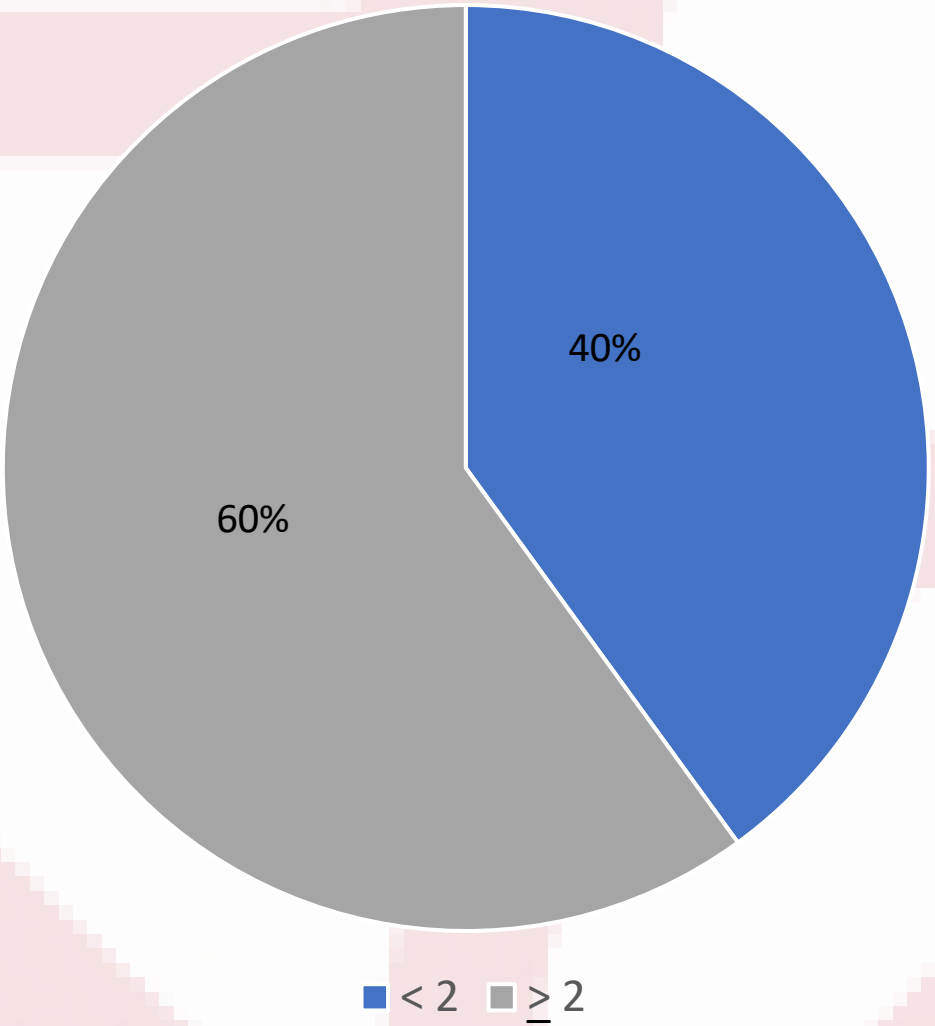
Limited English language Proficiency Interpreter use



Chronic Illness



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Addressing the Needs

Motivational Interviewing

Teach Back Method

Interpreters

Uber rides

Patient Advisory Council

PCP communication

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Preventive Cardiology/ Health Equity Center

Black	Initial	6 month		White	Initial	6 month		Hispanic	Initial	6 month		Total	Initial	6 month
Statin at Goal	62%	78%		Statin at Goal	62%	75%		Statin at Goal	43%	100%		Statin at Goal	60%	79%
True	43	7		True	13	3		TRUE	3	1		TRUE	59	11
False	27	2		False	8	1		FALSE	4	0		FALSE	39	3
BP at Goal	39%	56%		BP at Goal	52%	100%		BP at Goal	43%	100%		BP at Goal	42%	71%
True	28	5		True	11	4		TRUE	3	1		TRUE	42	10
False	43	4		False	10	0		FALSE	4	0		FALSE	57	4
Exercise at Goal	15%	22%		Exercise at Goal	5%	25%		Exercise at Goal	14%	100%		Exercise at Goal	13%	29%
True	11	2		True	1	1		TRUE	1	1		TRUE	13	4
False	60	7		False	20	3		FALSE	6	0		FALSE	86	10
Diet at Goal	26%	44%		Diet at Goal	24%	50%		Diet at Goal	43%	100%		Diet at Goal	26%	50%
True	18	4		True	5	2		TRUE	3	1		TRUE	26	7
False	52	5		False	16	2		FALSE	4	0		FALSE	72	7
Medication Compliance	84%	78%		Medication Compliance	95%	100%		Medication Compliance	86%	100%		Medication Compliance	87%	86%
True	59	7		True	20	4		TRUE	6	1		TRUE	85	12
False	11	2		False	1	0		FALSE	1	0		FALSE	13	2

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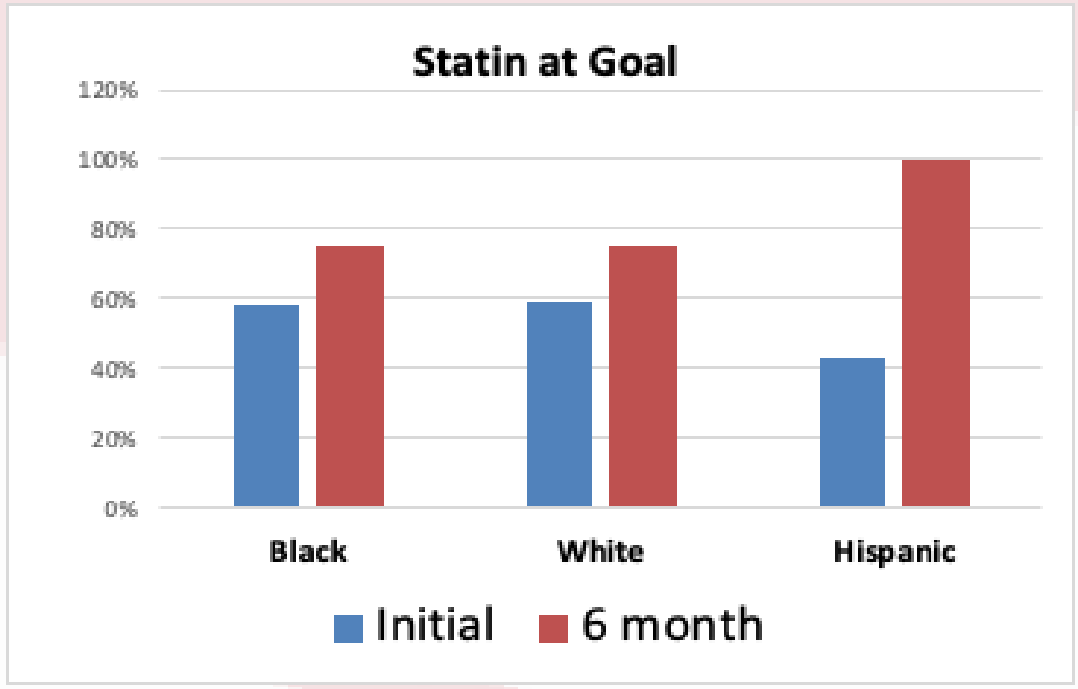

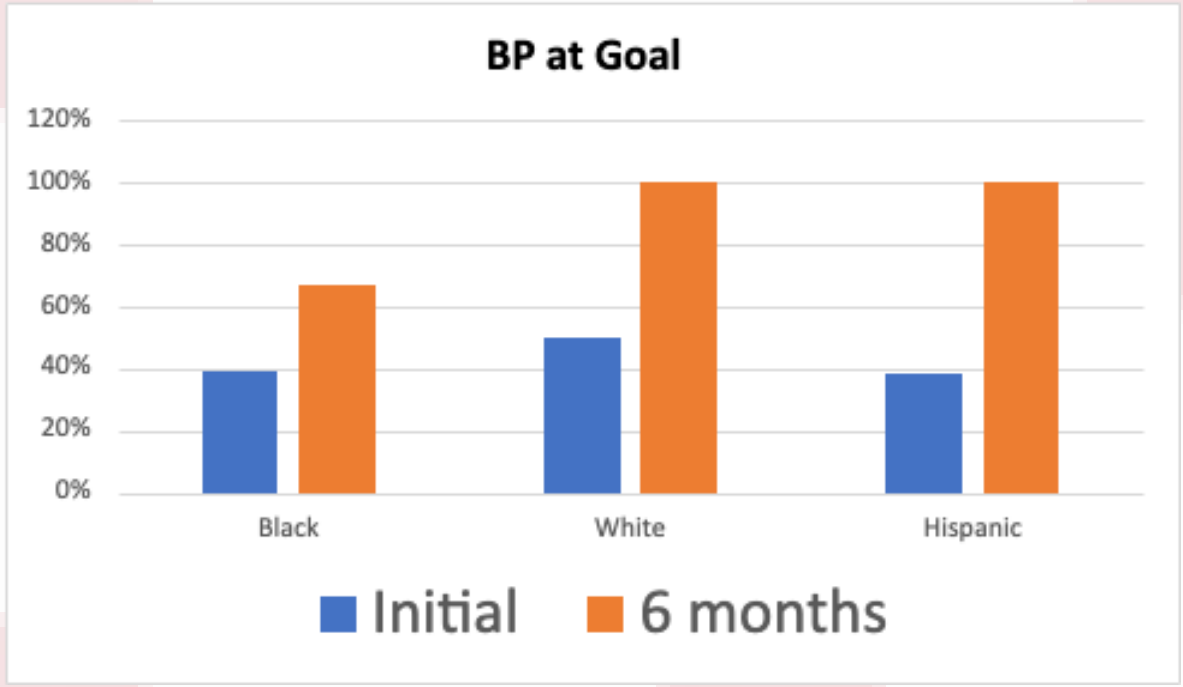

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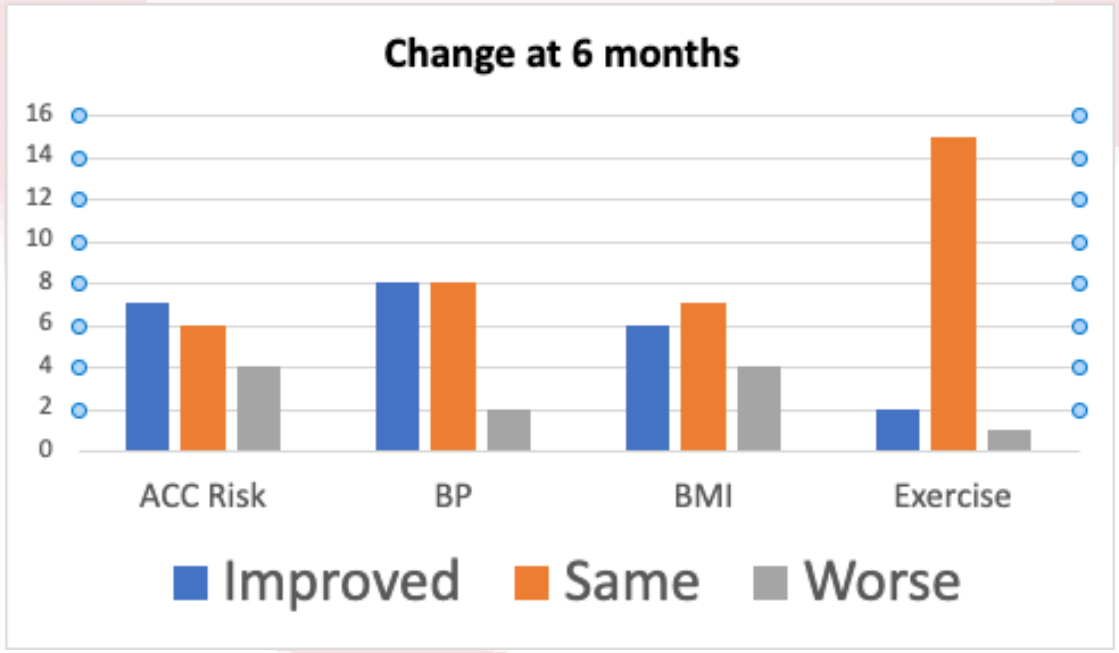

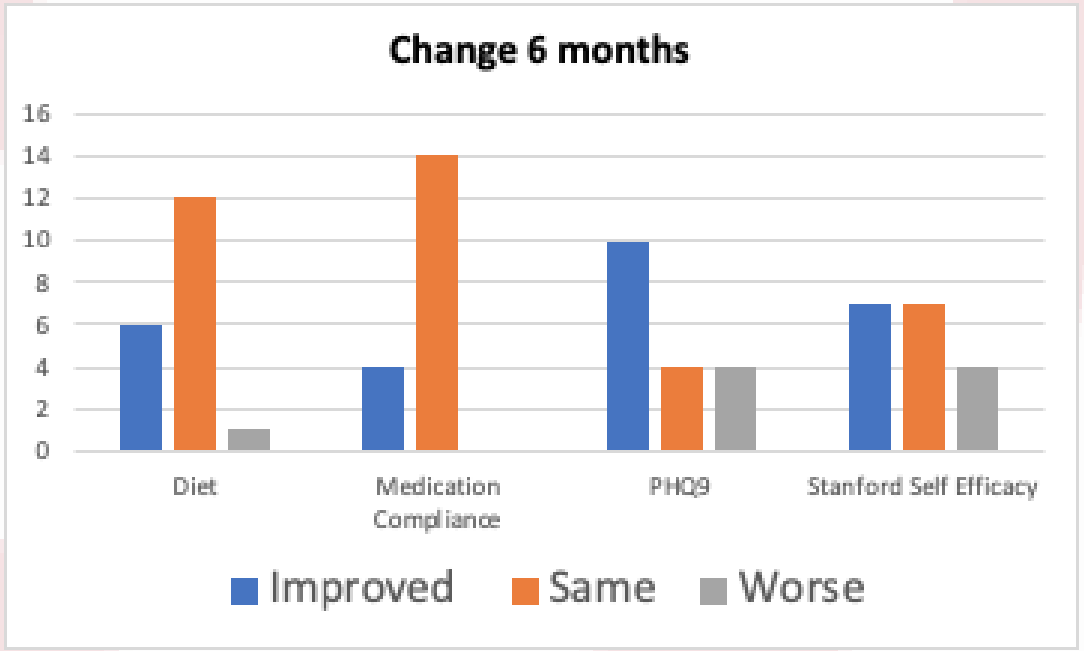

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Conclusion

1. **High Value/High Quality care can have a big impact in populations where healthcare disparity exits.**

2. **Need real outcome data**

3. **High value care takes more time.**

4. **Need coordination of care with Primary care providers.**

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Advocate for Policies to Improve Equity in the Social Determinants of Health.

- Health care leaders and providers should advocate for policy and system changes that will shape underlying opportunities to be healthy.

- The health care sector should advocate--along with other sectors--to seek the reversal of the underlying social inequities that contribute to worse health outcomes among marginalized groups.

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Conduct and/or Support Rigorous Evaluations of Health Equity Interventions to Identify What Works.

- Yet high-quality evidence is needed to identify which approaches yield positive results, for whom, and at what cost.
- To accomplish this, health care leaders, providers, researchers, and funders must insist on rigorous evaluation of health equity interventions.

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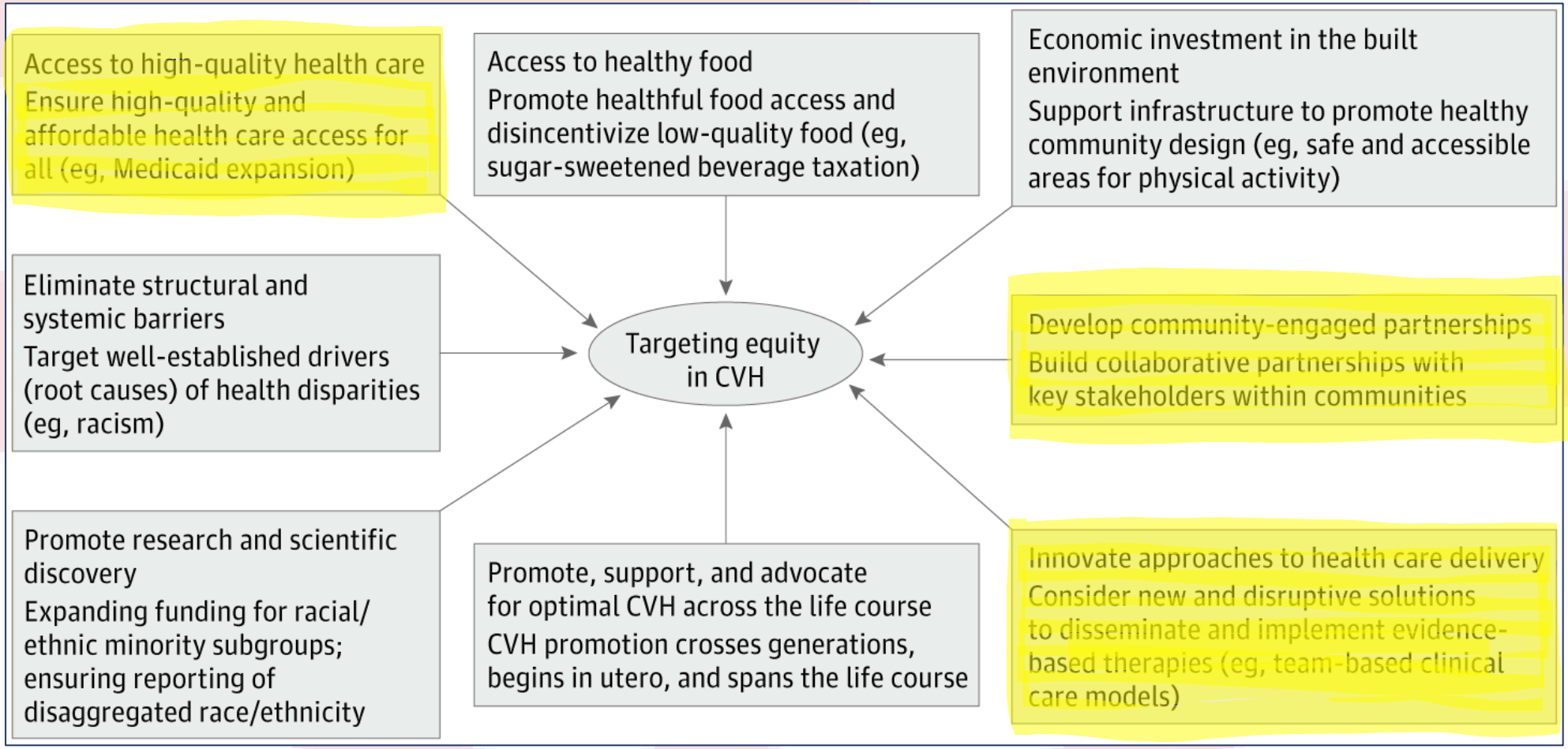
State of the Nation's Cardiovascular Health and Targeting Health Equity in the United States. A Narrative Review
JAMA Cardiol. Published online May 19, 2021. doi:10.1001/jamacardio.2021.1137



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