



Improving Health Care Access and Outcomes for Minority and High-Risk Populations

Discussion Summary
and Recommendations

June 2023 Roundtable



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EXECUTIVE SUMMARY – JUNE 2023

On June 20, 2023, the Association of Black Cardiologists (“ABC” or “Association”) convened an invitation-only roundtable titled, “Improving Health Care Access and Outcomes for Minority and High-Risk Populations.” The event, held in Washington, D.C., brought together a multidisciplinary and diverse group of nearly 60 stakeholders committed to expanding and enhancing access to care for members of racial/ethnic populations and high-risk heart patients. The most recent gathering built on three prior roundtable discussions hosted by the Association in 2016, 2017, and 2019 as part of ABC’s Access to Care initiative: a program dedicated to improving health care access and outcomes for Black and other high-risk patients and communities.¹

The goals of the June 2023 convening were to:

- Highlight current challenges impacting cardiovascular clinicians, health systems, patient advocacy organizations, industry, and other key stakeholders; discuss and identify top barriers impeding access to care;
- Illuminate innovative uses of technology to help expand care and advance health equity; explore new models of payment and care delivery beyond traditional approaches;
- Harness new opportunities for engagement, partnership, and collaboration; and
- Make targeted recommendations to improve access and outcomes for members of racial/ethnic populations and high-risk heart patients.

Throughout the convening, participants were encouraged to recommend specific actions that can be taken to improve access to care for members of racial/ethnic populations and high-risk individuals. Recommendations were made during the various discussion sections as well as through a discussion worksheet on which participants enumerated any additional recommendations or priorities they wished to suggest to the ABC. Roundtable co-chair, Dr. Barbara Hutchinson, provided a clear call to action, saying, “We have to come up with a future that gives priority and ensures some high quality, affordable, and whole-person care, particularly for our nation’s most underserved individuals, families, and communities.”

Pages 2-8 of this document present priority actions that roundtable participants wish to see advanced in the near term along with the complete set of recommendations that were put forth during the June 2023 roundtable. The pages that follow the recommendations present a summary of roundtable proceedings.

The recommendations are presented by sector:

- The federal government (further organized by subagency or branch of government);
- Health plans/payors;
- Industry;
- Patient advocacy organizations; and
- Clinicians and medical professional societies.

¹ ABC Access to Care Initiative. Association of Black Cardiologists. <https://abcardio.org/advocacy/abc-access-initiative/#:~:text=We%20believe%20that%20good%20health,committed%20to%20advocacy%20and%20diversity>



Please note that the recommendations are a summary from event discussions and discussion worksheets and do not imply endorsement from any of the event attendees other than the Association of Black Cardiologists.

Following the meeting, the ABC conducted a follow-up survey among meeting participants to help further prioritize and determine the most important actions to be taken. The following recommendations emerged as top-priority actions:

*Roundtable members urge the **federal government** to:*

- Leverage a whole-of-government approach to promoting health equity and reducing health disparities, lending specific attention to environmental barriers that drive care inequities (e.g., food deserts, safe spaces for exercise, etc.) and supporting partners working to bridge care gaps.
- Maintain COVID-era policies that reimburse telehealth visits at the same rate as in-office visits and expand payment policies that promote greater use of telehealth services and other remote care solutions.
- Enact legislation that bans under commercial insurance the use of harmful copay accumulator, copay maximizer, alternative funding, and other similar programs that limit access to care and deny vital patient assistance.
- Institute guardrails around prior authorization practices by payors to avoid care disruptions and reduce workforce strains, especially for guideline-directed medical therapies.

*Roundtable members urge **health care payors (government and commercial)** to:*

- Eliminate the use of burdensome prior authorization requirements and utilization management practices for procedures and medications that are clearly indicated in major national evidence-based guidelines and standards of care, such as those from the American College of Cardiology, the American Heart Association, etc., including medical services required by the FDA label or Risk Evaluation & Mitigation Strategy (REMS) for the initiation or monitoring of drugs and biologics.

Complete Set of Roundtable Recommendations

FEDERAL GOVERNMENT

GENERAL RECOMMENDATIONS

- Partner with shared outcome-interested organizations to amplify changes in cardiovascular care and equitably implement changes in communities.
- Leverage a whole-of-government approach to promoting health equity and reducing health disparities, lending specific attention to environmental barriers that drive care inequities (e.g., food deserts, safe spaces for exercise, etc.) and supporting partners working to bridge care gaps.
- Analyze data regarding cardiovascular disparities and circulate findings to state, local, and other community partners to advance equitable health policy.



CONGRESS

- Make permanent and expand COVID-era telehealth flexibilities to safeguard access to care, particularly for those living in remote, underserved, and other hard-to-reach communities.
- Enact legislation that aims to improve and increase diversity of participants in clinical trials for federally-funded research.
- Oversee implementation of diversity action plan requirements by the Food and Drug Administration (FDA) as part of the 2023 Consolidated Appropriations Act.
- Enact legislation that curbs the use of utilization management practices, such as fail first or “step” therapy by insurers and/or pharmacy benefit managers (PBMs).
- Enact legislation that bans, under commercial insurance, the use of harmful copay accumulator, copay maximizer, alternative funding, and other similar programs that limit access to care and deny vital patient assistance.
- Enact legislation that provides full, first-dollar coverage and adequate reimbursement for home blood-pressure monitoring and other remote patient monitoring services and devices for hypertension, diabetes, and other conditions that contribute to poor cardiovascular health; while legislation is being considered, direct the Center for Medicare and Medicaid Innovation (CMMI) to undertake a pilot in which co-payments for remote patient monitoring services and devices are waived to study the impact on access, equity, and outcomes.
- Institute guardrails around prior authorization practices by payors to avoid care disruptions and reduce workforce strains, especially for guideline-directed medical therapies.
- Amend Medicare policy to provide greater coverage for cardiovascular medical devices.
- Allocate sustained and robust funding to federal agencies (e.g., Health Resources and Services Administration) that provide support to community-based health workers, patient navigators, doulas, midwives, and other clinical teams that care for cardiovascular patients and others with complex health issues.
- Provide robust malpractice coverage and Federal Tort Claims Act (FTCA) coverage to help alleviate cardiology workforce strains and other national health workforce challenges.
- Increase pressure on payors to provide coverage of guideline-directed medical therapies and evidence-based medicine and hold payors responsible for outcomes when guideline-directed medical therapies are not covered.

CMS

- Maintain COVID-era policies that reimburse telehealth visits at the same rate as in-office visits and expand payment policies that promote greater use of telehealth services and other remote care solutions.
- Prohibit the use of harmful copay accumulator, copay maximizer, alternative funding, and other similar programs that limit access to care and deny vital patient assistance.
- Test and advance cutting-edge payment models that prioritize whole-person and preventive care.
- Organize a pilot under CMMI that would waive co-payments for remote patient monitoring services and devices to study the impact on access, equity, and outcomes.
- Fund demonstration projects seeking to advance access to care and reduce health disparities.
- Engage specialists, such as cardiologists, in the design and implementation of new models of care, such as Making Care Primary.
- Advance payment policies that support and otherwise incentivize efforts to expand access to imaging technology in underserved and rural areas to address care gaps and reduce health disparities.



HRSA

- Award funding opportunities for efforts that specifically address SDOH and are aimed at improving primary and preventive care, enhancing team-based care, and recruiting and strengthening a diverse workforce.
- Develop and disseminate culturally competent educational resources and solutions to help health centers and other community partners advance best practices across the nation.

HEALTH CARE PAYORS (GOVERNMENT AND COMMERCIAL)

- Ensure that plan documents and other plan-related materials are patient-centric by making them easy to understand (e.g., lay-friendly language) and accessible to all patients of different backgrounds.
- Ensure formulary changes, both mid-year and in the new plan year, allow for patients who are already stable on their medication to remain on their medication.
- Eliminate the use of burdensome prior authorization requirements and utilization management practices for procedures and medications that are clearly indicated in major national evidence-based guidelines and standards of care, such as those from the American College of Cardiology, the American Heart Association, etc., including medical services required by the FDA label or Risk Evaluation & Mitigation Strategy (REMS) for the initiation or monitoring of drugs and biologics.
- Honor financial assistance received by or on behalf of a patient toward their out-of-pocket maximum and deem all prescription medications, including specialty medications, as essential.
- Reduce high cost-sharing and lower premiums to promote affordability and continuity of care for primary, preventive, and cardiovascular services.
- Cover all guideline-based services at low or at no cost to patients.
- Reward—and partner—with individuals and organizations that deliver high-quality cardiovascular and cardiovascular obstetric care to underserved populations, particularly community health centers.
- Bolster high-quality and preventive care, support and advance value-based payment models, and work to transition from fee-for-service payment.
- Provide transparency in payment models so that trends in care, outcomes, and equity can be monitored for impact.
- Support value-based reimbursement to bolster high-quality primary and preventive care.
- Test and redesign payment models to align with health equity goals, including coverage of upstream factors influencing health, such as SDOH.
- Strengthen and broaden nontraditional care models, including team-based care and other alternative settings/modalities (e.g., retail health clinics, telemedicine, community health centers, self-diagnostic tools, etc.), by incorporating them into payment policies and providing financial support for care coordination activities and care team members in these settings.
- Advance payment policies that support and otherwise incentivize efforts to expand access to imaging technology in underserved and rural areas to address care gaps and reduce health disparities.
- Reimburse for patient education to help improve health, reduce preventable chronic disease, and decrease nonadherence.



PHARMACEUTICAL AND MEDICAL DEVICE INDUSTRY

- Lower patient out-of-pocket prescription drug and device costs to promote greater patient affordability and cardiovascular treatment accessibility, including incorporating education and awareness around the out-of-pocket cap and smoothing option under the Medicare Part D redesign.
- Lead global research initiatives to examine health inequities and highlight solutions that drive meaningful change.
- Boost clinical trial awareness to improve trial participation and enhance public understanding of the benefits of clinical research to health outcomes.
- Engage patients and advocates as early as possible in the clinical trial process, including trial design and the identification of endpoints, to ensure drug/device development comprehensively reflects the patients they are intended to serve.
- Encourage partnerships between academic institutions and community-based clinics to engage, educate, enroll, and retain diverse populations in clinical trials.
- Fund innovative programs and pilot initiatives specifically designed to reach patient populations who have been historically underrepresented in clinical research.
- Advance decentralized clinical trial models to better meet patients where they are and promote diverse participant enrollment and retention.
- Create and disseminate inclusive marketing campaigns to ensure members of racial/ethnic populations and other historically underserved patient groups gain awareness of new cardiovascular innovations.
- Explore and responsibly utilize artificial intelligence (AI) technologies to assist with patient recruitment for clinical trials and improve trial design.
- Address and respond to poor utilization rates of Transcatheter aortic valve replacement (TAVR) and other structural heart interventions by members of racial/ethnic populations and underserved heart patients and employ strategies to overcome treatment hesitancy.
- Identify potential access to care issues before a drug or device is brought to market and work with partners to help eliminate barriers in advance of market launch.
- Deliver in-kind technology and expertise to help clinicians administer guideline-indicated therapies and address SDOH, particularly to community health centers that traditionally provide care to underserved populations.
- Collaborate with individuals and organizations in implementing scalable solutions to advance health equity and reduce health disparities.

PATIENT ADVOCACY ORGANIZATIONS

- Empower patients to advocate for and advance their care with education and engagement tools, such as peer-to-peer support and other accessible resources.
- Illuminate and share patient stories with policymakers and payors to ensure that diverse lived experiences are reflected in new models of payment and care delivery.
- Partner with churches, barbershops, and other community centers to help build a culture of trust and health promotion among underserved communities.
- Translate and individualize resources for relevant patient communities to promote culturally and linguistically competent care and stronger health literacy, specifically materials around the vital importance of preventive care and other strategies to prevent heart disease.



- Expand capacity and strengthen organizational will to move advocacy efforts more upstream to address nonclinical issues that influence health outcomes, such as housing, transportation, and education (i.e., SDOH).
- Call out structural racism as a fundamental driver of poor health outcomes and cardiovascular disparities and hold policymakers and systems accountable to address it.
- Reflect, represent, and lift up challenges and barriers experienced by clinicians and patients.
- Collaborate and partner with industry and other key stakeholders to boost engagement, recruitment, and retention of diverse populations in clinical trials.
- Disseminate data and learnings to the broader stakeholder community to help foster comprehensive and aligned understanding of health equity issues facing members of racial/ethnic populations and underserved heart patients.
- Hold payors accountable when they do not cover or adequately reimburse for guideline-directed medical therapy or require prior authorization before it is provided.

CLINICIANS AND MEDICAL PROFESSIONAL SOCIETIES

- Adhere to guideline-directed medical therapy as often as possible to enhance and strengthen the evidence base on cardiovascular care.
- Employ innovative technologies—such as virtual reality—to help develop empathy and understanding among clinicians regarding different patient challenges and experiences.
- Develop trusted partnerships in the community to overcome hesitancy around cardiac interventions and work toward shared decision making pre- and post-intervention with patients.
- Encourage and utilize team-based care as appropriate to better meet patient needs, improve clinician well-being, and reduce burnout.
- Leverage innovative technologies and community-based screening programs to help proactively identify patients that are high-risk for developing chronic diseases, including cardiovascular disease.
- Include physicians and practitioners who are representative of the population at risk in all levels of training and in practice.
- Set direction and create alignment on health equity and DEI efforts within organizations and provide education for members.
- Support and strengthen networking and mentorship programs that bolster and advance a strong, diverse, and inclusive workforce.
- Develop new and amplify existing programs to increase diversity in the cardiology workforce.
- Amplify and support efforts to increase the number of nurses, especially those who are focused on cardiovascular care.
- Strengthen and mobilize advocacy of health policy at the local, state, and national levels, including providing advocacy training to members so they can engage with policymakers to enact change to benefit patients with cardiovascular disease and their care team.
- Connect patients with navigators and other peer-to-peer support opportunities to help build trust and contribute to informed decision making.
- Elevate and leverage embedded care models to advance whole-person care and reduce clinician burnout.



- Hold payors accountable when they do not cover or adequately reimburse for guideline-directed medical therapy or require prior authorization before it is provided.
- Explore the link between cardiovascular disease and maternal morbidity and mortality.
- Increase coordination and partnerships with wraparound services and supports and partner with community-based organizations to help with early detection and education.



INTRODUCTION

Cardiovascular disease stands as the leading cause of death for men, women, and most racial/ethnic groups in the U.S.² Each year, approximately 695,000 people in the U.S. lose their lives to heart disease, accounting for one in every five deaths or approximately one person every 33 seconds.³ The economic burden of the disease on the U.S. health care system is \$219 billion annually, resulting in \$147 billion in lost productivity.⁴ Despite significant improvements to public health and other groundbreaking medical advances in recent decades, cardiovascular disease-related mortality still remains strikingly uneven across racial and ethnic groups. From 1999 through 2020, Carballo et al. found that Black Americans alarmingly experienced more than 1.6 million excess deaths and more than 80 million excess years of life lost when compared to the white population.⁵ These disparities were incontrovertibly worsened in 2020 due to the COVID-19 pandemic and further highlighted the impact of social determinants (or “drivers”) of health (SDOH) on the lived experiences and outcomes of members of racial/ethnic populations and high-risk patients within the U.S. health care system.^{6,7}

Similarly, while improved cardiovascular disease management has led to a decline in mortality among the general population, these advancements have not been equitably distributed across racial and ethnic patient populations.⁸ For instance, Black adults bear a higher burden of cardiovascular risk factors, such as hypertension and obesity, and are more than twice as likely to die from heart disease compared to white adults.⁹ As magnified above, the unequal prevalence of cardiovascular disease in Black communities contributes significantly to the disparities in life expectancy between Black and white individuals.¹⁰ Approximately 30 percent of the mortality gap between Black and white men and 40 percent of the difference between Black and white women are attributed to disparities in cardiovascular disease outcomes.¹¹

² Heart Disease Facts. Centers for Disease Control and Prevention.

<https://www.cdc.gov/heartdisease/facts.htm#:~:text=Heart%20disease%20is%20the%20leading,groups%20in%20the%20United%20States.&text=One%20person%20dies%20every%2033,United%20States%20from%20cardiovascular%20disease>

³ Ibid.

⁴ Health and Economic Costs of Chronic Diseases. National Center for Chronic Disease Prevention and Health Promotion. Centers for Disease Control and Prevention. <https://www.cdc.gov/chronicdisease/index.htm>

⁵ Carballo C, Massey DS, Ndumele CD, et al. Excess Mortality and Years of Potential Life Lost Among the Black Population in the US, 1999-2020. JAMA. 2023;329(19):1662-1670. doi:10.1001/jama.2023.7022

⁶ Ibid.

⁷ This paper will use the term social *drivers* of health (SDOH), rather than social *determinants* of health, to refer to the non-medical factors influencing health outcomes. This definition is explained further on page 14.

⁸ Mazimba S, Peterson PN. JAHA Spotlight on Racial and Ethnic Disparities in Cardiovascular Disease. J Am Heart Assoc. 2021;10(17):e023650. doi:10.1161/JAHA.121.023650

⁹ National Center for Health Statistics. Racial and Ethnic Disparities in Heart Disease 2019. Accessed September 1, 2021. <https://stacks.cdc.gov/view/cdc/77732>

¹⁰ Carnethon MR, Pu J, Howard G, et al. Cardiovascular Health in African Americans: A Scientific Statement From the American Heart Association. Circulation. 2017;136(21):e393-e423. doi:10.1161/CIR.0000000000000534

¹¹ Gillespie CD, Wigington C, Hong Y; Centers for Disease Control and Prevention (CDC). Coronary heart disease and stroke deaths - United States, 2009. MMWR Suppl. 2013;62(3):157-160.



Given the longstanding and pervasive racial and ethnic inequities in cardiovascular disease, it is evident that new multistakeholder and multifactorial approaches are urgently needed to eliminate health disparities, advance equity, and promote high-quality, affordable cardiac care for all.

ROUNDTABLE OVERVIEW

As the leading national organization committed to advancing equity and preventing and addressing health disparities within cardiovascular health, on June 20, 2023, the Association of Black Cardiologists (ABC) held its fourth invitation-only roundtable symposium in advancement of the ABC’s Access to Care Initiative.¹² The first three roundtables were held in 2016, 2017, and 2019, all focused on improving health care access and outcomes for Black and other high-risk patients and communities. The June 2023 convening, “Improving Health Care Access and Outcomes for Minority and High-Risk Populations” was attended by an interdisciplinary group of nearly 60 stakeholders, including government officials, clinicians, researchers, members of national medical and public health associations, industry representatives, and patient advocates.

Racial and ethnic disparities in cardiovascular disease are extensively documented and show that members of racial/ethnic populations carry a disproportionate burden of myocardial infarction, heart failure, and stroke and experience other cardiovascular events at higher rates than whites—and fare worse after these events, including higher mortality rates and higher prevalence of unrecognized and untreated risk factors.¹³ As such, the goal of the meeting was to identify challenges and barriers that prevent members of racial/ethnic populations and high-risk patients from accessing high-quality and affordable care and enumerate the action steps that the federal government, health plans/payors, industry, clinicians, medical professional organizations, and patient advocacy groups can take to address health disparities and advance equity for heart patients nationwide. Roundtable participants were provided with and guided by an adapted definition of “access to care” from the National Academies of Sciences, Engineering, and Medicine (NASEM):

“An individual has timely and affordable access to the care, services, prescription therapies, and other supports (e.g., transportation, food) they need to achieve the best possible health outcome.”¹⁴

Roundtable participants, through a series of panel presentations and facilitated discussion, explored a range of topics, including challenges facing cardiovascular clinicians, top issues impacting patient access to health care, the promises and pitfalls of technology, the health care payment and delivery landscape and needed reform, and federal efforts to improve health equity and address SDOH. Concluding the

¹² ABC Access to Care Initiative. Association of Black Cardiologists. <https://abc cardio.org/advocacy/abc-access-initiative/>

¹³ Bonow RO, Grant AO, Jacobs AK. The cardiovascular state of the union: confronting healthcare disparities. *Circulation*. 2005;111(10):1205-1207. doi:10.1161/01.CIR.0000160705.97642.92

¹⁴ Institute of Medicine (US) Committee on Monitoring Access to Personal Health Care Services; Millman M, editor. *Access to Health Care in America*. Washington (DC): National Academies Press (US); 1993. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK235882/> doi: 10.17226/2009



convening was a facilitated group discussion to develop a set of recommendations to reduce health inequities and improve access and outcomes for members of racial/ethnic populations and high-risk heart patients.

CHALLENGES FACING CLINICIANS

Roundtable participants discussed some of the top challenges facing cardiovascular clinicians and explored these obstacles' impact on access to care, including the burdens of prior authorization administrative requirements and a changing post-pandemic reimbursement landscape.

“Everything we do—the time we took to make that decision, the time it took to explain to the patient that the test is needed—there is a delay... you then have to spend the same amount of time you spent with the patient sitting in front of the computer.”

— Roundtable Participant

Growing Use of Prior Authorization and Impacts on Cardiovascular Care

Prior authorization is a common utilization management tactic used by health plans and insurers for cost containment.¹⁵ A prior authorization request requires physicians and other clinicians to obtain advanced approval from a health plan before providing a medication, device, intervention, or service to a patient.¹⁶ Roundtable participants conveyed a shared frustration over how prior authorization adversely affects cardiovascular patients, clinicians, and their practices. Countless studies and surveys have shown that prior authorization requirements contribute to clinician dissatisfaction and burnout, cause care delays, lead to poorer patient outcomes, increase overall health care resource utilization, and result in other unintended consequences.¹⁷

A survey by the American Medical Association (AMA) found that clinicians spent an average of two business days (14 hours) each week on prior authorization requests, leading 35 percent of physicians to hire additional staff dedicated exclusively to handling these requests.¹⁸ Prior authorization requirements often interfere with clinician decision-making and have even been found to alter clinical decisions to avoid the administrative burdens associated with prior authorization.¹⁹ Additionally, roundtable participants shared how imposing prior authorization requirements on evidence-based therapies for cardiovascular

¹⁵ Psocka MA, Singletary EA, Bleser WK, et al. Streamlining and Reimagining Prior Authorization Under Value-Based Contracts: A Call to Action From the Value in Healthcare Initiative's Prior Authorization Learning Collaborative. *Circ Cardiovasc Qual Outcomes*. 2020;13(7):e006564. doi:10.1161/CIRCOUTCOMES.120.006564

¹⁶ Ibid.

¹⁷ Ibid.

¹⁸ 2022 AMA prior authorization physician survey. February 2022. <https://www.ama-assn.org/system/files/prior-authorization-survey.pdf>

¹⁹ Salzbrenner SG, Lydiatt M, Holding B, et. al. Influence of Prior Authorization Requirements on Provider Clinical Decision Making. *Am J Manag Care*. 2023;29(7):331-337. doi:10.37765/ajmc.2023.89394



conditions undermines proven, science-based standards of care and urged that these requirements be dropped, specifically for all guideline-directed medical therapies.

Attendees also discussed how prior authorization-related administrative hassles are compounding national health workforce strains and worker burnout. Reflecting these concerns, the U.S. Surgeon General's 2022 advisory on "Addressing Health Worker Burnout" notably identified prior authorization-related administrative burdens as a significant driver of clinician burnout and emphasized the need to eliminate these bureaucratic requirements to reduce current workforce pressures.^{20,21}

“Payors are putting up extraordinary barriers...step therapy or prior authorization or just not covering something...that is interfering with physician-patient medical decision making and that is such a significant contributor to our workforce issues.”

—Roundtable Participant

Roundtable participants acknowledged that the perpetual hurdles created by prior authorization undeniably divert critical time and resources away from direct patient care. According to the AMA, one in three physicians report that a prior authorization has led to a “series adverse event” for a patient in their care.²² Considering the administrative and resource burdens imposed by prior authorization requests and requirements, roundtable members warned how these policies could disproportionately harm lower-resourced cardiology practices that serve members of racial/ethnic groups and underserved patients, thereby exacerbating cardiac care inequalities in these populations. These concerns align with the findings of a survey previously conducted by the ABC, in partnership with the American College of Cardiology, which revealed that prior authorizations can cause delays in care, increase patient confusion, lead to higher rates of medication discontinuation, reduce medication adherence, and ultimately result in worse outcomes for members of racial/ethnic populations and underserved patients.²³

Roundtable participants collectively advocated for health plans, insurers, public and private payors, policymakers, and other stakeholders to reform the current prior authorization process to ensure timely and equitable delivery of patient-centered cardiovascular disease care.

²⁰ The U.S. Surgeon General’s Advisory on Building a Thriving Health Workforce. Washington DC: Office of the Surgeon General; May 2022. <https://www.hhs.gov/sites/default/files/health-worker-wellbeing-advisory.pdf>

²¹ Prior authorization reform vital to combat nationwide clinician burnout crisis, US surgeon general says. Fierce Healthcare. March 2023. <https://www.fiercehealthcare.com/providers/surgeon-general-current-prior-authorization-practices-fuel-rising-clinician-burnout#:~:text=Eliminating%20%E2%80%9Cbureaucratic%E2%80%9D%20requirements%20such%20as,Murthy%C%20M.D.%2C%20said%20Thursday>

²² 2022 AMA prior authorization physician survey. American Medical Association.

²³ The ABC Access to Care Initiative Prior Authorization Work Group. Identifying How Prior Authorization Impacts Treatment of Underserved and Minority Patients. Association of Black Cardiologists. 2019. <http://abcario.org/wp-content/uploads/2019/03/AB-20190227-PA-White-Paper-Survey-Results-final.pdf>



Inadequate Reimbursement for Telehealth, Remote Patient Monitoring, and Other Digital Health Tools and Services

Telehealth services and remote patient monitoring are vital cardiac care tools, particularly for members of racial/ethnic populations as well as high-risk and otherwise underserved heart patients. These tools leverage technology and other digital solutions to facilitate patient-clinician communication and crucial data collection and sharing outside of traditional care settings. Remote patient monitoring is a type of telehealth that utilizes technology, such as implantables, biosensors, blood pressure cuffs, glucometers, and pulse oximetry, to enable the real-time transmission of clinical data between patients and clinicians.²⁴ Remote patient monitoring technologies provide innumerable benefits to patients, including reduced hospitalization, shorter hospital stays, fewer visits to the emergency room, improved health outcomes for patients in rural areas, and better preventive management of chronic conditions, including heart disease.²⁵

Similarly, as exemplified throughout the COVID-19 pandemic, telehealth virtual visits serve as an indispensable lifeline to care for rural and underserved communities. Benefits of virtual visits include convenience, increased access to high-quality and cost-effective care from a distance, and decreased health care costs.²⁶ Telehealth services have also been integral to easing health workforce staffing shortages and ensuring that patients in hard-to-reach areas have access to high-quality care.²⁷ Further, remote patient monitoring and telehealth play a crucial role in reducing health inequities and tackling key SDOH, such as transportation or strict time off allowances.

Roundtable participants highlighted that, despite the widespread use and adoption of remote patient monitoring and other digital medicine tools, substantial reimbursement challenges hinder health care clinicians from fully utilizing these technologies. Participants raised concerns that the expiration of certain flexibilities and coverage expansions granted under the COVID-19 public health emergency (PHE), which dramatically increased the use of RPM and telehealth services, could further decrease clinician incentives to provide these crucial services going forward. Participants also noted how current reimbursement rates for RPM are barely covering the costs of deploying remote devices and further advocated for increased payment rates. As for telehealth virtual visits, roundtable members strongly conveyed the need to permanently extend payment parity, which requires insurers to reimburse at the same payment rate for telehealth services as in-person care.

Additionally, participants emphasized the need for government and private payors to address limitations of current payment models that fail to consider unique patient access challenges. For instance, clinicians

²⁴ Using Remote Patient Monitoring Technologies for Better Cardiovascular Disease Outcomes. American Heart Association. 2019. <https://www.heart.org/-/media/files/about-us/policy-research/policy-positions/clinical-care/remote-patient-monitoring-guidance-2019.pdf>

²⁵ Telehealth and remote patient monitoring. United States Department of Health and Human Services. <https://telehealth.hhs.gov/providers/preparing-patients-for-telehealth/telehealth-and-remote-patient-monitoring>

²⁶ Kichloo A, Albosta M, Dettloff K, et al. Telemedicine, the current COVID-19 pandemic and the future: a narrative review and perspectives moving forward in the USA. *Fam Med Community Health*. 2020;8(3):e000530. doi:10.1136/fmch-2020-000530

²⁷ Haleem A, Javaid M, Singh RP, Suman R. Telemedicine for healthcare: Capabilities, features, barriers, and applications. *Sens Int*. 2021;2:100117. doi:10.1016/j.sintl.2021.100117



who arrange an interpreter for a patient who is deaf or hard of hearing do not currently receive reimbursement for providing this essential form of assistance, or clinicians who spend extra time coordinating wraparound services for a patient may not receive adequate reimbursement. These are just several examples highlighted by participants that underscore the need for reimbursement policies that recognize clinicians working to overcome access challenges and deliver patient-centered care.

ADDRESSING PATIENT BARRIERS TO CARE

Roundtable participants discussed various barriers influencing access to care for members of racial/ethnic populations and high-risk heart patients. In particular, attendees identified several barriers to equitable care, including SDOH and the complex interplay of structural racism and distrust of the health care system as well as other access challenges, such as the unwinding of Medicaid, poor health and digital literacy, high cost-sharing for patients, and a lack of diversity in clinical trials.

“It’s a moral imperative that we do better. If we do not overcome these barriers, then we will not have a just society.

— Roundtable Participant

Social Drivers of Health and Structural Racism

Roundtable participants repeatedly cited SDOH as a significant impediment to care for members of racial/ethnic populations and high-risk heart patients. SDOH can be defined as the nonmedical factors that influence health outcomes.²⁸ Further, SDOH are “the conditions in the environments where people are born, live, learn, work, play, worship, and age” and “the wider set of forces and systems shaping the conditions of daily life.”^{29,30} In addition to health care access, these factors include, but are not limited to:

- Neighborhood and physical environment (e.g., housing, transportation, safety, zip code/geography) and education (e.g., language and literacy skills);
- Food (e.g., food insecurity, access to nutritious food options);
- Economic and social stability (e.g., employment, income, job opportunities, medical debt, discrimination, stress); and
- Environmental conditions, among other important factors.³¹

²⁸ Social determinants of health. World Health Organization. https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1

²⁹ Ibid.

³⁰ Social Determinants of Health. Healthy People 2023. <https://health.gov/healthypeople/priority-areas/social-determinants-health>

³¹ Artiga, S, Hinton, E. Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity. Kaiser Family Foundation. May 2018. <https://www.kff.org/racial-equity-and-health-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/>



Roundtable members’ concerns reflect well-documented evidence of the impacts of SDOH on access to health care and outcomes for members of racial/ethnic populations as well as high-risk and otherwise underserved individuals. Hood et al. estimated that, on average, clinical care was responsible for only 20 percent of variation in health outcomes in the U.S., while SDOH affected as much as 50 percent of health outcomes.³²

Guided by a SDOH framework, Javed et al. note that differences such as these arise for people of color—including Black, Hispanic, American Indian, Asian, and others—because these groups experience “varying degrees of social disadvantage that put these groups at an increased risk of cardiovascular disease and poor disease outcomes, including mortality.”³³ Further, patients in underrepresented racial and ethnic groups encounter more barriers to cardiovascular disease diagnosis and care, receive less optimal care, and experience worse adverse outcomes than white patients.³⁴ Recognizing these differential outcomes, roundtable members stressed the imperative of incorporating a SDOH-informed lens into emerging and existing strategies to reduce health disparities and advance health equity for cardiac care patients.

Additionally, roundtable participants called out structural racism as a fundamental cause of persistent cardiovascular disease disparities and overall health inequities nationwide. As laid bare by the pandemic, participants recognized how the underpinnings of an unjust U.S. health care delivery system—one that was originally founded and advanced on the separate and unequal treatments of others—continues to be felt today and has a significant, adverse impact on cardiovascular outcomes for members of racial/ethnic populations and high-risk patients. Further, the preservation and complex interplay of systems, policies, programs, practices, beliefs, and other interpersonal interactions—and their intersection with SDOH—perpetuates inequitable access to high-quality health care and exacerbates cardiovascular-related disparities.³⁵

Medicaid Continuous Coverage Unwinding

Roundtable participants addressed the adverse impacts of the end of the COVID-19 PHE-era Medicaid continuous coverage requirement on health care access for millions of at-risk individuals. The Medicaid continuous coverage provision, enacted during the pandemic, played a vital role in safeguarding access to care for vulnerable populations and served as a significant reason for which the uninsured rate reached an all-time national low.³⁶ Unfortunately, these crucial coverage protections expired at the end of the PHE on April 1, allowing states to resume their redetermination processes.

³² Hood CM, Gennuso KP, Swain GR, Catlin BB. County Health Rankings: Relationships Between Determinant Factors and Health Outcomes. *Am J Prev Med.* 2016;50(2):129-135. doi:10.1016/j.amepre.2015.08.024

³³ Javed Z, Haisum Maqsood M, Yahya T, et al. Race, Racism, and Cardiovascular Health: Applying a Social Determinants of Health Framework to Racial/Ethnic Disparities in Cardiovascular Disease. *Circ Cardiovasc Qual Outcomes.* 2022;15(1):e007917. doi:10.1161/CIRCOUTCOMES.121.007917

³⁴ Mazimba S, Peterson PN. JAHA Spotlight on Racial and Ethnic Disparities in Cardiovascular Disease. *J Am Heart Assoc.* 2021;10(17):e023650. doi:10.1161/JAHA.121.023650

³⁵ Mazimba S, Peterson PN. JAHA Spotlight on Racial and Ethnic Disparities in Cardiovascular Disease. *J Am Heart Assoc.* 2021;10(17):e023650. doi:10.1161/JAHA.121.023650

³⁶ Hanson C, Hou C, Percy A, Vreeland E, Minicozzi A; Congressional Budget Office Coverage Team. Health Insurance For People Younger Than Age 65: Expiration Of Temporary Policies Projected To Reshuffle Coverage, 2023-33. *Health Aff (Millwood).* 2023;42(6):742-752. doi:10.1377/hlthaff.2023.00325



Since the Medicaid unwinding period began, more than 600,000 Americans have lost Medicaid coverage, and experts predict that this number could rise to upwards of 17 million over the 12-month unwinding period.^{37,38} Alarming, nearly one-third of enrollees expected to lose coverage are Latino (4.6 million) and 15 percent (2.2 million) are Black.³⁹ This poses significant concern considering that Medicaid serves as the largest public health insurance program for low-income and disabled Americans and more than half of its beneficiaries identify as people of color.^{40,41} Roundtable participants further emphasized that Medicaid disenrollment could result in catastrophic losses of coverage for high-risk members of racial/ethnic populations and underserved individuals and impede access to life-saving medical services, including primary, preventive, and specialty care, including evidence-based cardiovascular therapies.

Low Health and Digital Literacy

Roundtable participants identified low health and digital literacy as additional barriers to access. Approximately 36 percent of U.S. adults have basic and below basic levels of health literacy skills.^{42,43,44} Health literacy is inextricably linked to advancing health equity and reducing health disparities.⁴⁵ Research has demonstrated that health literacy can increase the use of preventive care, reduce unintended emergency room visits, lower preventable stays in hospitals and readmission rates, help patients better manage chronic conditions, improve health outcomes, and boost patient satisfaction, among other

³⁷ Recht, H. As Medicaid Purge Begins, ‘Staggering Numbers’ of Americans Lose Coverage. June 2023.

<https://kffhealthnews.org/news/article/medicaid-unwinding-state-data-coverage-loss/>

³⁸ Unwinding the Medicaid Continuous Enrollment Provision: Projected Enrollment Effects and Policy Approaches. U.S. Department of Health and Human Services. August 2022.

https://aspe.hhs.gov/sites/default/files/documents/404a7572048090ec1259d216f3fd617e/aspe-end-mcaid-continuous-coverage_IB.pdf

³⁹ Unwinding the Medicaid Continuous Enrollment Provision: Projected Enrollment Effects and Policy Approaches. Assistant Secretary for Planning and Evaluation. Office of Health Policy. August 2022.

https://aspe.hhs.gov/sites/default/files/documents/404a7572048090ec1259d216f3fd617e/aspe-end-mcaid-continuous-coverage_IB.pdf

⁴⁰ Distribution of the Nonelderly with Medicaid by Race/Ethnicity. Kaiser Family Foundation.

<https://www.kff.org/medicaid/state-indicator/medicaid-distribution-nonelderly-by-raceethnicity/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>

⁴¹ Racial and Ethnic Disparities in Medicaid: An Annotated Bibliography, MACPAC. April 2021.

<https://www.macpac.gov/wp-content/uploads/2021/04/Racial-and-Ethnic-Disparities-in-Medicaid-An-Annotated-Bibliography.pdf>

⁴² Kutner M, Greenberg E, Jin Y, Paulsen C. The Health Literacy of America's Adults: Results from the 2003 National Assessment of Adult Literacy (NCES 2006-483). Washington, DC: U.S. Department of Education, National Center for Education Statistics; 2006. <https://nces.ed.gov/pubs2006/2006483.pdf>

⁴³ Healthy People 2030 proposes a two-pronged definition of health literacy: personal health literacy and organizational health literacy. Personal health literacy is “the degree to which individuals have the ability to find, understand, and use information and services to inform health-related decisions and actions for themselves and others”; organizational health literacy “is the degree to which organizations equitably enable individuals to find, understand, and use information and services to inform health-related decisions and actions for themselves and others.”

⁴⁴ Health Literacy in Healthy People 2030. U.S. Department of Health and Human Services.

<https://health.gov/healthypeople/priority-areas/health-literacy-healthy-people-2030>

⁴⁵ Ibid.



benefits.⁴⁶ Roundtable participations acknowledged their individual and collective roles in improving health literacy.

Similarly, participants highlighted that digital literacy—the ability to understand, effectively use, and navigate digital technologies, tools, and information—as essential to good health and a key component in accessing health care. While technology has the power to expand access and provide patients with access and information at their fingertips, millions of Americans still lack access to broadband, do not own smartphones, and/or have limited data plans that do not allow them to deploy their phones and other devices in a manner that facilitates access to care and supports their health and well-being.^{47,48,49} Being “digitally literate” means being able to navigate using digital tools (technical skills) as well as cognitive skills, such as being able to effectively communicate via digital modalities. Academics have increasingly noted that the combination of digital literacy, health literacy, and internet connectivity can be recognized as “super social determinants of health.”^{50,51} In other words, a person’s digital literacy and access to the web significantly impacts their health outcomes at greater levels than most other social phenomena, like race, ethnicity, and income.

Recommendations included using layperson terminology and other culturally and linguistically appropriate tools to aid informed decision making and empower patients as well as advocating for improved access to broadband and affordable data plans and ensuring that audio-only telehealth remains available and reimbursed so it can continue to be available to patients for whom a video visit is not feasible.

High Cost-Sharing and Total Cost of Care Concerns

Roundtable participants repeatedly noted that having health insurance alone is not a determinant of health care access. High out-of-pocket costs—including monthly premiums, coinsurance, copayments, deductibles, and other medical costs not covered by insurance—can lead individuals to make consequential tradeoffs between their health and other necessary expenses. In 2022, 28 percent of U.S.

⁴⁶ Health Literacy. Health Resources & services Administration.

<https://www.hrsa.gov/about/organization/bureaus/ohe/health-literacy>

⁴⁷ Goldberg, R. New NTIA Data Show Enduring Barriers to Closing the Digital Divide, Achieving Digital Equity. National Telecommunications and Information Administration. Office of Policy Analysis and Development. 2022. <https://www.ntia.gov/blog/2022/new-ntia-data-show-enduring-barriers-closing-digital-divide-achieving-digital-equity>

⁴⁸ People in Low-Income Households Have Less Access to Internet Services. Office of the Assistant Secretary for Planning and Evaluation. April 2020.

https://aspe.hhs.gov/sites/default/files/private/pdf/263601/Internet_Access_Among_Low_Income.pdf

⁴⁹ National Strategy Needed to Guide Federal Efforts to Reduce Digital Divide. U.S. Government Accountability Office. May 2022.

⁵⁰ Turcios, Y. Digital Access: A Super Determinant of Health. Substance Abuse and Mental Health Services Administration. March 2023. <https://www.samhsa.gov/blog/digital-access-super-determinant-health>

⁵¹ van Kessel R, Wong BLH, Clemens T, Brand H. Digital health literacy as a super determinant of health: More than simply the sum of its parts. *Internet Interv.* 2022;27:100500. Published 2022 Feb 7. doi:10.1016/j.invent.2022.100500



adults elected to forego medical care because they could not afford it.⁵² High cost sharing is associated with medication and treatment nonadherence, which is strongly correlated with poor health outcomes, increased mortality, and preventable costs.^{53,54} Health care costs have been found to disproportionately affect uninsured adults, Black and Hispanic adults, and those with lower incomes.⁵⁵ Despite the groundbreaking Medicare provisions passed in the Inflation Reduction Act (IRA)—including a \$2,000 annual cap on prescription drug costs covered under Medicare Part D beginning in 2025—roundtable participants acknowledged that many adults are still concerned about prescription affordability, with three in four adults reporting that it would be “somewhat difficult” or “very difficult” to pay \$2,000 out of pocket each year for their prescriptions.⁵⁶ Valero-Elizondo et al. found that nearly half of U.S. heart disease patients (45 percent) under age 65 experienced financial hardship from medical bills and that heart disease patients typically spend more than \$2,000 in out-of-pocket costs annually, with almost half of expenses being dedicated to medications.⁵⁷

“It does not take a whole lot [in terms of a co-payment] for someone to walk away from the pharmacy counter without their prescription filled.”

— Roundtable Participant

Roundtable participants also discussed how copay accumulator, maximizer, and alternative funding programs are significant drivers of out-of-pocket prescription medication costs and can further deny access, including to specialty medications.^{58,59} Participants shared how other indirect costs, including transit costs and lost wages, can also influence the total cost of care, which may result in added

⁵² Economic Well-Being of U.S. Households in 2022. Board of Governors of the Federal Reserve System. May 2023. <https://www.federalreserve.gov/publications/files/2022-report-economic-well-being-us-households-202305.pdf>

⁵³ A Report in Response to the Executive Order on Lowering Prescription Drug Costs for Americans. U.S. Department of Health and Human Services.

⁵⁴ Higher Prescription Drug Cost-Sharing Raises Mortality among Medicare Beneficiaries. National Bureau of Economic Research. June 2021. <https://www.nber.org/bh-20212/higher-prescription-drug-cost-sharing-raises-mortality-among-medicare-beneficiaries>

⁵⁵ Montero A, Kearney A, Hamel, L, et al. Americans’ Challenges with Health Care Costs. Kaiser Family Foundation. July 2022. <https://www.kff.org/health-costs/issue-brief/americans-challenges-with-health-care-costs/>

⁵⁶ Adults on Medicare: financial burden of out-of-pocket costs and impact of a Part D cap. PAN Foundation. October 2022. <https://www.panfoundation.org/app/uploads/2022/11/Polling-Adults-on-Medicare-Nov2022.pdf>

⁵⁷ Valero-Elizondo J, Khera R, Saxena A, et al. Financial Hardship From Medical Bills Among Nonelderly U.S. Adults With Atherosclerotic Cardiovascular Disease. *J Am Coll Cardiol.* 2019 Feb, 73 (6) 727–732. <https://doi.org/10.1016/j.jacc.2018.12.004>

⁵⁸ PBMs and insurers are increasingly turning to harmful copay accumulator and copay maximizer programs. These programs exclude patient financial assistance (e.g., funds from charitable foundations, manufacturer assistance programs, friends and family, faith-based community organizations, etc.) from counting toward a patient’s deductible or out-of-pocket responsibilities, imposing higher financial burdens, and undermining access to necessary medications and treatments. Similarly, health plan sponsors use alternative funding programs (or “specialty carve outs”) to exclude expensive specialty medications from coverage and instead direct enrollees to outside vendors for their medications in efforts to circumvent Affordable Care Act laws and regulations.

⁵⁹ Ban copay accumulator, maximizer, and alternative funding programs. PAN Foundation. <https://www.panfoundation.org/our-positions/ban-copay-accumulator-maximizer-alternative-funding-programs/>



affordability barriers. To address these concerns, roundtable members called for industry and payor commitments to lowering the cost of care—including reducing premiums and cost-sharing responsibilities—and advancing legislation to curb the use of programs, like copay accumulators and copay maximizers, that deny valuable patient financial assistance.

Lack of Diversity in Clinical Trials

Roundtable participants stressed how diverse enrollment in clinical trials is paramount to reducing health disparities and must continue to be a national priority. Racial and ethnic minority groups have been historically underrepresented in clinical research, including cardiovascular trials.⁶⁰ Lack of representation in clinical trials threatens the overall generalizability of clinical research findings and creates blind spots in the efficacy and safety of new treatments for members of racial/ethnic populations. Chen et al. found that, despite shouldering a disproportionate burden of cardiovascular disease, Black adults are persistently underrepresented in clinical trials for new cardiovascular drugs, whereas white adults were equally represented and even overrepresented.⁶¹ The National Academies of Sciences, Engineering, and Medicine (NASEM) highlights how poor representation in clinical trials may hinder access to effective medical interventions since “approval and indications for new therapies are often limited to the demographics of the populations originally included in the clinical trials.”⁶²

While roundtable members commended national efforts to improve diversity in clinical trials, participants discussed the need for intensified commitments to equitably recruit and retain diverse clinical trial participants and the need to mobilize new solutions to support this undertaking. Furthermore, various strategies were explored and put forth, including efforts to engage patients as early in the trial design process as possible, meeting prospective enrollees in their communities to increase retention and build trust, partnering with community organizations, and taking steps to improve overall clinical trial awareness, among other recommendations.

⁶⁰ Clark LT, Watkins L, Piña IL, et al. Increasing Diversity in Clinical Trials: Overcoming Critical Barriers [published correction appears in *Curr Probl Cardiol*. 2021 Mar;46(3):100647]. *Curr Probl Cardiol*. 2019;44(5):148-172. doi:10.1016/j.cpcardiol.2018.11.002

⁶¹ Chen S, Li J. Participation of Black US Residents in Clinical Trials of 24 Cardiovascular Drugs Granted FDA Approval, 2006-2020. *JAMA Netw Open*. 2021;4(3):e212640. Published 2021 Mar 1. doi:10.1001/jamanetworkopen.2021.2640

⁶² National Academies of Sciences, Engineering, and Medicine; Policy and Global Affairs; Committee on Women in Science, Engineering, and Medicine; Committee on Improving the Representation of Women and Underrepresented Minorities in Clinical Trials and Research, Bibbins-Domingo K, Helman A, eds. *Improving Representation in Clinical Trials and Research: Building Research Equity for Women and Underrepresented Groups*. Washington (DC): National Academies Press (US); May 17, 2022.



LEVERAGING TECHNOLOGY TO IMPROVE ACCESS TO CARE

Roundtable participants explored the use of technology as a significant opportunity for expanding access to care. From new innovations, like virtual reality to wearable devices, to the use of telehealth and other digital tools to connect patients and clinicians, advancements in technology are revolutionizing care delivery across the nation unlike ever before. However, the digital divide contributes to, exacerbates, and reinforces existing inequities, so caution must be taken when considering technology solutions, as they may not work for all communities.

“Bringing health care closer to people increases the value of care.”

— Roundtable Participant

Deploying Telehealth and Other Digital Platforms

Roundtable participants discussed the great promise of telehealth and other digital tools in expanding access to and promoting continuity of care. The COVID-19 pandemic illuminated the transformative capabilities of remote care services, particularly for patients living in underserved, rural, or other hard-to-reach areas.⁶³ Roundtable members discussed the many advantages of telehealth virtual visits, such as reduced wait times, increased patient and clinician flexibility, and enhanced patient satisfaction. They also identified several significant barriers impacting equitable access to virtual care. These limitations include disparities in device ownership, poor digital literacy, lack of broadband access, and privacy concerns.

As for broadband inequities, as noted earlier, internet access has been increasingly defined as a “super determinant” of health, as it influences other SDOH, such as education, employment, and health care access.⁶⁴ Participants acknowledged that digital health technology uptake is currently unachievable for all patient populations due to the “digital divide.”^{65,66} Although there have been historic investments made to support broadband deployment and affordability, roundtable members described how additional strategies are needed to ensure that digital health technologies are within reach for millions of underserved Americans. This includes, but is not limited to, collaborating with community health workers and other trusted partners to equitably implement new technologies, designing platforms that are user-friendly and in plain language, and improving cultural competence training.

⁶³ Shaver J. The State of Telehealth Before and After the COVID-19 Pandemic. *Prim Care*. 2022;49(4):517-530. doi:10.1016/j.pop.2022.04.002

⁶⁴ Turcios, Y. Digital Access: A Super Determinant of Health. Substance Abuse and Mental Health Services Administration. March 2023.

⁶⁵ The digital divide can be defined as the gap between those who have access to internet and high-speed Internet/advanced telecommunications and those who do not. Dempsey, J and Sun, P. The Digital Divide in U.S. Mobile Technology and Speeds. Office of Economics and Analytics. Federal Communications Commission. December 2020. <https://docs.fcc.gov/public/attachments/DOC-369010A1.pdf>

⁶⁶ Closing the Digital Divide for the Millions of Americans without Broadband. U.S. Government Accountability Office. February 2023. <https://www.gao.gov/blog/closing-digital-divide-millions-americans-without-broadband#:~:text=The%20digital%20divide%20has%20issues,deployment%20to%20provide%20better%20access>

“You cannot out train your bias. It exists and it is very real.”

— Roundtable Participant

Using Technology to Address Biases and Assist in Predictive Clinical Decision-Making

Roundtable participants discussed how cutting-edge technologies can help reduce and eliminate implicit bias and reveal predictive decision-making in clinical settings. Sabin notes how implicit and explicit biases are drivers of health disparities and negatively affect patient care.⁶⁷ A large and growing body of evidence exists that links the role of clinician and institutional biases to racial disparities in health.⁶⁸ In 2022, the Pew Research Center reported that the majority of Black Americans (56 percent) had at least one of several negative health care experiences, “including having to speak up to get the proper care and being treated with less respect than other patients.”⁶⁹ Roundtable attendees explained how new emerging technologies can help minimize negative interpersonal interactions in health care settings. Through immersive technologies, clinicians are able to embody patient perspectives and develop empathy as well as gain a deeper understanding of their patients' lived experiences and backgrounds.⁷⁰ Additionally, virtual reality can help introduce real-world care scenarios that can provide insight into clinical decision making. Participants shared how embracing new tools like these are critical to creating positive patient experiences, building patient-clinician trust, strengthening shared decision making, and ultimately reducing racial and ethnic disparities in health care.

Understanding Artificial Intelligence in Health Care: The Opportunities and Challenges

Artificial intelligence (AI) is rapidly transforming the health care industry and can have a profound impact on health and the provision of medical services. Roundtable participants discussed how the ability of AI to quickly analyze massive amounts of clinical research and medical data could be tremendously helpful to health disparity tracking and identifying other patterns and trends to help improve care delivery and health outcomes. Despite the numerous benefits of AI, participants highlighted several challenges and ethical considerations surrounding the use of the technology and modeling in health care. In particular, participants warned of algorithm biases, which can lead to misdiagnosis, treatment delays, and poorer health outcomes. For example, Obermeyer et al. found that a widely used commercial prediction algorithm that influences health care decisions for over 100 million Americans exhibited a significant racial bias—Black patients had to be deemed much sicker than their white counterparts to be recommended

⁶⁷ Sabin JA. Tackling Implicit Bias in Health Care. *N Engl J Med.* 2022;387(2):105-107. doi:10.1056/NEJMp2201180

⁶⁸ Institute of Medicine (US) Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care, Smedley BD, Stith AY, Nelson AR, eds. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care.* Washington (DC): National Academies Press (US); 2003.

⁶⁹ Funk, C. Black Americans' Views of and Engagement With Science. Pew Research Center. April 2022. <https://www.pewresearch.org/science/2022/04/07/black-americans-views-about-health-disparities-experiences-with-health-care/>

⁷⁰ Equity Commons. <https://equity-commons.com/>



for the same care.⁷¹ This was because the algorithm falsely relied on past health care spending as a proxy for health, which ignored structural inequalities that have led Black patients to traditionally spend less on care than whites. This case study reinforces and aligns with participants’ advocacy for responsible AI use in health care, such as careful model building and data vetting, in efforts to avoid unintended consequences for health equity and care delivery.

REIMAGINING PAYMENT, CARE DELIVERY, AND THE HEALTH CARE WORKFORCE

Roundtable participants discussed the current system of incentives shaping health care payment and delivery policies across the nation. Recognizing that payment drives practice, participants emphasized the importance of transitioning from fee-for-service (FFS) payment systems, testing and implementing new models that prioritize team-based and whole-person care, recruiting and retaining a diverse health care workforce, and supporting community health centers.

“It is not just about having an insurance card. It is also about the model that you pay for and the practice that allows you to deliver the care you need.”

— Roundtable Participant

Redesigning Payment Policies Toward Whole-Person Care and Promoting Team-Based Care

Roundtable participants described the need to fix the current system of “broken financial incentives” that are based on a health care payment structure and system that impede access and outcomes for cardiovascular patients. Specifically, participants emphasized the importance of efforts to move away from traditional fee-for-service payment models toward value-based payment models.^{72,73} Consistent with longstanding criticisms of fee-for-service, participants argued that inherent financial incentives of FFS result in uncoordinated care, duplication of services, and raised cost-sharing responsibilities for patients. The fee-for-service model also rewards the provision of “high-margin services and large turnover.”⁷⁴ Under the fee-for-service system, Edmiston warns that clinicians are disincentivized from treating members of underserved and racial/ethnic populations because these patients “often need low-

⁷¹ Obermeyer Z, Powers B, Vogeli C, Mullainathan S. Dissecting racial bias in an algorithm used to manage the health of populations. *Science*. 2019;366(6464):447-453. doi:10.1126/science.aax2342

⁷² Fee-for-service is a payment model where providers receive compensation for each individual service performed, rather than receiving a fixed salary or capitated payment. A common criticism of the model is that it rewards “volume” over “value,” often leading to higher patient costs and the overutilization of healthcare services. An alternative to fee for service, value-based payment models reward providers for “quality” over “quantity” of services provided, which has been shown to reduce costs and improve quality of care.

⁷³ Lewis, C, Horstman, C, Blumenthal, D, et al. Value-Based Care: What It Is, and Why It’s Needed. The Commonwealth Fund. February 2023.

<https://www.commonwealthfund.org/publications/explainer/2023/feb/value-based-care-what-it-is-why-its-needed>

⁷⁴ Edmiston, Kelly D. Alternative Payment Models, Value-Based Payments, and Health Disparities. Center for Insurance Policy & Research Report. National Association of Insurance Commissioners. August 2022. <https://content.naic.org/sites/default/files/cipr-report-alternative-payment-methods.pdf>



margin services such as primary care, monitoring of chronic diseases like hypertension and diabetes and behavioral health care.”⁷⁵ Alternatively, under a value-based payment system, reimbursement is linked to provider performance based on various cost, quality, and equity measures.⁷⁶ For cardiac care, value-based payment has been recognized as a “key pathway” to improving care delivery for preventive services, such as cardiovascular risk screening, and addressing cardiovascular challenges with respect to inequities in risk factors, treatment, and outcomes.”⁷⁷

“[We must prioritize] redesigning payment and the delivery system so that it is centered on equity and focused on prevention.”

— Roundtable Participant

Roundtable participants emphasized the need for payors—both government and commercial—to test, design, and adopt alternative payment models that prioritize equity and unlock whole-person care.^{78,79} Specifically, participants addressed the need for more innovative payment models that promote greater integration of primary and preventive care services as well as other specialists and supports that holistically address SDOH. Additionally, participants highlighted the importance of payment and delivery models that support team-based care. Team-based care has increasingly been found to improve patient outcomes as well as clinician well-being and has been recognized as essential to delivering comprehensive cardiac care.^{80,81,82}

⁷⁵ Ibid.

⁷⁶ Lewis, C, Horstman, C, Blumenthal, D, et al. Value-Based Care: What It Is, and Why It’s Needed. The Commonwealth Fund. February 2023.

⁷⁷ Improving Heart Health Through Value-Based Payment. American Heart Association and the Duke-Margolis Center for Health Policy. March 2022. <https://www.heart.org/-/media/Files/About%20Us/Policy%20Research/Policy%20Positions/Access%20to%20Healthcare/Improving%20Health%20Through%20Value%20Based%20Payment.pdf>

⁷⁸ According to the National Academies of Sciences, Engineering, and Medicine, whole-person health, is “physical, behavioral, spiritual, and socioeconomic well-being as defined by individuals, families, and communities.” Whole health care is also “an interprofessional, team-based approach anchored in trusted relationships to promote well-being, prevent disease, and restore health.”

⁷⁹ National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Health Care Services; Committee on Transforming Health Care to Create Whole Health: Strategies to Assess, Scale, and Spread the Whole Person Approach to Health, Meisner M, South-Paul J, Krist AH, eds. Achieving Whole Health: A New Approach for Veterans and the Nation. Washington (DC): National Academies Press (US); February 15, 2023.

⁸⁰ The Institute of Medicine (IOM) defines team-based health as “the provision of health services to individuals, families, and/or their communities by at least two health providers who work collaboratively with patients and their caregivers—to the extent preferred by each patient—to accomplish shared goals within and across settings to achieve coordinated, high-quality care.”

⁸¹ Welp A, Manser T. Integrating teamwork, clinician occupational well-being and patient safety - development of a conceptual framework based on a systematic review. BMC Health Serv Res. 2016;16:281. Published 2016 Jul 19. doi:10.1186/s12913-016-1535-y

⁸² Miller AP, Handberg EM, Rodgers GP. It Takes a Team to Deliver Optimal Cardiovascular Care. J Am Coll Cardiol. 2018;72(8):948-951. doi:10.1016/j.jacc.2018.07.017



The Community Preventive Services Task Force (CPSTF), Surgeon General’s “Call to Action to Control Hypertension,” and the Center for Disease Control and Prevention’s (CDC) Best Practices for Cardiovascular Disease Prevention Programs have all respectively recommended and promoted the use of team-based care for hypertension management, including among patients who are Black, Hispanic, or Latino.⁸³ Further, the CDC recognizes team-based care as an important driver of health equity, as integrated support teams can help empower patients to manage their own care and improve medication adherence.⁸⁴ Participants further called for the greater development and adoption of health care payment models that reinforce multidisciplinary, coordinated care to promote efficient, patient-centered care delivery and provider empowerment.

“We need to make sure that people have a primary care foundation. They need to have someone who they can have an ongoing continuous relationship with, regardless of what other specialists they need, because that is where you build trust over time. We need payment models that support leveraging those physician’s patients and all of the other people in the world who could be helpful to them, some of whom we have not even identified yet, because we have not yet paid for the models that allow us to be creative and innovative in that space. And if we fail to address the social determinants and political determinants of health, it is going to be irrelevant.”

— Roundtable Participant

Participants also highlighted efforts to advance health equity through payment, including the development and redesign of models like the ACO Realizing Equity, Access, and Community Health (ACO REACH) Model.⁸⁵ Participants stressed how additional, similar payment models are needed to further break down care silos and help deliver high-quality, coordinated care to underserved communities throughout the nation.

Recruiting and Strengthening a Diverse and Inclusive Health Care Workforce

Roundtable participants stressed the importance of recruiting and retaining a diverse health workforce to bridge care gaps for members of racial/ethnic populations and high-risk and otherwise underserved heart patients. Black, Hispanic, and Native American people are currently underrepresented in the U.S. health care workforce.⁸⁶ For instance, despite the Black community representing 13 percent of the U.S. population, only 5.7 percent of physicians are Black.⁸⁷ Attendees underscored how developing a diverse

⁸³ Team-Based Care to Improve Blood Pressure Control. Centers for Disease Control and Prevention. <https://www.cdc.gov/dhdsp/pubs/team-based-care.htm>

⁸⁴ Ibid.

⁸⁵ ACO Reach. Centers for Medicare & Medicaid Services. <https://innovation.cms.gov/innovation-models/aco-reach>

⁸⁶ Salsberg E, Richwine C, Westergaard S, et al. Estimation and Comparison of Current and Future Racial/Ethnic Representation in the US Health Care Workforce. JAMA Netw Open. 2021;4(3):e213789. Published 2021 Mar 1. doi:10.1001/jamanetworkopen.2021.3789

⁸⁷ What’s your specialty? New data show the choices of America’s doctors by gender, race, and age. Association of American Medical Colleges.



health workforce is essential to delivering racially concordant care, which has been found to improve communication, trust, and treatment adherence.⁸⁸

“There are not enough cardiologists. There are not enough advanced practice nurses. We have an underdeveloped health care delivery system. The money is there, the devices are being developed, the new medicines are coming, but the people supply is short.”

— Roundtable Participant

The impact of provider shortages is particularly evident in the cardiovascular care of members belonging to racial/ethnic populations. Recent research has shown that more than 16.8 million Black Americans reside in counties with limited or no access to cardiologists.⁸⁹ These "cardiology deserts" force residents to travel excessive distances, sometimes more than 80 miles, to reach the nearest clinic, significantly hampering their access to critical cardiac care. Adding to the concern, shortages of not only cardiologists but also primary care, dental, and mental health practitioners pose a severe threat to overall care delivery and risks exacerbating existing racial, ethnic, and rural-urban health disparities. Roundtable participants urged for increased resources and investments to ensure that the U.S. health workforce reflects the diverse communities it serves.

Increasing Support for Community Health Centers

Roundtable participants highlighted the importance of federally-funded community health centers (CHCs) in providing affordable health care to millions of patients who identify as members of racial/ethnic groups, underserved, or high-risk. Community health centers serve one in eleven people in the U.S., with 63 percent identifying as racial/ethnic minorities.⁹⁰ Additionally, CHCs serve populations with complex needs, including 1.3 million patients experiencing homelessness, 7.4 million patients who require language services other than English, 5.7 million residents of public housing, and a disproportionate share of low-income and uninsured individuals in the U.S.⁹¹ Further, CHCs serve as critical care hubs for underserved and medically disadvantaged communities and, oftentimes, are the first point of contact for many individuals seeking medical attention. Given the affordable, integrative, and comprehensive approach of CHCs, these settings are critical to responding to the unique medical needs of diverse patient populations, including the provision of primary care and other preventative care services.⁹²

⁸⁸ Guillaume G, Robles J, Rodríguez JE. Racial Concordance, Rather Than Cultural Competency Training, Can Change Outcomes. *Fam Med.* 2022;54(9):745-746. doi:10.22454/FamMed.2022.633693

⁸⁹ Cisneros, T. More Than 16 Million Black Americans Live in Counties With Limited or No Access to Cardiologists. May 2023. <https://www.goodrx.com/healthcare-access/research/black-americans-cardiology-deserts>

⁹⁰ Community Health Centers Chartbook 2023. April 2023. National Association of Community Health Centers. <https://www.nachc.org/resource/community-health-center-chartbook-2022/>

⁹¹ Ibid.

⁹² What is a Health Center? HRSA Health Center Program. <https://bphc.hrsa.gov/about-health-centers/what-health-center#:~:text=Health%20centers%20reduce%20health%20disparities,practices%2C%20including%20health%20infomation%20technology>



Participants reflected on how, unfortunately, CHCs have been chronically underfunded and are currently facing unprecedented financial challenges due to the impacts of the Medicaid continuous coverage unwinding, which will further decrease revenue and increase care costs due to more uninsured patients.⁹³ Community health centers also face unique staffing challenges, including high rates of workforce attrition and struggles with recruitment due to an inability to offer the same competitive salary and benefits as other health care organizations.⁹⁴ Roundtable members repeatedly reiterated the indispensable role of CHCs in caring for members of racial/ethnic populations and high-risk and underserved patients and further advocated for increased investment in and funding for these critical sites of care.

A CALL TO ACTION: 2023 ROUNDTABLE ACTIONS

Throughout the convening, participants were encouraged to recommend specific actions that can be taken to improve access to care for members of racial/ethnic populations and high-risk and otherwise underserved individuals. Recommendations were made during the various discussion sections as well as through a discussion worksheet on which participants enumerated any additional recommendations or priorities they wished to raise up to ABC. The concluding roundtable session was dedicated to a discussion about recommendations and next steps.

The recommendations exemplify the importance of a collaborative, multistakeholder approach in addressing health inequities and improving health outcomes for members of racial/ethnic populations and underserved heart patients. Due to the extensive number of recommendations, the ABC distributed a follow-up survey among meeting participants in order to further prioritize top actions. Please note that the following recommendations are a summary from event discussions and discussion worksheets and do not imply endorsement from any of the event attendees other than the ABC.

***If there is one thing I can take away from today it is that we all have a collective commitment...
to achieve health equity, reduce health disparities, and improve health
outcomes for cardiovascular disease.”***

— Roundtable Participant

⁹³ Community Health Centers Brace for the Impact of Medicaid Redeterminations. National Association of Community Health Centers. March 2023. <https://www.nachc.org/resource/community-health-centers-brace-for-the-impact-of-medicaid-redeterminations/>

⁹⁴ Current State of the Health Center Workforce: Pandemic Challenges and Policy Solutions to Strengthen the Workforce of the Future. National Association of Community Health Centers. March 2022. <https://www.nachc.org/wp-content/uploads/2022/03/NACHC-2022-Workforce-Survey-Full-Report-1.pdf>



Priority Recommendations for Action in the Near Term

*Roundtable members urge the **federal government** to:*

- Leverage a whole-of-government approach to promoting health equity and reducing health disparities, lending specific attention to environmental barriers that drive care inequities (e.g., food deserts, safe spaces for exercise, etc.) and supporting partners working to bridge care gaps.
- Maintain COVID-era policies that reimburse telehealth visits at the same rate as in-office visits and expand payment policies that promote greater use of telehealth services and other remote care solutions.
- Enact legislation that bans under commercial insurance the use of harmful copay accumulator, copay maximizer, alternative funding, and other similar programs that limit access to care and deny vital patient assistance.
- Institute guardrails around prior authorization practices by payors to avoid care disruptions and reduce workforce strains, especially for guideline-directed medical therapies.

*Roundtable members urge **health care payors (government and commercial)** to:*

- Eliminate the use of burdensome prior authorization requirements and utilization management practices for procedures and medications that are clearly indicated in major national evidence-based guidelines and standards of care, such as those from the American College of Cardiology, the American Heart Association, etc., including medical services required by the FDA label or Risk Evaluation & Mitigation Strategy (REMS) for the initiation or monitoring of drugs and biologics.

Complete Set of Roundtable Recommendations

FEDERAL GOVERNMENT

GENERAL RECOMMENDATIONS

- Partner with shared outcome-interested organizations to amplify changes in cardiovascular care and equitably implement changes in communities.
- Leverage a whole-of-government approach to promoting health equity and reducing health disparities, lending specific attention to environmental barriers that drive care inequities (e.g., food deserts, safe spaces for exercise, etc.) and supporting partners working to bridge care gaps.
- Analyze data regarding cardiovascular disparities and circulate findings to state, local, and other community partners to advance equitable health policy.

CONGRESS

- Make permanent and expand COVID-era telehealth flexibilities to safeguard access to care, particularly for those living in remote, underserved, and other hard-to-reach communities.
- Enact legislation that aims to improve and increase diversity of participants in clinical trials for federally-funded research.
- Oversee implementation of diversity action plan requirements by the Food and Drug Administration (FDA) as part of the 2023 Consolidated Appropriations Act.



- Enact legislation that curbs the use of utilization management practices, such as fail first or “step” therapy by insurers and/or pharmacy benefit managers (PBMs).
- Enact legislation that bans, under commercial insurance, the use of harmful copay accumulator, copay maximizer, alternative funding, and other similar programs that limit access to care and deny vital patient assistance.
- Enact legislation that provides full, first-dollar coverage and adequate reimbursement for home blood-pressure monitoring and other remote patient monitoring services and devices for hypertension, diabetes, and other conditions that contribute to poor cardiovascular health; while legislation is being considered, direct the Center for Medicare and Medicaid Innovation (CMMI) to undertake a pilot in which copayments for remote patient monitoring services and devices are waived to study the impact on access, equity, and outcomes.
- Institute guardrails around prior authorization practices by payors to avoid care disruptions and reduce workforce strains, especially for guideline-directed medical therapies.
- Amend Medicare policy to provide greater coverage for cardiovascular medical devices.
- Allocate sustained and robust funding to federal agencies (e.g., Health Resources and Services Administration) that provide support to community-based health workers, patient navigators, doulas, midwives, and other clinical teams that care for cardiovascular patients and others with complex health issues.
- Provide robust malpractice coverage and Federal Tort Claims Act (FTCA) coverage to help alleviate cardiology workforce strains and other national health workforce challenges.
- Increase pressure on payors to provide coverage of guideline-directed medical therapies and evidence-based medicine and hold payors responsible for outcomes when guideline-directed medical therapies are not covered.

CMS

- Maintain COVID-era policies that reimburse telehealth visits at the same rate as in-office visits and expand payment policies that promote greater use of telehealth services and other remote care solutions.
- Prohibit the use of harmful copay accumulator, copay maximizer, alternative funding, and other similar programs that limit access to care and deny vital patient assistance.
- Test and advance cutting-edge payment models that prioritize whole-person and preventive care.
- Organize a pilot under CMMI that would waive copayments for remote patient monitoring services and devices to study the impact on access, equity, and outcomes.
- Fund demonstration projects seeking to advance access to care and reduce health disparities.
- Engage specialists, such as cardiologists, in the design and implementation of new models of care, such as Making Care Primary.
- Advance payment policies that support and otherwise incentivize efforts to expand access to imaging technology in underserved and rural areas to address care gaps and reduce health disparities.

HRSA

- Award funding opportunities for efforts that specifically address SDOH and are aimed at improving primary and preventive care, enhancing team-based care, and recruiting and strengthening a diverse workforce.
- Develop and disseminate culturally competent educational resources and solutions to help health centers and other community partners advance best practices across the nation.



HEALTH CARE PAYORS (GOVERNMENT AND COMMERCIAL)

- Ensure that plan documents and other plan-related materials are patient-centric by making them easy to understand (e.g., lay-friendly language) and accessible to all patients of different backgrounds.
- Ensure formulary changes, both mid-year and in the new plan year, allow for patients who are already stable on their medication to remain on their medication.
- Eliminate the use of burdensome prior authorization requirements and utilization management practices for procedures and medications that are clearly indicated in major national evidence-based guidelines and standards of care, such as those from the American College of Cardiology, the American Heart Association, etc., including medical services required by the FDA label or Risk Evaluation & Mitigation Strategy (REMS) for the initiation or monitoring of drugs and biologics.
- Honor financial assistance received by or on behalf of a patient toward their out-of-pocket maximum and deem all prescription medications, including specialty medications, as essential.
- Reduce high cost-sharing and lower premiums to promote affordability and continuity of care for primary, preventive, and cardiovascular services.
- Cover all guideline-based services at low or at no cost to patients.
- Reward—and partner—with individuals and organizations that deliver high-quality cardiovascular and cardiovascular obstetric care to underserved populations, particularly community health centers.
- Bolster high-quality and preventive care, support and advance value-based payment models, and work to transition from fee-for-service payment.
- Provide transparency in payment models so that trends in care, outcomes, and equity can be monitored for impact.
- Support value-based reimbursement to bolster high-quality primary and preventive care.
- Test and redesign payment models to align with health equity goals, including coverage of upstream factors influencing health, such as SDOH.
- Strengthen and broaden nontraditional care models, including team-based care and other alternative settings/modalities (e.g., retail health clinics, telemedicine, community health centers, self-diagnostic tools, etc.), by incorporating them into payment policies and providing financial support for care coordination activities and care team members in these settings.
- Advance payment policies that support and otherwise incentivize efforts to expand access to imaging technology in underserved and rural areas to address care gaps and reduce health disparities.
- Reimburse for patient education to help improve health, reduce preventable chronic disease, and decrease nonadherence.

PHARMACEUTICAL AND MEDICAL DEVICE INDUSTRY

- Lower patient out-of-pocket prescription drug and device costs to promote greater patient affordability and cardiovascular treatment accessibility, including incorporating education and awareness around the out-of-pocket cap and smoothing option under the Medicare Part D redesign.
- Lead global research initiatives to examine health inequities and highlight solutions that drive meaningful change.
- Boost clinical trial awareness to improve trial participation and enhance public understanding of the benefits of clinical research to health outcomes.
- Engage patients and advocates as early as possible in the clinical trial process, including trial design and the identification of endpoints, to ensure drug/device development comprehensively reflects the patients they are intended to serve.



- Encourage partnerships between academic institutions and community-based clinics to engage, educate, enroll, and retain diverse populations in clinical trials.
- Fund innovative programs and pilot initiatives specifically designed to reach patient populations who have been historically underrepresented in clinical research.
- Advance decentralized clinical trial models to better meet patients where they are and promote diverse participant enrollment and retention.
- Create and disseminate inclusive marketing campaigns to ensure members of racial/ethnic populations and other historically underserved patient groups gain awareness of new cardiovascular innovations.
- Explore and responsibly utilize artificial intelligence (AI) technologies to assist with patient recruitment for clinical trials and improve trial design.
- Address and respond to poor utilization rates of Transcatheter aortic valve replacement (TAVR) and other structural heart interventions by members of racial/ethnic populations and underserved heart patients and employ strategies to overcome treatment hesitancy.
- Identify potential access to care issues before a drug or device is brought to market and work with partners to help eliminate barriers in advance of market launch.
- Deliver in-kind technology and expertise to help clinicians administer guideline-indicated therapies and address SDOH, particularly to community health centers that traditionally provide care to underserved populations.
- Collaborate with individuals and organizations in implementing scalable solutions to advance health equity and reduce health disparities.

PATIENT ADVOCACY ORGANIZATIONS

- Empower patients to advocate for and advance their care with education and engagement tools, such as peer-to-peer support and other accessible resources.
- Illuminate and share patient stories with policymakers and payors to ensure that diverse lived experiences are reflected in new models of payment and care delivery.
- Partner with churches, barbershops, and other community centers to help build a culture of trust and health promotion among underserved communities.
- Translate and individualize resources for relevant patient communities to promote culturally and linguistically competent care and stronger health literacy, specifically materials around the vital importance of preventive care and other strategies to prevent heart disease.
- Expand capacity and strengthen organizational will to move advocacy efforts more upstream to address nonclinical issues that influence health outcomes, such as housing, transportation, and education (i.e., SDOH).
- Call out structural racism as a fundamental driver of poor health outcomes and cardiovascular disparities and hold policymakers and systems accountable to address it.
- Reflect, represent, and lift up challenges and barriers experienced by clinicians and patients.
- Collaborate and partner with industry and other key stakeholders to boost engagement, recruitment, and retention of diverse populations in clinical trials.
- Disseminate data and learnings to the broader stakeholder community to help foster comprehensive and aligned understanding of health equity issues facing members of racial/ethnic populations and underserved heart patients.
- Hold payors accountable when they do not cover or adequately reimburse for guideline-directed medical therapy or require prior authorization before it is provided.



CLINICIANS AND MEDICAL PROFESSIONAL SOCIETIES

- Adhere to guideline-directed medical therapy as often as possible to enhance and strengthen the evidence base on cardiovascular care.
- Employ innovative technologies—such as virtual reality—to help develop empathy and understanding among clinicians regarding different patient challenges and experiences.
- Develop trusted partnerships in the community to overcome hesitancy around cardiac interventions and work toward shared decision making pre- and post-intervention with patients.
- Encourage and utilize team-based care as appropriate to better meet patient needs, improve clinician well-being, and reduce burnout.
- Leverage innovative technologies and community-based screening programs to help proactively identify patients that are high-risk for developing chronic diseases, including cardiovascular disease.
- Include physicians and practitioners who are representative of the population at risk in all levels of training and in practice.
- Set direction and create alignment on health equity and DEI efforts within organizations and provide education for members.
- Support and strengthen networking and mentorship programs that bolster and advance a strong, diverse, and inclusive workforce.
- Develop new and amplify existing programs to increase diversity in the cardiology workforce.
- Amplify and support efforts to increase the number of nurses, especially those who are focused on cardiovascular care.
- Strengthen and mobilize advocacy of health policy at the local, state, and national levels, including providing advocacy training to members so they can engage with policymakers to enact change to benefit patients with cardiovascular disease and their care team.
- Connect patients with navigators and other peer-to-peer support opportunities to help build trust and contribute to informed decision making.
- Elevate and leverage embedded care models to advance whole-person care and reduce clinician burnout.
- Hold payors accountable when they do not cover or adequately reimburse for guideline-directed medical therapy or require prior authorization before it is provided.
- Explore the link between cardiovascular disease and maternal morbidity and mortality.
- Increase coordination and partnerships with wraparound services and supports and partner with community-based organizations to help with early detection and education.



An ABC Roundtable: Improving Health Care Access & Outcomes for Minority and High-Risk Populations

June 20, 2023

8:00 AM – 3:15 PM ET

Venable LLP

600 Massachusetts Avenue NW

Washington, DC 20001

MEETING AGENDA

- | | |
|-----------------------|---|
| 8:00 – 8:15 AM | Breakfast and Registration |
| 8:15 – 8:30 AM | Welcome and Housekeeping <ul style="list-style-type: none">▪ Moderator: Ilisa Halpern Paul, MPP
Senior Policy Advisor, Venable LLP▪ Keith C. Ferdinand, MD, FACC, FAHA, FASH, FNLA, FASPC
Chair, Access to Care Initiative and Roundtable Co-Chair
Association of Black Cardiologists▪ Barbara Hutchinson, MD, PhD, FACC
Board Chair and Roundtable Co-Chair
Association of Black Cardiologists |
| 8:30 – 9:00 AM | Welcome Remarks <ul style="list-style-type: none">▪ The Honorable Bobby L. Rush
Former U.S. Congressman (D-IL-01) |
| 9:00 – 9:45 AM | Agenda, Meeting Objectives, and Participant Introductions <ul style="list-style-type: none">▪ Moderator: Ilisa Halpern Paul, MPP
Senior Policy Advisor, Venable LLP▪ Dr. Keith C. Ferdinand, MD, FACC, FAHA, FASH, FNLA, FASPC
ABC Chair, Access to Care Initiative and Roundtable Co-Chair▪ Barbara Hutchinson, MD, PhD, FACC
ABC Board Chair and Roundtable Co-Chair |



9:45 – 10:45 AM

**Panel Presentation & Group Discussion:
*Existing and Emerging Challenges to Access***

- **Moderator: Ilisa Halpern Paul, MPP**
Senior Policy Advisor, Venable LLP

- **Bryan Jefferson**
Patient and President of Washington DC Chapter
Mended Hearts

- **Staci Lofton, JD, MPH**
Senior Director, Health Equity
Families USA

- **Amy Niles, MBA**
Chief Advocacy and Engagement Officer
Patient Access Network Foundation (PAN) Foundation

- **Cheryl Thompson, MSPH**
Team Lead/Senior Public Health Analyst
Office of Quality Improvement
Bureau of Primary Health Care (BPHC)
Health Resources and Services Administration (HRSA)

10:45 – 11:00 AM

Break

11:00 – 12:00 PM

**Panel Presentation & Group Discussion:
*Leveraging Technology to Expand Access:
Opportunities and Challenges***

- **Moderator: Ilisa Halpern Paul, MPP**
Senior Policy Advisor, Venable LLP

- **Jessica Boyd, MD, MPH**
President & CEO
Unity Health Care

- **Aubrey Grant, MD, FACC**
Founder and CEO, Equity Commons
Director, Sports Cardiology, Medstar Health

- **Nicol Turner Lee, PhD**
Senior Fellow, Governance Studies
Director, Center for Technology Innovation
The Brookings Institution



12:00 – 12:30 PM

Networking Lunch

12:30 – 1:30 PM

**Panel Presentation & Group Discussion:
*Innovation in Delivery Models & Payment to Improve Access
& Address Social Determinants of Health: Progress & Barriers***

- **Moderator: Ilisa Halpern Paul, MPP**
Senior Policy Advisor, Venable LLP
- **Natalie Ludaway, JD**
Chief Growth and Legal Officer
CINQCARE
- **Margot Savoy, MD, MPH, FAFAP**
Senior Vice President
Education, Inclusiveness and Physician Well-Being
American Academy of Family Physicians (AAFP)
- **Naomi Senkeeto, MPP**
Managing Director, Health Equity Policy
Blue Cross Blue Shield Association
- **Julia Skapik, MD, MPH**
Chief Medical Information Officer
National Association of Community Health Centers (NACHC)

1:30 – 2:30 PM

**Panel Presentation & Group Discussion:
*Federal Efforts to Expand and Improve Access to Care & Address Social
Determinants of Health***

- **Moderator: Ilisa Halpern Paul, MPP**
Senior Policy Advisor, Venable LLP
- **Ernia Hughes, MBA**
Director, Office of Health Center Investment Oversight (OHClO)
Bureau of Primary Health Care (BPHC)
Health Resources and Services Administration (HRSA)
- **Janet Wright, MD, FACC**
Director, Division for Heart Disease and Stroke Prevention (DHDSPP)
Centers for Disease Control and Prevention (CDC)



2:30 – 3:00 PM

Facilitated Participant Townhall Discussion to Identify Priority Recommended Action Items

- **Moderator: Ilisa Halpern Paul, MPP**
Senior Policy Advisor, Venable LLP

3:00 – 3:15 PM

Final Reflections and Next Steps

- **Moderator: Ilisa Halpern Paul, MPP**
Senior Policy Advisor, Venable LLP
- **Barbara Hutchinson, MD, PhD, FACC**
ABC Board Chair and Roundtable Co-Chair

3:15 PM

Adjourn



Roundtable Attendee List

Thought Leaders

Srinath Adusumalli, MD, MSHP, MBMI, FACC
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CVS Health Corporation

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Director, Sports Cardiology, MedStar Health

Allison Hill, PharmD
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Mended Hearts

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Board Member, Heart Valve Voice-US



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American Academy of Family Physicians (AAFP)

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