

Cardiology: Real-World Tactics to Address Health Inequities



CMEO Podcast Transcript

Monica Peek, MD, MPH, MS, FACP:

Hello, and welcome to a special BriefCase activity that is part of a series I am leading on diversity, equity, and inclusivity with CME Outfitters. Today's CMEO BriefCase is titled, *Cardiology: Real-World Tactics to Address Health Inequities*. Today's program is supported by an educational grant from Johnson & Johnson. I'm Dr. Monica Peek, and I'm the Ellen H. Block Professor for Health Justice in the Department of Medicine at the University of Chicago, where I also serve as the Associate Director of the Chicago Center of Diabetes Translation Research. I'm also the Director of Research for the MacLean Center of Clinical Medical Ethics. I'm delighted to be joined today by two outstanding colleagues who will ask to introduce themselves, starting with Dr. Rachel Bond.

Rachel Bond, MD, FACC:

Thank you so much, Monica. So, my name is Dr. Rachel Bond. I am currently out in Arizona where I oversee our women's cardiovascular program at Dignity Health. I also am an Assistant Professor of Internal Medicine at Creighton University School of Medicine. And lastly, I'm the Co-chair of the Cardiovascular Disease in Women and Children's Committee for the Association of Black Cardiologists.

Monica Peek:

Thank you so much for joining us. And Dr. Utibe Essien is also with us. Utibe, can you introduce yourself?

Utibe Essien, MD, MPH:

Absolutely. So, a pleasure to be here. My name's Utibe Essien, and I'm an Assistant Professor of medicine at the University of Pittsburgh School of Medicine.

Monica Peek:

Thank you so much for being with us. I'm honored to have you both sharing the space with me today and I'm excited for our discussion. Our first learning objective today is to identify the impact of health inequities in cardiology patients with atrial fibrillation. But before we begin, I want to remind our audience that this CMEO briefcase is a continuation of our initiative to address unconscious bias, health disparities, and racial inequities. We're building a comprehensive library of educational activities addressing these very important issues. And today's activity continues the discussion with a focus on cardiology. On this slide are titles of some of the activities in the series with links to each of them. To view any of these programs, simply click on the activity title. If you participate in at least three of the programs in our D&I Hub, you'll also be eligible to perceive a digital badge demonstrating your commitment to an education on diversity, equity, and inclusivity.

Before we jump into today's program, let's get a sense of our baseline familiarity with inequities associated with cardiovascular care. Our learners, the audience, you can answer now, the questions are on the screen. And so, the question is, how familiar are you with health inequities in cardiovascular care? A, not familiar; B, somewhat

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familiar; C familiar; or D, very familiar? You can go ahead and vote now and we'll revisit the responses later in the program.

So, as we begin to address cardiovascular care disparities, I want to make sure that we review some foundational points regarding historical racism to remind us all how we got here. We've done previous programs that cover these topics in depth, and those programs can be found in our D&I Hub. We really have a groundwater issue, and I encourage everyone to participate in our foundational program so we can learn and do better. But just to sort of provide an overall summary that begins with the issues around structural inequities due to race, and we call that structural racism, so we know that we broadly define structural racism as disparate or differential access to good services, resources, risks and opportunities because of race.

And so right now, we're talking a lot about social determinants of health, and so that means poverty and unstable housing and food insecurity, limited education and opportunities. All of these social determinants of health aren't randomly occurring in the population. Part of their distribution is being driven by racism, and their effects are differentially felt depending on the social identity within our country. And so, structural inequities means that people who are racialized minorities are more likely to experience these social determinants of health. It also means that within the healthcare system, that there are implicit biases that providers have against racialized minorities within the communities that racialized minorities live. It's not just the external things that they may be less likely to have like goods and services, but it's things that are in the built environment, in the social environment, but also the natural environment in the air, the water, the things that are naturally occurring. And so, we think about communities of color that are more likely to be close to a landfill or close to the industries that are polluting the air.

And so, all of these things are a result of intentional policies and procedures and norms that make certain populations, racialized populations, more likely to be exposed to things that ultimately cause them to be ill. And so, these indirect effects have pathophysiologic changes that occur within people's bodies that increase their cortisol levels, that dysregulate their autonomic nervous systems, and then increase their risk for chronic diseases, the very diseases that me, as an internist, I see every day. There's also just an immediate increased risk of things like anxiety, depression, post-traumatic stress disorder (PTSD) from experiencing an increase of discrimination and racism in our country.

We also know that, again, when we think just about the healthcare system, that providers through the implicit bias and sometimes explicit bias that patients are experiencing differences in care that they get, or there's variation from standards of care, SOC. And so, all of this can lead to differential health outcomes for the most marginalized populations who need more care, but within those healthcare systems, they're receiving disparate care in the first place. And so, in the long term, what we see is the communities who are most in need requiring more care from care institutions, but they're being some issues around access, but also issues around hesitancy to sometimes go and receive that care. And we saw that with the COVID pandemic, issues of both access and some hesitancy because of this long history of institutional distrust that had been earned.

And so, structural racism is not just about what may have happened in the past, it's about what continues to happen on a daily basis as far as the structures and policies around us, but is also how it impacts the behaviors between the patients that come into our offices with their lived experiences and how they interact with us as health providers and ultimately what that means for health outcomes. And so, as we understand that as a larger,

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sort of, context and framework, we can then dive into our individual diseases that we talk about. And today, that means atrial fibrillation and cardiovascular health. So, I'm going to ask Rachel how what I just discussed is applicable to many, if not most specialties, and if you could talk some about the specific disparities that you know in cardiovascular health.

Rachel Bond:

Absolutely. Thank you first for that introduction, and a lot of what you touched upon absolutely impact cardiovascular disease. We know cardiovascular disease being that umbrella term impacts the atherosclerotic buildup either in the coronary arteries or the cerebral vascular system or the peripheral vascular system, but also it implies that atrial fibrillation, such as an arrhythmia, is also under that umbrella term. And when we think about cardiovascular disease, we know that it's across the board where these disparities lie. We've made several strides over the past several decades in terms of decreasing both morbidity and mortality, but it's not equal in the sense that there remains to be both sex, gender, race, and ethnic disparities. And when you actually look at the level of even primary consultations, initially bringing a patient to a cardiologist like myself to actually, hopefully, diagnose their condition early and provide an appropriate management course, we know that women are less likely than men to receive such a consultation.

Similarly, we know that community health centers, specifically that care for patients, are less likely to also refer to a cardiologist as opposed to hospital-practice patients. And this is a lot, a lot of this comes with possibly access to cardiologists and or subspecialties of cardiology. But beyond that, we have to think about those social aspects that you reference even internally, possibly biases, implicit biases as an example. And when we think about race and ethnicity, we know that Black patients and Hispanic patients are more importantly less likely to be treated for conditions such as acute coronary syndrome, specifically acute myocardial infarction. And as a result, they either have delayed revascularizations and/or may not be provided the same guideline-directed medical therapy.

When we think about what has guided us in terms of management, it has been researched. And when you look at all of the research trials, we know that from 1986 to 2018, only 56% of cardiovascular trials reported information on race, and only 20% actually reported race information when it came specifically to heart failure trials. And the same could be said for sex and gender, where we know that female enrollment in many of these cardiovascular trials are very low, at best, 30%. And predominantly, there's a lower percentage of female enrollment when it comes to procedural trials, much more than pharmacologic trials. So, what this highlights is that we need to get to the core issue, which is that, that enrollment of patients such as women, such as racial and ethnic minorities, needs to be at the forefront in order for us to actually adequately treat these patients best, but also refer them as early as possible to the cardiologist.

Monica Peek:

I thank you so much, Rachel. One of the things I think that was important was that only 20% of heart failure trials even reported race information. Utibe, you recently looked at the underrepresentation of racial and ethnic groups in atrial fibrillation studies. What can you tell us about this data?

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Utibe Essien:

Yeah, absolutely. So just piggybacking off of what Rachel shared, you know, it's not just a heart failure issue, but we see the same thing in story, play out in atrial fibrillation where my colleagues and I last year looked at the last decade or so of atrial fibrillation trials, especially those focused on anticoagulation therapy, anti-arrhythmic therapy, catheter ablation therapy. And we really saw from 2009 to 2019 a significant dearth of non-White individuals, so Black, Hispanic, Asian, American Indian, Alaskan Native represented in these trials, some of the leading trials that are the reasons why we used direct oral anticoagulants or DOACs to help with stroke prevention in patients with atrial fibrillation.

And Monica, you had alluded earlier to hesitancy in the COVID-19 vaccine and kind of, the legacy of structural racism of experimentation that has taken place in our country around research. And often those have been used as the, I would say, excuses for why individuals from communities of color don't participate in research. But I think the time is now for us to really dive into some of these systemic structural challenges. How easy is it for a patient to park at our university health system hospitals to be able to participate in clinical trials? How easy is it to get childcare or time off of work to go in for multiple visits every few months or every week? And so, these are some of the structural challenges that I think we have to address so that we can really start to increase those numbers, both in atrial fibrillation and heart failure and in all the other cardiovascular diseases that Dr. Bond mentioned earlier.

Monica Peek:

And I would say, not just for clinical trials but for clinical care. We think about ... I think the, you know like the parking structure is sometimes the largest money maker for some hospital systems. You know, and so, when we have people coming in who are, we know are vulnerable patients and how important it is to have family support and when we think about the outrageous prices for parking, and people need, they're sometimes there for months, and so, why are the parking costs so high?

And, you know, there's so many other ways in which we should be wrapping care around patients in a way that makes it easier for them. And so, it's absolutely true about how can we become more trustworthy? How can we provide safer spaces? How can we make things optimally easy for people to engage in research, but also just engage in their care in general? And so, I think these are the kinds of questions that have most loudly risen to the surface as a result of the pandemic, sort of calling all of our healthcare institutions to task, but including how we think about doing our research.

So now, let's begin translating some of these constructs and data into a clinical case. So Rachel, what can you tell us about our first patient, or our patient April?

Rachel Bond:

Yeah. So, April's a 45-year-old Black female. She was born and raised in Alabama. She currently has a body mass index of 30.4, placing her in the obesity category. She was referred by her primary care clinician after she suffered a recent transient ischemic attack (TIA). She was diagnosed two years prior with atrial fibrillation, and now she's experiencing symptoms including fatigue. She's currently on warfarin and her international normalized ratio (INR)

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last month was 2. Her primary care clinician noted that her CHA2DS2-VASc score was roughly 4. And her comorbidities include diabetes, sleep apnea, for which she is using her continuous positive airway pressure (CPAP) machine, unfortunately, inconsistently.

Monica Peek:

Utibe, is there anything interesting at this point that are typical or atypical for patients in your practice that you want to point out?

Utibe Essien:

Yeah, I think this is a really important case. As a generalist, I think about some of the risk factors that April has. So, the type 2 diabetes, how well is that being controlled? Her sleep apnea, again, the CPAP use being inconsistent can also increase her risk of stroke. Rachel mentioned her CHA2DS2-VASc score of 4, which really puts her at a high risk of developing a stroke. And so, when I think about that, I think about her anticoagulant therapy, which was noted to be warfarin. And I'm really curious about that choice, I would want to hear a little bit more about why her team of physicians put her on that therapy because at least in a lot of the work that we're doing, there really is a new standard of care for how we treat and prevent strokes and patients with atrial fibrillation (AFib).

Monica Peek:

Absolutely. You know, I think it's the very rare patient now who should really be on warfarin, not just for medical reasons but because of all of the logistical burden associated with warfarin and what that means for implications for the ability to adhere to that regimen and that undue burden that is then placed on patients of color when they're still remaining on a treatment that really has fallen out of favor, unless you really need to be on that for complex medical reasons. So Utibe, what do you think that April may have been started on warfarin? And it is possible that she was overlooked for DOAC, which may have been a better fit?

Utibe Essien:

Yeah. So, this is what I've been obsessed with over the last, I guess seven or eight years or so, ever since I met a patient similar to April in my clinic as a primary care resident. And this was the only patient all throughout residency that I would get paged about consistently, who was on warfarin with atrial fibrillation, African American patient who would come in with an INR of 1.0 one day, of 5.7 another day, and 3. And there was just a lot of waxing and waning in his ability to control his warfarin, and consistently wondered why can't he be switched to a direct oral anticoagulant or DOAC, which for me has been one of the more transformational medications that we've seen, at least in my early career as a physician. Where in medical school, when I started in 2009, there was really only one drug available in warfarin. And then by the time I started residency a few years later, there was now a new therapy available that was really improving outcomes. And like you mentioned, Monica, just easier to use for patients.

But as I went through my residency and I went into my fellowship, what was pretty consistent was that patients who looked like me and my family members were far less likely to have been started on these therapies, at least anecdotally. And unfortunately, we've been able to lead some of the studies nationally, including the one on your

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screen here that we just published a few weeks ago that shows that unfortunately even Black patients who are admitted to the hospital with atrial fibrillation are less likely to be discharged on direct oral anticoagulant or DOAC therapy. So, I think we have to pay attention to April's race in this case and really do a deep dive into understanding whether it's implicit or otherwise, what are some of the reasons why she would not have gotten, really now, guideline-appropriate care.

Monica Peek:

Mm-hmm. Absolutely. And how does socioeconomic status impact the incidence of mortality in atrial fibrillation?

Utibe Essien:

Yeah, it's a really important question. You know, the data around socioeconomic status here in the US has been fairly limited. A lot of that data actually comes out of Sweden and Europe that really shows that patients in some of the highest incomes are more likely to ... or, are less likely to develop the untoward outcomes such as stroke and mortality with atrial fibrillation, and even less likely to carry that diagnosis. And so, there's some income-based disparities that have been shown. If you look at the slide on your screen here, that demonstrates that individuals from some of the highest socioeconomic deprivation status had a 12% higher risk of atrial fibrillation and had a 26% higher fatality risk. And so, really there is a close tie between atrial fibrillation and socioeconomic status and some of the downstream complications of this condition.

Monica Peek:

Rachel, anything that you want to add from your clinical experience?

Rachel Bond:

Yeah. I mean, those staggering statistics are not necessarily shocking from my perspective. When we think about, at least social deprivation, we know that there's a higher burden of cardiometabolic risk factors, and many of those are risk factors for atrial fibrillation. So, it goes back to the core of really trying to deal with those risk factors as early as possible and optimizing them more importantly. Looking back at April, optimizing her CPAP utilization and figuring out what are the limitations as to why she isn't consistently using it. And I think a lot of that feeds back into having those conversations with our patients as to how we could limit their overall chronic medical conditions. But more importantly, as we've been addressing, get them on the recommended medications that the guidelines are suggesting. And preferably for April, that would be a DOAC. So, as we walk through her case, hopefully we'll come to the conclusion as to what would be the best approach for us to move forward in her overall care.

Monica Peek:

Excellent. Thank you both. Some really just important points that we've made here so far. To continue, we're going to revisit the audience response question that we had early and see if we've moved the needle a bit. So, we'll ask the same question again. Now, how familiar are you with health inequities in cardiovascular care? You

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can go ahead and vote now. The options are the same as they were before: not familiar, somewhat familiar, familiar, or very familiar.

Okay, and so now I'm going to ask another question of our audience. How often do you consider social determinants of health when developing treatment plans for cardiovascular care? And so, let's all be honest. We have five options this time: never, rarely, sometimes, often, and always. You can go ahead and vote now. And again, we'll look at your answers later in the program.

All right. So, the social determinants of health have a very significant impact on an individual's journey as they, sort of, are making their walk to wellness. And here you see five categories. Race and ethnicity, and really what that is, is a marker for exposure to racism. Financial resources, geography, so that can either be rural versus urban, the local community or neighborhood. And a lot of times we use measures like area deprivation index or other measures of how resilient that community might be. Health literacy, and then social network, which implies that there are social supports which may help that person either manage their chronic diseases or to get a community block group started to help fight crime or just to sort of, help that person or their neighborhood or their family in times of distress. So, Rachel, why don't you take us through each of these in more depth? And Utibe and I may jump in and add some additional comments.

Rachel Bond:

Absolutely. So just starting off with race and ethnicity, we know that the most important thing to understand, and hopefully by the end of this you will actually understand, is that it's not the biological aspects of race, it's the structural aspects of race which fall into structural racism, the biases and the discrimination, the poor access to specialty care, and all of that leading to under-studied pathophysiology in many of these disenfranchised populations. And that's, I think, key for us to realize why we see a higher burden of disease in certain race and ethnicities when it comes to atrial fibrillation. The same could be said when we think about financial resources because we know that these racial health inequities don't exist, again, because people of different races are biologically different. It has a lot more to do with the structural differences and access to economic resources all going back to, again, the structural racism category.

And when we think about financial resources, we know that urban areas have higher environmental pollution, which can pose many chronic medical conditions, be it pulmonary, but also cardiovascular, cardiovascularly as well. And we know that when it comes to rural and neighborhoods, or rurality and neighborhoods, we know that there is higher risk factor burden in those particular populations within the United States with higher rates of un- or underinsured. We also know that transportation barriers to allow access to healthcare providers could be a key limitation in the patients actually getting the care for both primary prevention, but once diagnosed with the condition, actually ensuring that they have that close follow up and follow through. And to that same point, having low-volume healthcare facilities or limited access to healthcare could be one reason why where you live, your ZIP code, really does impact your health. And we know that there's a lot of data that actually focuses a lot on that.

But the same could be said about health literacy, and this is why it's important, even when going back to our case, that we actually explain to the particular patient that this is why you have atrial fibrillation and this is what the clear management will be. Because when you don't have those conversations with your patients, and there may

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be a component of health literacy, there could be a limited perception of atrial fibrillation and its related complications. And as a result, that could lead to a limited adherence to medications as well as health care utilization. And I think it's important that we define health literacy because it does, many of times, get overlooked, especially in a very busy clinician practice where we may not think that we have to take the time to actually really explain and hone in well on what that particular condition is.

Health literacy is best defined by a degree to which individuals have the capacity to obtain, process, and understand basic health information needed to make appropriate health decisions. It also should be considered comorbid, or to consider, comorbid neurodegenerative and mental health diagnoses, culture, learning style, processing speed, medical jargon, education system, and access as possible reasons why we may have limited health literacy.

So if we see that our patients may be struggling with compliance, if we see that there are limitations in them getting to our healthcare facilities and we think it's beyond the means of access, but perhaps there is not a key understanding as to why they have this medical condition and the actual best management for it, it's important that we look to see if it's any of the comorbidities that can commonly cause it, ranging from, again, neurodegenerative, mental health, culture, learning style. But many of times it could just be the medical jargon that we as clinicians are using when speaking with our patients and not putting ourselves in the shoes of them when we're having these conversations. And with that, I'm going to pause to let my colleagues have any thoughts or comments as well.

Monica Peek:

Thank you. I think that looks very comprehensive, and I really appreciate the, that last bit about health literacy and that a lot of times we think about it in the context of educational attainment and not in terms of how it may vary over time, particularly as related to comorbid medical conditions. And so, I think that that's an extra thing that may be helpful for viewers to sort of add to their knowledge base. And Utibe, one of the things I want to ask you is about the data around health literacy in atrial fibrillation patients, and then anything else you have to add about what Rachel has talked.

Utibe Essien:

Yeah, absolutely. Thank you again, Rachel, for that overview. I mean, the sad fact of the matter is that about 20% of patients with AFib, so one in five, have inadequate or limited health literacy. And you can kind of walk through the atrial fibrillation journey as you think about that number. So literally, the words that we're using today, atrial fibrillation, anticoagulants, DOACs, we have anti-arrhythmic therapies, and all these words that we can barely type into our EMR notes, much less telling our patients about them. It's such a complicated condition where sometimes you have symptoms, sometimes you don't. Your doctor tells you that based on a CHA2DS2-VASc score and they're like, "Wait, what is that phrase? I don't know what you're talking about." "You have an X percent risk of stroke in one year," and showing all these figures and numbers.

One of the studies that our team led a couple of years ago actually ask patients about what they presume their risk of stroke would be at one year. And a lot of these patients who had a CHA2DS2-VASc score of about 2 or 3, so maybe they had about a 2 or 3% risk, thought that their stroke risk was 50%, 75% at one year. And again, it goes

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back to Rachel's point about how that actually determines and affects their decision to be on their blood thinner medication or to come into their cardiologist for a regular visit. And so, we really have to think deeply about health literacy when it comes to atrial fibrillation, this really complicated disease with complex terminology and symptoms that sometimes you feel, sometimes you don't. And I'm hopeful that just as we put some of these medications and other therapies at the forefront, we really put this social determinant of health literacy up at the front as well.

Monica Peek:

One of the other things I'll add is that the rules and laws changed a few years ago about how companies are allowed to name medications. And so, they used to be able to name them in ways that made sense, but could be perhaps misleading. So like Lescol may lower your cholesterol, you know, but at least it was sort of easy and intuitive. But now they can't do that, it's against the rules. So, they have to name things in ways that could in no way be interpreted as related to how the medication acts.

And so now we have this sort of, these words that are almost impossible to pronounce, more impossible to remember. And so, it's a challenge for physicians, much exponentially more of a challenge for patients. And so, we're getting flooded with new medications that just really are a challenge, and so keeping in mind that we're bilingual as physicians, patients are not, and then we have this additional layer of new medications that really have no, that that language has nothing to do with how they actually act, it just adds another layer of complexity. So, as we're making our way around this pentagon, we come up to the social network, and I've briefly talked about why that might be important, but Rachel, can you expand on this a little bit more and talk about the components of one's social network and why it's considered a social determinant of health?

Rachel Bond:

Yes, absolutely. So, the social network allows for that connectedness. It allows for possibly even the utilization of digital health tools to bring hopefully at least education to the patient. And we know that there are limitations with that, either be it through broad brands or limitations, just depending on the location of where one may live and the access they have to the internet or to use such digital health tools. But we also know that social networking could just be something as basic as that social integration where a partner or caregiver provides support.

And in many of these disenfranchised populations, we know that that partnership and caregiver coming from a trusted member within their community is such a key driver that many of times could help with all the other aspects of the social determinants of health, such as health literacy, just providing them an extra set of eyes and ears and resources so they could fully understand, hopefully, why they have this medical condition, and most importantly, why it's important that we actually treat them accordingly.

So although social networking and the aspects of it definitely are negative social determinants of health, we want to think about the positives that can come out of it, which is a utilization of that trusted community, the caregivers within their households, or even the partners that can come to the office visit with them so they have another set of eyes, another set of ears that could listen in and understand the medical conditions. And hopefully we can come up with good decisions together about how we best treat these particular patients.

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Monica Peek:

Great. So, I think it's clear that social determinants of health have a real impact on our patients, and these issues need to be discussed with patients and are as important as our history and physical exams.

Before we move on to our second learning objective, I want to check in with the audience again on social determinants. And you can vote now. The question is the same as it was before, but now, how will you consider social determinants of health when developing your individual treatment or care plans for cardiovascular care? And the options again, are never, rarely, sometimes, often, or always.

So, thank you both for your fantastic insights. Our second learning objective for today is to individualize a holistic treatment plan for cardiology care to improve patient outcomes. So, Rachel, let's go back to our patient April and learn more about her so we can develop a treatment plan.

Rachel Bond:

April states, "My doctor said warfarin is probably all my insurance will cover, but lab testing is difficult with work and kids." She mentions that she had the past mild TIA, but she is unsure about details of that. April also stated that she does not have family nearby to help in case she does have medical needs. In terms of her diet when questioned about that, there are not many grocery stores where she lives, and on the news they call her location a food desert. In terms of exercise, she states that she doesn't live near a park where she can take her kids to actually play. And as a result of that, her exercise is rather limited.

Monica Peek:

So Utibe, let me ask you if there's some issues that April has brought up that most likely could impact how you would individualize her care, and can you take us through some of these and how we can individualize equitable care?

Utibe Essien:

Yeah, no, thank you, Rachel, for getting us to some of the key points in that case. And just to clarify and emphasize that a lot of those points don't end up always getting asked, right? And so, I think really empathizing and listening beyond the chief complaint is a huge, huge way to get us to be able to individualize equitable care. So, we don't just write down the CHA2DS2-VASc score, write down the chronic conditions, and send our patient out the door with a script. We try and understand what are some of the drivers, such as an inability to access food like Rachel mentioned, or exercise, and how that may actually change the way we put patients on medications or not. And so, I think really empathizing and listening beyond the chief complaint is key.

Learning is the other point I like to make that, for our colleagues, really inquire about home life, work, and social environment. There's a lot of policy change that we need to make so that we can actually have enough time to spend with our patients to capture some of that history. But that's really going to help us understand, "Hey, are there family, friends, caregivers or caretakers who can help you with your childcare or help you get out of work a little bit earlier so you can exercise? Who do you go to for medical advice or who can come with you to doctor's

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appointments? So, if you don't feel comfortable advocating for yourself in the same way, perhaps you have someone who can come along with you." Really encouraging folks to develop and implementing, implement a communication strategy for patients and caregivers that, again, goes beyond the medical jargon, as Rachel mentioned earlier, to try and empathize with our patients.

And this is easier said than done. I'm hoping we can learn from this talk that we do have the opportunity to learn and do it, but really meeting patients where they are. A lot of us who are in medicine, as some of the data suggest, have reached a socioeconomic status that unfortunately is very different from that of our patients. And we may have forgotten even those of us who had harder times growing up, how challenging it is to take time off of work to provide childcare and to be able to take care of your physical needs. So hopefully, again, meeting patients where they are can also help us get and provide more equitable care down the road.

Monica Peek:

Excellent. So, Rachel, can you give us an update on April and what did you do with her treatment plan and how she doing now?

Rachel Bond:

So, April is very active in the church. She thinks her friends from the church could absolutely help her in any emergency. She was referred to a cardiovascular exercise program as well as a dietician to help with some of her cardio metabolic risk factors. Her clinician did set her up for telemedicine appointments for follow up. After making sure she had access to the portal, she understands the use of the platform, and more importantly, that she was able to easily access her medical records. And she was switched to a DOAC, so warfarin was discontinued. Her INR was less than 3 and she was placed on rivaroxaban 20 milligrams in the evening with meals as prescribed.

Monica Peek:

Wonderful. Happy ending. All right. Utibe, are there other resources that we can use to help address social determinants of health in our patients with atrial fibrillation?

Utibe Essien:

Absolutely. You know the, I always tell people that we may tell patients not to go to Dr. Google, but we can always go to Google to find our community resources for our patients, you know, the patient who finally we develop a relationship enough with to admit that they're struggling with food insecurity or housing insecurity. We have data that shows that patients who are homeless also have poor access to some of these therapies we're talking about. Really using those resources to connect our patients. Community health workers, peer navigators, those are going to be some of the key partners we have in this work. Rachel mentioned that April's engaged in her church. There's church-based efforts such as screenings and discussions on health that can help our patients. Medicine is a team sport, and really engaging with our social workers and other hospital advocates who may be able to find the rebates that help rivaroxaban be more affordable for April. And I know Rachel's involved in other national organizations that have really great resources as well.

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Monica Peek:

And so, we also have created a downloadable checklist that you can share with your patients and for other additional resources that you can use, and you can find it at our D&I Hub. Rachel, did you want to add any additional resources for patients?

Rachel Bond:

Yeah. Well, as Utibe mentioned, one organization, the Association of Black Cardiologists, does provide free online resources, most importantly to cookbooks and other really advice that allows them to target the core. When we think about, again, even a condition like atrial fibrillation, we know many of the risk factors are those cardio metabolic risk factors like blood pressure, diabetes, cholesterol, all things that increase their burden and risk of having such a condition, and an organization like the ABC that focuses quite a bit on these particular populations really have gone a long way to try to decrease the burden of those very preventable conditions. So, I would offer anybody the opportunity to go to the website, everything is complimentary and it's a wonderful resource for our patients.

Monica Peek:

Wonderful. Rachel, Utibe, I cannot thank you enough. This was such a great discussion. I feel like we learned some practical pearls that we can all use to provide more culturally competent care for our patients with cardiovascular disease. So let me try and summarize our discussion with our SMART goals, SMART standing for specific, measurable, attainable, relevant, and timely. And then Rachel, Utibe, you jump in and let me know what I may have missed. First, advocate for the patient and engage with both patients and their families. Maintain cultural competency, including addressing language barriers and providing patients with proper resources in the office. Listen to the patient's viewpoint to reduce barriers to care and formulate an effective treatment plan that addresses the needs of the whole patient. Determine the most appropriate method of treatment based on the individual patient and be prepared to advocate for them. And that mainly means they need a DOAC. Treat each patient with dignity, respect, and kindness. Provide care as if the patient was your own loved one. Anything that I've missed?

Utibe Essien:

That sounded like a great summary to me, Monica. And thanks so much for the opportunity to share with you all. Really great to learn from you, Rachel, today.

Monica Peek:

Excellent. Before we sign off, here are just some of the other topics that we've covered so far and we'll be adding new content every month. CME Outfitters also has a Diversity and Inclusion Hub with a number of excellent resources to share with your peers and your patients. And to receive credit for today's activity, please complete the post-test and the evaluation online. You can then download your certificate immediately.

Cardiology: Real-World Tactics to Address Health Inequities



Thank you again, Dr. Bond and Dr. Essien for sharing this space with me today. I feel so honored. And I thank you all who are listening and doing this incredible work to provide equitable care to our underserved patients. Again, I want to thank the audience for joining us today. Be safe and take care of yourselves so you can provide the best care possible for your patients and especially for our underserved patients. Thank you, everyone.