'ONE SIZE FITS ALL' MEDICINE **IS NOT** FIT FOR ALL

Though the gap in heart health disparities between whites and African Americans is narrowing, there is still much work to be done.

By Camille Torres

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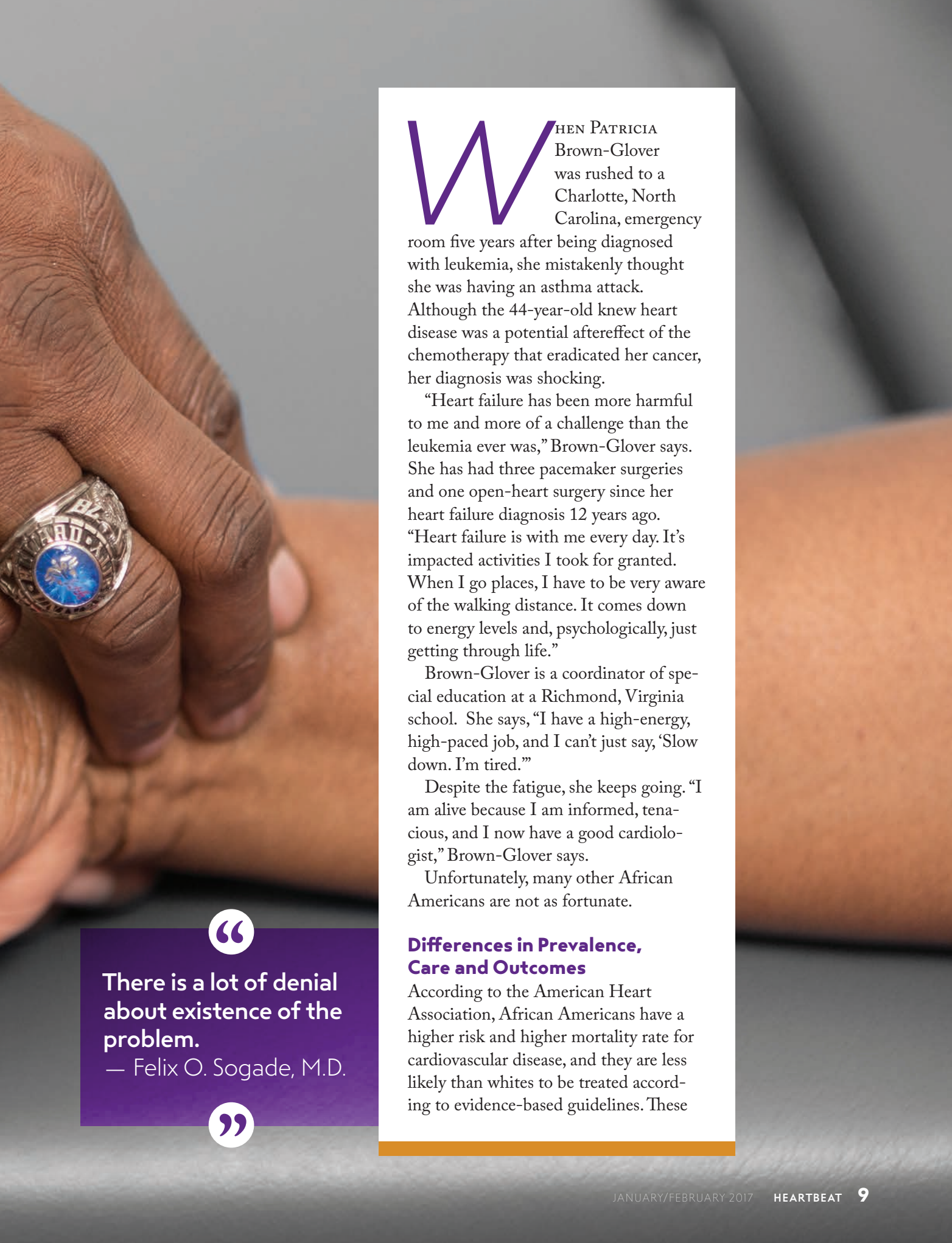
Photo: Kevin Manning



When Patricia Brown-Glover was rushed to a Charlotte, North Carolina, emergency room five years after being diagnosed with leukemia, she mistakenly thought she was having an asthma attack. Although the 44-year-old knew heart disease was a potential aftereffect of the chemotherapy that eradicated her cancer, her diagnosis was shocking.

"Heart failure has been more harmful to me and more of a challenge than the leukemia ever was," Brown-Glover says. She has had three pacemaker surgeries and one open-heart surgery since her heart failure diagnosis 12 years ago. "Heart failure is with me every day. It's impacted activities I took for granted. When I go places, I have to be very aware of the walking distance. It comes down to energy levels and, psychologically, just getting through life."

Brown-Glover is a coordinator of special education at a Richmond, Virginia school. She says, "I have a high-energy, high-paced job, and I can't just say, 'Slow down. I'm tired.'"

Despite the fatigue, she keeps going. "I am alive because I am informed, tenacious, and I now have a good cardiologist," Brown-Glover says.

Unfortunately, many other African Americans are not as fortunate.

Differences in Prevalence, Care and Outcomes

According to the American Heart Association, African Americans have a higher risk and higher mortality rate for cardiovascular disease, and they are less likely than whites to be treated according to evidence-based guidelines. These

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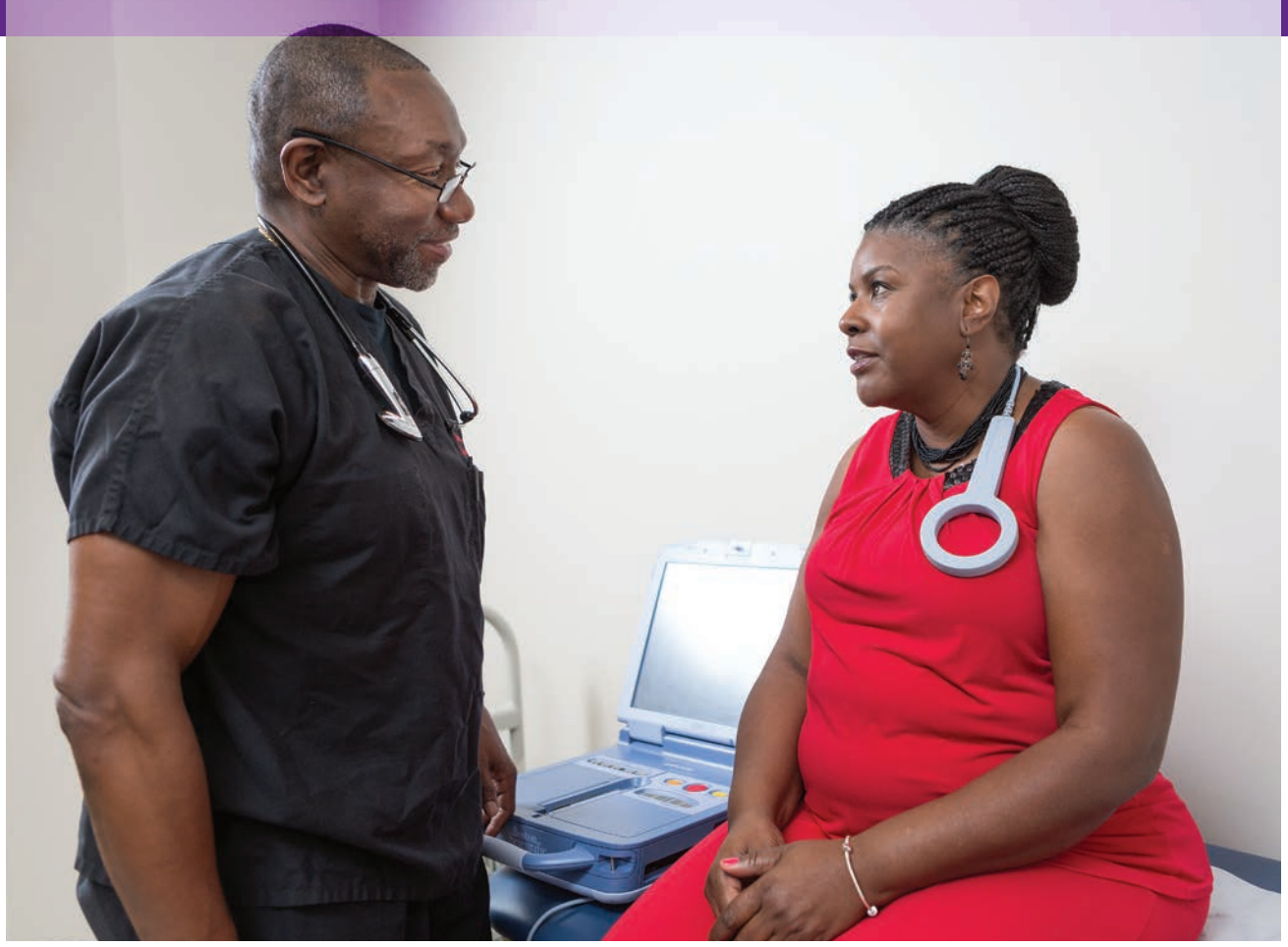
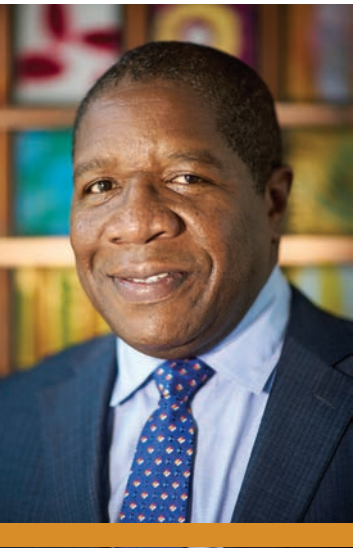


Unhappy with the care she initially received after her diagnoses, Brown-Glover finally found a cardiologist she trusts, Dr. Phillip B. Duncan of Virginia Heart Group. He was the fourth cardiologist that she saw, and stuck with him "because I trust him and I can talk with him in ease," she says.



Felix O. Sogade, M.D., FACC, FHRS, CEO of Georgia Arrhythmia Consultants & Research Institute and chairman of the board of the Association of Black Cardiologists

disparities exist even when the patients' income, insurance status and other factors are taken out of consideration.

African Americans also develop heart disease at an earlier age and with more advanced heart damage than whites. "Among patients admitted with heart failure in our community and under the age of 50, a significantly higher percentage of them are African Americans," says Felix O. Sogade, M.D., FACC, FHRS, CEO of Georgia Arrhythmia Consultants & Research Institute and chairman of the board of the Association of Black Cardiologists.

Nationwide, African Americans younger than 50 have a 20% higher prevalence of heart failure than whites of the same age, and black men are more than 30% more likely than white men to die from heart disease.

When researchers study disparities in health care, they often look at two main aspects: quality of care and access to the right medical services when needed. African Americans and other minority populations fare worse in both regards, according to *National Healthcare Quality and Disparities Report*, which has been published annually since 2003.

And although the 2015 edition shows that many improvements have been made to narrow the gap in both quality and access, there is plenty of work to be done. The report, which includes data on more than 250 aspects of health care, found that:

- In more than half of the health care access measures, blacks fare worse than whites.
- Blacks also receive poorer quality of care for approximately 40% of the quality measures.

In a different report, published in the

Bottom photo courtesy of Dr. Felix Sogade | Top photo: Kevin Manning

Journal of the American Medical Association for Surgery, researchers looked into racial disparities in mortality rates after coronary artery bypass graft (CABG) surgeries. They found that nonwhite patients had 33% higher mortality rates after CABG surgery than white patients.

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Drug Works More Effectively in Blacks

Perhaps most alarmingly, a drug that's clinically proven to reduce the mortality rate in African Americans with heart failure is grossly underused, despite being recommended by the American College of Cardiology and the American Heart Association. The fixed-dose regimen of hydralazine and isosorbide dinitrate (sold under the brand name BiDil) has been shown to reduce mortality for African American patients by 43%. A study in the *New England Journal of Medicine* showed the treatment improved patient quality of life and reduced first-time heart failure hospitalization by 39%.

Interestingly, the medication does not have the same effectiveness for whites and other ethnicities. Although it's unknown which genetic marker is responsible for the treatment's success in African Americans, race is a proxy to identify which patients are likely to benefit from the therapy.

"It's very complex, as the use of this agent represents a unique situation where a therapy is approved for a particular racial group. Physicians need to be educated more about the science behind the advantages of this therapy in African Americans," Dr. Sogade says.

Despite the clinical evidence and leading organizations' recommendations, less than one in four eligible heart failure patients receives the treatment or either of its two components. And less than 10% of eligible patients on Medicare Part D receive the treatment. As a result of the lack of treatment, more than 6,500 blacks die prematurely each year, according to a 2011 report in the *American Heart Journal*.

"It's a clear failure of our health care system. These patients are not being provided a life-saving therapy, and there's no excuse for it," says Gary Puckrein, Ph.D., president and CEO of the National Minority Quality Forum and executive director of the Alliance of Minority Medical Associations.

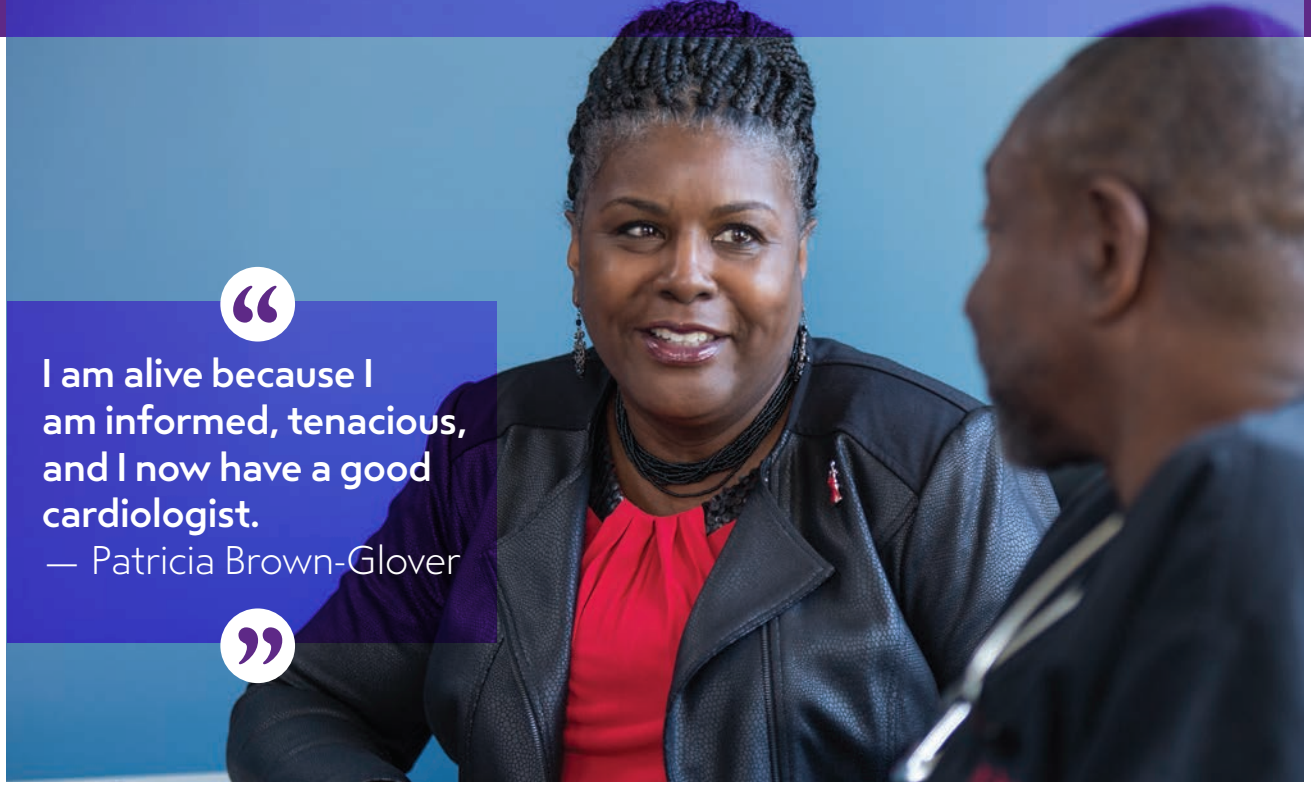
The Centers for Medicare and Medicaid Services (CMS) is partially to blame for the underuse of fixed-dose treatment, according to Dr. Puckrein. "The CMS has systematically undervalued the medication and made it difficult by propagating bad information to providers about the value of the medication," he says.

The CMS's emphasis on performance measures fails to recognize the need for African Americans to receive the fixed-dose treatment. Instead, it emphasizes a standard treatment for all patients. Because the fixed-dose treatment is effective only for a subsector of the population, it is not included in the CMS's recommendations.

"I think every American ought to be very concerned about this. When CMS starts

Gary Puckrein, Ph.D., president and CEO of the National Minority Quality Forum and executive director of the Alliance of Minority Medical Associations.

Photo courtesy of Dr. Puckrein



Addressing disparities in health care is a both a moral and economic issue. Racial health disparities cost the U.S. an estimated $35 billion in excess health care spending and $10 billion in illness-related lost productivity, according to the National Institutes of Health.

to intervene and push policies that are not aligned with what the clinical evidence says, every patient has to be concerned about that. In that regard, African Americans are like the canary in the coal mine," Dr. Puckrein adds. "[The CMS doesn't] recognize patient variability — the differences between men and women, the etiology of diseases between populations, that patients metabolize medicine differently. It's an utter disaster, and African Americans are losing their lives because of it, and other Americans are too."

Although the health system is partially responsible for the disparities in care and outcomes, other factors are also at play. Disparities also stem from the fact that minorities often have higher rates of risk factors that contribute to poor heart health. These include high cholesterol, smoking, high blood pressure, obesity and diabetes.

Role of Advocacy in Narrowing the Gap

Recognizing the disparities in care is not only a moral issue — one of fairness and equity — but an economic one as well. Racial health disparities cost the U.S. an estimated $35 billion in excess health care expenditures and $10 billion in illness-related lost productivity, according to the National Institutes of Health.

Despite these numbers, Dr. Sogade says, "There is a lot of denial about the existence of the problem." He adds that reducing and eventually eliminating disparities in cardiovascular care will take "dedicated commitment and immediate action from local, state, and national health agencies; professional medical associations, patient advocacy organizations; patients and caregivers and others within and beyond the health sector."

That's where groups like Mended Hearts come in. According to Dr. Sogade, organizations like Mended Hearts can begin by developing a long-term plan to support cardiovascular health equity. "This could include a commitment to partner and coalesce in the areas of education, research, advocacy and health policy with organizations like the Association of Black Cardiologists, The

Photo: Kevin Manning

American Heart Association and others to address health disparities," he says.

Advocacy is key. Often, the patient isn't aware he's receiving substandard care, making it imperative for patient groups to intercede. That's why the Patient Advocacy Network, Mended Hearts' advocacy program, has made it a priority to advocate on behalf of patients by raising awareness of the health disparities that exist in heart care.

Mended Hearts' plan is to focus on empowering African American patients to be their own advocates and provide them with the education and tools they need.

"Addressing policies that currently widen the gap in health care disparities will be an important part of this process as well," says Andrea Baer, Director of Patient Advocacy for Mended Hearts. These policies will include addressing issues with access to care, treatment and cardiac rehab. "African American and other minority voices need to be brought to the table as equal partners in the discussions, and Mended Hearts is dedicated to accomplishing this task."

For Brown-Glover, the steps toward a solution include personal involvement. "When I had open-heart surgery, that was very traumatic both physically and psychologically. I was just left alone medically," she recalls. "I later found out there was cardiac rehab I was never offered. I felt very isolated. That could have been a big help." To connect with other patients and to provide support she didn't receive, Brown-Glover joined her local chapter of Mended Hearts this year. She plans to undergo training to visit patients.

She emphasizes being deliberate about racial diversity, along with making sure all cardiovascular patients are visited at the hospital and followed up with afterwards. "When a person of color visits another with heart failure, they get a hope from someone from a similar background, especially in this chapter where the people are all white. There are a lot of African Americans and other racial minorities that don't see a lot of people who look like them, and that can make a big impact," Brown-Glover says. "If there's a patient who is waking up from heart surgery, they can see my face and say, 'I can get out of this bed and walk. My life is just starting, not ending.'"

She adds: "I've been given these charges in life to remain humble and to give help. Now things are becoming very clear to me on what my next path in life is. This has given me focus. We experience things in life, so it can give us perspective, so we can give service to mankind."

VARIABLE QUALITY OF CARE

Disparities in cardiac care aren't limited to African Americans. Many minorities face similar lapses in preventative care and treatment. To help drive down these inequalities, it's essential to provide culturally diverse and competent care to all different types of populations.

Hispanics experience many of the same disparities as blacks, though to a lesser degree. Like African Americans, Hispanics are more prone to develop heart disease than whites and are more likely to die from it. This is due in part to a higher percentage of Hispanics being overweight or obese.

There are also health disparities between women and men. **Following a heart attack, 42% of women die within one year, compared to 24% of men.** According to a 2009 study, women are more likely than men to experience delays in emergency department care for cardiac symptoms. Women are 52% more likely to be delayed 15 minutes or more reaching the hospital after calling 911. This delay in receiving treatment has been shown to increase damage to the heart.