Transcript Details
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Addressing Racial Disparities in Cardiovascular Care

Dr. Brown:
For clinicians and patients, alike, we're fortunate enough to live in a time when our understanding and management of cardiovascular diseases are constantly evolving, thanks to the advancements in the field. But when it comes to practical application of those developments, do all of our patients really have a fair chance at reaping those benefits?

Welcome to *Heart Matters* on ReachMD. I'm Dr. Alan Brown, and joining me to discuss cardiovascular healthcare disparities among African Americans, is Dr. Keith Ferdinand. Keith is Professor of Medicine at the Tulane University School of Medicine, he's also Tulane University's Gerald S. Berenson Endowed Chair in Preventative Cardiology. Keith, thank you very much and welcome to the program. I'm looking forward to speaking with you.

Dr. Ferdinand:
My pleasure. Thank you, Alan.

Dr. Brown:
So, to start off, let's talk about some of the disparities that we see among African Americans when it comes to diagnosis and management of cardiovascular disease.

Dr. Ferdinand:
Well, the disparities are real. This is not social science. Let's first look at 2002, that was the landmark Institute of Medicine's report called, "Unequal Treatment", and they identified almost two decades ago, an increase in hypertension, chronic kidney disease, end-stage renal disease, heart failure, and a wide range of cardiovascular conditions in African Americans when compared to the general population. Fast-forward to 2021, where we are right now, unfortunately, these disparities are persistent, especially for the cardiologists, we have an increased risk of heart failure, morbidity and mortality, rehospitalizations, especially at early ages, an increase in premature myocardial infarction and an increase in strokes, along with an increase in peripheral arterial disease and, unfortunately, associated amputations. So, the disparities are real, they're persistent, and they're unacceptable.

Dr. Brown:
So, yeah, you know, the data's pretty compelling on that, and despite everyone feeling that they, deliver the same care to everybody, the data is very clear that that's just not the case. I wanna get into is that the care we're delivering versus other issues, we discuss all kinds of issues that lead to disparities in care and maybe you could just give us a few thoughts, regarding access and trust in the healthcare system as well subconscious, differences in the way we care for our patients.

Dr. Ferdinand:
Well, the question always arises, "Is it nature, or just genetics or nurture, the environment?", and while there may be some genetic factors such as cardiac amyloid, heart fluid, we know is higher in African Americans, there's some alleles, the apolipoprotein L1, which increases the risk of chronic kidney disease, but I think overwhelmingly, it's the social determinants of health, it's a term you're hearing a lot now, it means where people work, live and play. It's having an environment which is unstable, living in an environment where you have a lot of violence, you have food deserts, you have unequal access to care; there have been several studies looking at African Americans with heart failure and they're less referred to cardiologists and hopefully, we would think being referred to a cardiologist give them benefit and I think it does, or there's less use of advanced therapies in African Americans, so it's a wide range in effects that come into play. I think the genetics, perhaps, are a minor effect, the main effect is access to healthcare, the social determinants of health, the built environment and how we treat patients. You made a statement about 'we all think we're doing a great job', and I think you know

that when you ask physicians, “Do you treat everyone the same?”, of course we say, “Yes. We are all in this to help people”, but when we do analyses of registries, controlled trials in clinical settings, we see that black patients don’t get the same amount of evidence-based medicines or even devices, advanced devices, such as TAVR and MitraClip.

Dr. Brown:
I have no doubt about that. I think having recently taken a class on diversity and inclusion, I found a lot of things that we don’t think about, not just our hidden bias about racial and ethnic differences, but even about how we treat older patients versus younger patients, people who speak different languages, there’s so much work that we need to do on this subject and really need to make it part of our training program, so people deal with the subconscious bias they have. Do you agree with that?

Dr. Ferdinand:
I absolutely agree. We say “subconscious bias” or “elicit bias” meaning that the person really is not trying to do anything bad, they’re not trying to treat people differently, but when you look at the medical records, the African Americans have less intensity of statin treatment, less control of blood pressure, less use of the novel oral anti-coagulants, less referral for the advanced therapies that I mentioned before, TAVR, MitraClip, so these are not things that I think physicians and other practitioners are doing purposefully, but it’s somewhat built into the system.

Dr. Brown:
Yeah, so let’s talk a little bit more about access issues. I mean, someone on the surface of it might say, “Well, maybe the higher level or more intense or more state-of-the-art care might not be available in certain communities.”, but that isn’t really what the issue, is it? It’s just a matter of referring patients, even when there is the availability of those therapies and could you dive in a little bit more about the access to care issues and what the real issues are?

Dr. Ferdinand:
Sure. There’ve been some hard studies looking, for instance, at the Affordable Care Act, which expands the use of insurance. In those counties in the United States that did not expand the use of insurance, did not expand Medicaid, there’s higher cardiovascular mortality. You look at persons who have blood pressure control, there’s a recent report from Paul Muntner published in 2020, one of the predictors of having poor blood pressure control is not having insurance and the worse predictor is not seeing a physician or other provider within the year. Many patients who are admitted to the hospital get appropriate care if they don’t have insurance, they can’t afford the multiple medicines that are often needed with evidence-based therapies to control heart failure, don’t get the medicines, therefore, don’t take the medicines, don’t have follow up, don’t have an identifiable source of care and they get care when it’s a rehospitalization. So, this access to care needs to be addressed. I think it’s not just if you’re black or African American, I think all Americans should be concerned that we have equitable care that we have the application of evidence-based medicine, regardless of race, ethnicity, social class, sex gender, or geography.

Dr. Brown:
I couldn’t agree more with that and you know unfortunately, though, the ACA tended to give more people some sort of coverage, a lot of folks, the cost of their care actually went up, the people who had you know, higher co-pays and sometimes that meant that they would seek medical care less and I think that’s across the broad population.

Dr. Ferdinand:
There are several reasons why there was an increase in cost and that was the removal of the individual mandate, while it sounds like a freedom issue, if you don’t have everyone buy into the system, then those persons who buy into the system are going to be the more high-risk persons. The higher risk patients are therefore going to have higher premiums. So, while it sounds the right thing, we all are Americans, we believe in individualism and bootstraps, in a way, it’s the wrong thing. If you look at life expectancy among developed societies, that’s western Europe, and Japan, although we spend more per dollar for healthcare in the United States, our longevity is 16th among developed societies and certainly we can’t be proud.

Dr. Brown:
Yes, I just looked at that data. I think overall quality, we’re probably last in the developed nations and we spend the most and it’s very interesting. I think you’re getting to the heart of the matter, is how we distribute those dollars, and in many cases, we’re ordering lots of expensive tests when we have them available and not distributing them in such a way that necessarily gets the best outcomes. So, let me ask you about preventative care a little bit, Keith, ‘cause I know this is dear to your heart and you’re one of the thought leaders nationally on that topic. Do you think there’s disparities in preventative care and if so, what’s the reason?

Dr. Ferdinand:
So, the endowed chair that I hold at Tulane University in New Orleans is named after Gerald S. Berenson, the late Dr. Berenson was

known for the Bogalusa heart study. Bogalusa is a small, biracial town on the other side of Lake Pontchartrain, and that's that lake right above New Orleans that you see in the map, and what he identified is that early in life, in preteens, there's an increased risk in cardiometabolic diseases: dyslipidemia, elevated glucose, obesity, and hypertension and it tends to show up earlier in the black kids. So, that first goes to what's called primordial prevention, that means you're preventing disease even before you have an identifiable risk factor. Then we look at primary prevention, that's treating risk factors and we know that although African Americans don't necessarily have higher levels of LDL, in fact they're similar to the general population, there's less use of statins and less intensity of statin and of course, hypertension is the most prevalent and potent respect of all, it's more common in African Americans, control is worse, and target organ damage is worse. Then we have secondary prevention, that's when you have a disease, and you treat it. Within the hospital setting, it appears that African Americans will get adequate treatment and the treatment appears to be somewhat equitable, that's because we have a lot of algorithms and mandated care in the hospital setting. But once the person is sent home, if they don't have an identifiable source of primary care, if they don't have an insurance that covers their medication, then they will not follow up for visits, they will not adhere, and they will seek care, but that care is going to be to emergency room with hospitalizations, amputations, recurrent strokes, heart failure, end-stage renal disease, so it's not a gene or a set of genes that can really explain all of these various cardiovascular catastrophes, obviously there's something in the way that we deliver and structure care in the United States that leads to these unwittingly increased disasters in terms of cardiovascular and cardiometabolic conditions.

Dr. Brown:
So, Keith, if you stratify by socioeconomic status, do you see the same disparities in the African American community, in other words, the people who are a little better off in a socioeconomic state, get better care or is the disparity pretty much equivalent across African Americans?

Dr. Ferdinand:
Socioeconomic status appears to be the most potent driver of the disparities among African Americans. But even African Americans who have means tend to do worse. There's one study, which was published several years ago called, "The Hopkins-Meharry Study", Johns Hopkins, as we know is in Baltimore, world class institution. Meharry is a traditionally black medical college in Nashville, Tennessee. And when it looked at physicians who graduated the same year, decades ago from Meharry, and compared them to those who graduated from Johns Hopkins, the Meharry physicians had more cardiovascular disease, heart attacks, and strokes. We also know, looking at data in terms of African Americans from the south immigrate to the north, they tend to have higher degrees of disease burden, regardless of socioeconomic status. Now why could that be that black doctors and recent immigrants who may have good education would have an increase in risk? That may be related somewhat to health-seeking behavior in culture. There's a high level of mistrust in the black community and it's not because patients are simply ignorant, but the history of orthodox medicine has been very unacceptable to many blacks in terms of how they are treated. And there, perhaps, is a culture in which patients don't do the right steps in terms of prevention and health-seeking behaviors. So, it's what we call in America, south, a gumbo, it's a mixture of things, a little okra, a little shrimp, a little oysters, put a little bay leaf in, some hot sauce, you make a mixture of different conditions, but I think socioeconomic status is the most profound driver, but it doesn't explain everything.

Dr. Brown:
Well based on our discussion today, it's clear that there are many barriers left to overcome in order to eliminate racial disparities in cardiovascular healthcare. I want to thank my guest, Dr. Keith Ferdinand, for joining me in this very important discussion, and for sharing some of the barriers in access to care for the African American community. I'm Dr. Alan Brown. To access this and other episodes in our series, please visit ReachMD.com/HeartMatters, where you can be part of the knowledge. Thanks very much for listening.