

Unique Collaborative Initiative to Overcome Barriers to Access

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On June 1, 2019, the Association of Black Cardiologists hosted its Second Roundtable: Health Care Access for Minority and High-Risk Populations in Washington, D.C. This year's Roundtable brought together 16 diverse stakeholders and champions of health access equity around the theme of Growing Impact of Access in Patient Outcomes to discuss how innovative ideas, solutions and opportunities have been implemented, while exploring additional ways attendees could improve access in our health care system.

Unique Collaborative Initiative to Overcome Access

The Association of Black Cardiologists (ABC) developed a collaborative and transdisciplinary team of experts in 2016 to address the critical issue of access to quality healthcare. The objectives of the ABC Access Roundtable group are:

- Promulgate American College of Cardiology (ACC)/American Heart Association (AHA) guidelines in CVD management
- Promote the identification of cardiac amyloidosis, considering new therapies becoming available
- Foster understanding of cardiovascular benefits of new pharmacologic agents in managing diabetes
- Promote benefits of transcatheter aortic valve replacement (TAVR) in all patient groups with valvular aortic stenosis

- Continue to recognize geographic maps of disparities in access and outcomes in minorities
- Promote new models of healthcare deliveries that engages and trains all healthcare professions, including pharmacists, nurse practitioners, etc.

The ABC Access Roundtable Group reconvened at the ACC Heart House in Washington D.C., for further discussions and identification of solutions to help address the objectives described above. The Roundtable consisted of experts from a diverse variety of organizations including academia, industry, healthcare team members, advocacy organizations, as well as a patient representative. Ultimately, the goal was to address the issues and formulate potential solutions to the complex and chronic issues related to patient access among minority and underserved populations.

Overview

Recently, the National Center for health Statistics published the midcourse review of the progress made towards the Healthy People 2020 goals and objectives at the halfway mark to the 10-year initiative (Healthy People 2020 Midcourse Review, 2017).

According to data from the Healthy People 2020 Midcourse Review, there are significant disparities in access to care by sex, age, race, ethnicity, education, and family income. These disparities exist with all levels of access to care, including health and dental insurance, having an ongoing source of care, and access to primary care.

Although the proportion of persons under age 65 with medical insurance increased from

83.2% in 2008 to 86.7% in 2014, there was little to no change (76.3% in 2007 and 76.5% in 2012) in the proportion of persons with a primary care provider. Moreover, the proportion of those who were unable to obtain or who delayed receipt of needed prescription medicines actually worsened from 3.1% in 2007 to 3.6% in 2012.

Disparities also exist by geography, as millions of Americans living in rural areas lack access to primary care services due to workforce shortages.

Socioeconomic status (SES) has a sizeable impact on cardiovascular disease (CVD) morbidity, mortality, and medication adherence. Although health disparities in the United States are not limited to race, racial/ethnic disparities are well documented and persistent, with evidence of earlier onset and greater severity of disease at various levels of SES (Ferdinand, 2017). Biological, behavioral, and psychosocial risk factors prevalent in disadvantaged individuals accentuate the link between SES and CVD.

According to Schultz and colleagues, there are four measures that have been consistently associated with CVD in high-income countries: income level, educational attainment, employment status, and neighborhood socioeconomic factors (Schultz, 2018). In order to impact disparities in health, a multilevel, collaborative approach must be integrated with a focus upon identifying those communities and populations at greatest risk and successfully applying resources toward these groups, improving access to quality health care, increasing cultural competence, and revamping medical education. For instance, the geographic distribution of preventable death from CVD and stroke was skewed with significantly higher death in southeastern states. The higher

preventable mortality in these areas was driven primarily by adverse social determinants of health and correlated with Centers for Disease Control and Prevention socio-environmental maps of poverty, unemployment, education, and lack of health insurance. Recently though, the Affordable Healthcare Act provided an avenue for access to health insurance especially for those with chronic conditions, which appeared to reduce financial barriers to care and increase treatment rates (Mulcahy AW, 2016). Additionally, by controlling CV risk factors in the high-risk population, the result is the “best buy” or “biggest bang for the buck”. By identifying the communities in the greatest need, there needs to be an investment in these communities (i.e., implementation of low-cost programs that can make a difference, Barbershop Study). To close the loop, aggressive treatment of comprehensive CV risk factors and incorporation of newer antihyperglycemic agents into routine clinical practice must be undertaken. Another measure to improve access to health care would be “task shifting”, the redistribution of health care management from the physician to non-physician team members (i.e., physician assistants, nurse practitioners), as well as team approaches to care involving all health care team members (i.e., clinicians, pharmacists, nurses, etc.). Finally, the integration of SES into the traditional CVD risk prediction models may allow improved management of individuals with high risk by stratification and intensification of the evidence-based guidelines.

Perspectives: Identification of Potential Solutions

Medication Therapy Management (MTM)

Medication Therapy Management (MTM) became a formal requirement for Medicare Part D over fifteen years ago and involves a range of services provided to individual patients to optimize therapeutic outcomes (help patients get the most benefit from their medications) and detect and prevent costly medication problems. To ensure the best therapeutic outcomes for patients, MTM includes services provided by health care team members, including pharmacists. There are five core elements included in MTM: medication therapy review, a personal medication record, a medication-related action plan, intervention or referral, and documentation and follow-up. Problems may include medications not being used correctly, duplication of medications, unnecessary medications, and the need for medication(s) for an untreated or inappropriately managed condition; in-depth, medication-related education, consultation, and advice provided to patients, family and/or caregivers to help assure proper use of medications; collaboration with the patient, physician, and other health care team members to develop and achieve optimal goals of medication therapy. MTM is especially effective for patients with multiple chronic conditions (3 or more), complex medication therapies (7-8 medications), high prescription costs (drug costs >\$3,919/year), and multiple prescribers. Evidence demonstrates that MTM programs reduce the risk of CV events by about 50% (Bunting, 2008). Moreover, physicians observe that MTM helps with patient outcomes (i.e., hospitalization rates, safety (drugs to be avoided in the elderly, ACEI/ARB use in patients with hypertension and diabetes, etc.), and clinical outcomes (LDL control, A1C control, medication adherence, etc.), as well as high patient satisfaction (Ai AL, 2014).

Evaluate Communities and Expose Disparities According to Zip codes

One method used to optimize care initiatives within diverse populations is spearheaded by the National Minority Quality Forum (NMQF). The NMQF collects data on performance measures that report on how well individuals or communities are functioning. The Forum has developed a comprehensive database comprised of more than 5 billion patient records, which it uses to define disease prevalence, costs, and outcomes for demographic subpopulations at the zip code level. Health equity is a function of community-based collaborative networks. When these networks operate sub-optimally they contribute to health disparities. The goal is the existence of an equilibrium of conditions to preserve high-quality life. The NMQF develops maps to provide a method to visualize data to help expose predictive patterns so that resource management could be improved at a population level. For example, assessing a community by zip code provides an opportunity to evaluate community support, number of visits to the provider, and even availability of primary care physician. The concept that outcome numbers are not an accident and by omission, we are allowing people to die; thus, by stepping into communities to evaluate outcomes we can shift from “accountable care” to high-quality health care after instilling deep collaborations within communities.

Claims Data Maps

The Partnership to Advance Cardiovascular Health (PACH) works towards advancing public policies and practices that result in accelerated innovation and improved cardiovascular health for cardiac patients. PACH addresses structural access barriers (i.e., prior authorization) and utilizes multiple methods to ensure access to appropriate prevention and treatment options for everyone. For instance, PACH is involved in patient advocacy and partners with members and patients to present expert podcasts or YouTube informational videos. One such method used to assess access to medications is via the Claims Data Map which is an interactive access map which presents geographical data on claims filtered by race with CV risk factors to screen for access to PCSK9 inhibitors.

Additionally, the Prior Authorization Work Group for the Association of Black Cardiologists Access to Care initiative developed resources to help cardiology practices better respond to the administrative needs of the current prior authorization process and improve patient access to appropriate, evidence-based therapies, specifically for underserved minority patients.

Helping Individuals with Cardiovascular Risk Factors

Prevention is equivalent to high value care. For example, by improving the diagnosis of conditions such as familial hypercholesterolemia [FH], effective treatment can be initiated thus improving the underutilization that has been documented among adults diagnosed with this condition (deGoma EM, 2016). Recently, Amrock and colleagues

demonstrated that health disparities contribute to the undertreatment of FH patients in the U.S. Gender disparity was prevalent as women were less likely than men to receive statin therapy (OR, 0.60, 95% CI, 0.50–0.73) and less likely to receive a high-intensity statin (OR, 0.60, 95% CI, 0.49–0.72). The low-density lipoprotein cholesterol (LDL-C) goal also varied by race/ethnicity, with Asians and blacks being less likely to achieve LDL-C levels <100 mg/dL (Asians, OR, 0.47, 95% CI, 0.24–0.94; blacks, OR, 0.49, 95% CI, 0.32–0.74), when compared to whites (Amrock, 2017).

Access to Transcatheter Aortic Valve Replacement (TAVR)

Despite the increased utilization of TAVR in the U.S. and the concomitant reduction in mortality particularly for these patients deemed inappropriate for open surgical therapy, the number of procedures remain abysmally low for African Americans and other minorities. The percentage of African American patients who received TAVR from 2012 to 2015 remained disparate at 3.8% compared to 93% in whites (Holmes DR, Jr, Nishimura RA, Grover FL, 2015). Interestingly, this disheartening statistic is not solely due to an increased concentration of TAVR centers in communities with high population densities of Caucasians. Notably, on March 26, 2019, the Centers for Medicare & Medicaid Services (CMS) proposed reimbursement coverage for TAVR to treat symptomatic aortic stenosis according to the Food and Drug Administration-approved indication. Moreover, the TAVR Medicare Evidence Development and Coverage Advisory Committee (MEDCAC) panel acknowledged that there is an under diagnosis and treatment of aortic stenosis in the AA population regardless of the aortic valve

therapy approach (e.g., SAVR, TAVR, etc.). In order to provide appropriate patient access while ensuring hospitals reduce unintended barriers to TAVR, CMS proposed changes introducing increased flexibility to the heart team and hospital volume requirements, as well as, expiration of hospital volume requirements for established TAVR programs. As a future initiative, strengthening the understanding of patient barriers to TAVR use and utilizing that information to inform awareness campaigns directed toward patients and physicians for shared decision-making is a priority. Additionally, given the geographical barriers that are demonstrated, there must be increased access to clinicians offering the full range of treatment options to allow all patients the opportunity to undergo the options for lower risk procedures.

Access Considerations for a Diverse Population

According to Wu and colleagues, in 173 heart failure (HF) patients, both African American race/ethnicity and poor financial status were associated with poor outcomes ($p < 0.005$) in patients at baseline (Wu, 2017). Heart failure patients who were AA with lower financial status reported engaging in fewer self-care maintenance behaviors than those with higher financial status than Caucasian HF patients. African Americans with lower financial status had a four- to six-times higher risk of experiencing cardiac events compared to patients who were Caucasian with higher financial status before and after controlling for covariates. Access to pharmacologic and advanced therapies may be part of the challenge, however there are also systems barriers, where medications are not on formulary for patients to receive. For instance, when BiDil is not on an inpatient

formulary, but is covered as an outpatient, this can lead medication errors and or unnecessary interruptions in therapy. Despite outpatient formulary availability, it is often not the preferred first line option, thus having a prohibitively high copay. Many patients are unaware of specific medications that may be uniquely beneficial.

Commitment to Action: Action Items to Overcome CVD Disparities

1. Access versus Coverage
 - Services and therapy versus coverage: The patient may have medication coverage, but may not have 100% coverage (high co-pay)
2. Patient advocacy—activating local voices, and incorporating the patient in the decision-making process
3. Learning institutions must focus on educating faculty, staff and students on cultural competency training
4. Champions in underserved areas—Partnerships across all races
 - a. Op-eds, videos, education initiatives
5. Incorporate a check list/tool to assess if the patient is on appropriate therapeutic medications according to guidelines
6. Education
 - a. Electronic clinical tools embedded in the electronic health record (EHR) to provide updated educational information for patients, linked to their diagnosis with additional therapeutic options
 - b. Educational CME programs

7. Patient population advertisement—incorporation of social media series podcast
8. Physician advocacy and organizations incorporating patient voice for shared decision-making
9. Supporting out-of-pocket limit—addressing the issues for out-of-pocket costs.
 - a. Out-of-pocket costs for prescription medications should be spread more evenly throughout the benefit year.
 - b. Out-of-pocket costs for prescription medications should be capped through the use of monthly and/or annual limit.
10. Policy tools with coverage affect access (HHS)
11. Establish Disparity Health Initiative (just as CMS and administration developed the Rural Health Initiative)
12. Clinicians are not prescribing per evidence-based guidelines. Initiate an educational series on streamlining care and integrating the guidelines when treating patients.
13. Patient-Centric campaign around Structural Heart Disease (SHD), CME-focused on how to treat (SHD):
 - a. 35% refusal of TAVR secondary to distrust, must be addressed
14. Partner with ABC on HF and TAVR community-based monitor
15. Policy—Reason why CMS can do demonstration in TAVR—Must be fixed, the CMS “common rule” that they can do
16. Economic—Collaboration with payers

17. Structural—Engaging the public by involving health care consumers to maintain patient involvement throughout the course of the process to improve the quality of outcomes.
 - a. Promote a culture change in the development and delivery of services.
 - b. Engage the public in formal structures such as steering committees or that enable patients to set the agenda, develop shared mission and purpose statements, and participate in all/most stages of health care planning, administration, and evaluation. Development of educational materials and tools with public involvement. Additional examples may include, group discussions, peer interviews, questionnaires, etc. which provide patients with a stronger voice in the discussion and process and potentially even introduce debriefing to provide feedback for additional input.
18. Value-based care = Quality/COST
19. Hierarchy of Data, space on disparities
 - a. Demonstration project or compassionate use looking at data on TAVR and HF (check readmission/mortality)
 - i. SHD Advisory group of experts—consulting services to the community
 - ii. HF, readmission/mortality areas, prioritize geographical areas and find etiology of readmission.

20. National Minority Data—obtain input on how to address disparities, potentially collaborate with the National Institute on Minority Health and Health Disparities on outreach to the disparate population.

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Appendix A: Summit Participants

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