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Exploring Strategies to Eliminate Disparities in Cardiovascular Care

Dr. Brown:
Despite decades of research and advancements in the field of cardiology, racial disparities remain an obstacle in patient care. What are some strategies we can adopt to improve access to care and eliminate this inequality? Welcome to *Heart Matters* on ReachMD. I'm Dr. Alan Brown, and today I'm joined by Dr. Keith Ferdinand, Professor of Medicine at the Tulane University School of Medicine, to discuss strategies to overcome the disparities in cardiovascular healthcare for the African American community.

So, Keith, what kind of things can we do to try and minimize these disparities, and are there any studies that have shown efficacy and attempts to try to reduce disparities?

Dr. Ferdinand:
Well, one of the first steps is that we have to have universal insurance, or universal healthcare and within that healthcare, an identifiable source of primary care. One of the models would be Keiser of California. Now remember, this is a closed system, so people by very definition have insurance. The rates of blood pressure control and overall cardiovascular disease outcomes are better in Keiser than you would see in the general population. Now, there's still a disparity even within Keiser, where their black patients have less blood pressure control than the whites, but both for blacks and whites within the Keiser system, the disparities are smaller, and the overall control of blood pressure is much better than that seen in the general population. So, universal healthcare, have an identifiable source of care, I think is one of the first big steps and we, as physicians, and other providers cannot be passive in terms of that. We should support initiative to expand the access to insurance and the healthcare safety net. The other thing that we need to look at is, perhaps, community interventions. I don't know if you know, Alan, but along with the late Elijah Saunders out of Baltimore, we have the Healthy Heart Community Prevention Project, here in New Orleans, and my wife Daphne P. Ferdinand, she has a PhD in nursing, for decades, we've gone into the community, we've pioneered some of the ideas of using barber shops, beauty shops, sporting events, but just going into the churches, going to the community centers, the social and pleasure clubs and educating patients about their cardiovascular risks, helping them to do self-monitor blood pressure, where they're able to become partners in care, appears to have a great effect. So, the first step, I think is universal healthcare, the next step is going to be going back into the community, community health workers, lay educators, faith-based, other novel sources of education and empowerment. I think those are two big steps. I have others, but those are two big ones.

Dr. Brown:
Yeah, that's very interesting. What you're really talking about with Keiser is having and integrated system of care, right. The patients not only have an identifiable caregiver, but that caregiver is part of a system that, as you say, has algorithms and protocols to manage patients and they collect data to make sure that they're actually managing patients well. And I think that's one of the things we all look for in the future is to have integrated healthcare delivery systems that all the doctors can have access to communication about the patients, that you can see all their test results and that, if you can't measure it, you can't make it better, right, so that provides data to tell us how we we're doing and identify patients who are falling out of the fold.

Dr. Ferdinand:
Well, the data consistently shows, within closed systems, the African American patients don't do as well, and these are even systems that have access to insurance. But I think overall, when you look at the national burden of outcomes in terms of cardiovascular morbidity and mortality, the lack of insurance, socioeconomic status, the social determinants of health have a profound effect. Now, once you're within a system, then you have to deal with the implicit bias. For instance, you've had the experience, and I know I have, where you

have a middle age or older black person who has markedly elevated blood pressure, 160,165 systolic. And the patient will inform you, “Oh, baby, that’s just my blood pressure. It’s been like that for years”. In other words, the patient has been “taught” that elevated blood pressure is part of her natural makeup. We need to fight against that.

Dr. Brown:
And I think the other point you made is equally important about going out into the community and treating people where they live, which I think is going to be the way a lot of things move in the future. We’ve even talked about building grocery stores in areas where there are food deserts and building health clubs as an investment buyer healthcare system in the populations we serve. But it’ll take more than that, as you pointed out, it’ll take being out there in the community, building trust and encouraging people to utilize these resources. If you’re in a community where you worried about your life every time you go out to the store, it’s hard to get enthused about taking care of your blood pressure, right?

Dr. Ferdinand:
That trust piece is very, very important. Many African Americans don’t really trust orthodox medicine, so they’ll be very pleasant during the visit, they’ll look at you and smile, but won’t refill the medicine and won’t continue care. I think we need to empower our patients, educate them why they need to take the statin, why they need to control their glucose and blood pressure, why they need to take the oral anti-coagulant for atrial fibrillation. So, an educated patient, and I don’t mean formal education, I mean, someone who knows what time it is in terms of their own personal health, an educated patient will then be empowered to make sure they get their medicines taken on time and are refilled and will actually drive care. For instance, in the blood pressure field, where I do a lot of work, self-monitored blood pressure now has a class A1A recommendation in the new guidelines, the U.S. Preventive Task Force also says class A, that means that we should have our patients know how to take their blood pressures and not wait for that magic 15 minute visit with the primary care provider or a cardiologist once or twice a year to control blood pressure, which again, is the most prevalent and potent risk factor for cardiovascular disease.

Dr. Brown:
So, Keith, you know, I’m just thinking we’ve talked, about the long-term situation where a lot of healthcare systems around the country are discussing how they can deliver care out in the community. But how about in the short term? Do you have programs at Tulane to talk about diversity and inclusion with not just your doctors but your interns, residents, and staff, everybody working from registration on down? I’m interested what you’re doing at Tulane and whether you have any thoughts on what could we do, locally, as a first step in the short term?

Dr. Ferdinand:
Well, first of all, I’m not gonna say that Tulane is a paradigm of excellence when it comes to eliminating disparities, we do have an Office of Minorities there, and we do have lectures looking at bias. More importantly, since we are a medical school, I’ve given a presentation to all of the freshmen about the history of medicine and how medicine has, unfortunately, shown these disparities, not for just decades, but for hundreds of years and how we treat our African American population. So, I’m not gonna say that we have some excellent pathway to success, but at least we are trying. I think one thing that might be important within systems is that if we do collect data, and I suggest we do, not because it’s genetic based, but because it may be a marker for social determinants. If we do collect data on race, ethnicity, social class, etc., at some point, in a de-identified manner, we talk to the providers about that data and many are gonna be surprised that their black patients versus their white patients are just not doing as well, in terms of A1C, blood pressure, LDL, recurrent hospitalization. Now, why should we, as clinicians who are not self-identified as black-why should we care? Because you’re paying for it. You’re now paying at a tune of 90 to $120,000, per year, for a condition which was largely preventable by controlling blood pressure and diabetes.

Dr. Brown:
Yeah, that’s very important. I do think we have people’s attention on disparities, now, because the media has raised our awareness of disparities in care related to the COVID-19 crisis, so it’s a top-of-mind for everybody and it just seems like this is maybe a great time to ride that train and put things in place while people are actually thinking about it. That data is being collected during COVID and we ought to do something with it to try and continue to raise awareness and take advantage of the visibility of this topic, right now, do you agree?

Dr. Ferdinand:
Yes. One of the areas that we’re working in, now, in Louisiana is looking at these disparities related to race, ethnicity, and geography. The Louisiana Task Force for COVID-19 Health Equity, and I’m a member of that, actually looks at that data and we early showed in Louisiana, higher degrees of hospitalizations and higher degrees of death and it’s been seen in several areas, including, the Chicago area, where you are now, it’s also seen in certain Hispanic populations and Native American or American Indians. Now, why is that? I do not think that the coronavirus electively seeks out racial ethnic minorities. It’s related again, to those social determinants of health, living in an environment where you have a multi-generational home, having a blue-collar worker, now called in a social worker, who can’t work

from home, who can't use Zoom conferences in order to get their paycheck, having a person who uses public transportation or even working in the service industry, we know that many of the transit operators in New York City, and here in New Orleans, early on in the pandemic actually died because they were being exposed, and then early testing. If you can recall, we first only tested in suburban shopping malls with the drive-thru testing, well, if you live in a community, or you don't have a car and public transportation doesn't allow you to just walk up and get early testing, these patients were not diagnosed early and only showed up into the emergency room when they were in the throes of respiratory distress. So, a lot of factors led to these disparities. And then specifically for African Americans, and we're gonna have to deal with this with the vaccines, there's the real disparity that's driven by mistrust. So, we have to overcome this mistrust, we have to have what's called trusted messengers, it's a term of art that we're using now in the COVID-19 pandemic and a trusted messenger is someone who has a history of working and serving that community, it could be a doctor, a nurse, pharmacist, it could be minister, could be a political activist or an elected politician, but someone who can talk to the community about how to do mitigation, wear a mask, social distance, washing your hands and then with the vaccines, that's a whole different discussion because we know the national data suggests that African Americans, even those who work in a healthcare system, are reluctant to be vaccinated.

Dr. Brown:
Thank you, very much, Keith for all your thoughts. It's encouraging to know that there are ways that we can ensure that all of our patients have equal access to quality care. A lot of work still needs to be done on that topic. But that brings us to the end of today's program, and I want to thank my guest, Dr. Keith Ferdinand for joining me in this very important discussion. Keith, it was great having you on the program. I always learn something when I get a chance to interact with you, Keith. Are there any parting thoughts that you might want to share with the audience before we close?

Dr. Ferdinand:
I thank you for this opportunity, Alan. I think we're looking, now, of eliminating disparities, not just identifying disparities. We have to do more than just say "there are disparities related to race, ethnicity, social class, sex gender and geography", we have to eliminate them and as long as we have a group of people who are less healthy than others, then no one is healthy. Thank you for this opportunity.

Dr. Brown:
And thank you, Keith. I really enjoyed it. 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.