ASCVD Episode #1 – Lipid Management: The Importance of Bridging the Gap
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Narrator: The 2018 American Heart Association/American College of Cardiology Guidelines on the Management of Blood Cholesterol set a new emphasis on patients at very high risk for future atherosclerotic cardiovascular disease, or ASCVD events, and appropriate guideline-directed therapies based on risk. We aim to have constructive conversations about caring for these patients throughout the continuum of care for longer, healthier lives. Through support of Amgen, the American Heart Association has created a three-part podcast series that discusses models for treating to guidelines and patient experiences as they are diagnosed with ASCVD.

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Narrator: This series elaborates on helping all members of the care team to properly manage and support their patients from all socioeconomic backgrounds diagnosed with ASCVD.

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Dr. Haft: Hi, everyone. My name is Dr. Howard Haft. I'm the senior medical advisor at the Maryland Department of Health, as well as the chair of the American Heart Association Outpatient Quality Advisory Committee. I'll be hosting a series of conversations with special guests focused on patients with diagnosed atherosclerotic cardiovascular disease, better known as ASCVD, and the barriers and challenges health care providers face with supporting their patients. Today's really important topic is Lipid Management: The Importance of Bridging the Gap. I'm happy today to be with Dr. Keith Ferdinand. Dr. Ferdinand is Professor of Medicine at Tulane University and also the Gerald S. Berenson Endowed Chair in Preventative Cardiology. Dr. Ferdinand is also a member of the Association of University Cardiologists, past chair of the National Forum of Heart Disease and Stroke Prevention and Prior Chief Science Officer and Chair of the Association of Black Cardiologists. He is presently on the boards of the Partnership to Advance Cardiovascular Health, National Lipid Association, and the American Society for Preventive Cardiology.

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Dr. Haft: Hi, Dr. Ferdinand, thank you for joining us today. I'm really eager to hear about your experience in providing not only excellent lipid management care, but equally important equitable care for your patients.

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Dr. Ferdinand: Thank you for allowing me to participate in this important conversation.

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Dr. Haft: Let's kick it off here with a scenario. The pandemic and many other notable events in the past two years put our longstanding issues with disparities in equitable access to care in a very bright spotlight. If you don't mind, let's start with this provocative question and a scenario. As you know, many Americans face food and housing insecurity and issues with many other social barriers that impact their overall health. If you had a recently diagnosed ASCVD patient come to you and is currently facing some of these challenges, how would you address that in regard to their care plan and their lipid management?

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Dr. Ferdinand: I think the best approach to any patient is team-based care. I'm a cardiologist and I have clinical practice, but it's not just me. I have an advanced practice nurse and registered nurses who work with me. We have diabetes educators and nutritionists and even social services. In fact, I can recall early in medicine where social services was a big part of medicine. Before a person would leave the clinic, they were having difficulty, you could refer them to social services. That's not done as much anymore, but I also integrate my care with other members of the team.

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Dr. Haft: So, the team-based care is really important issue because it can get down into the more direct issues and questions that patients face as they embark on a new therapy. And some of those issues are social-related issues. How does your team approach the kind of the social issues, whether it's transportation issues or housing issues or access to insurance or the financial ability to continue medications? Does a team get involved in all of those aspects, as well as the prescription of the appropriate medication?

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Dr. Ferdinand: Surely, I do. One of the first questions I will ask my patients when they come in for their clinical visit is, first of all, who brought you here today or how did you get here? And if the person was brought in by a significant other, it could be a son or daughter or it may be a church member. I will say if you want them to come into the room, that's fine. HIPAA doesn't say we can't discuss care with other parts of a person's social network. We just have to get approval from that patient. In fact, many times the older person who may not have the degree of health literacy or I.T. literacy necessary to understand some of the complex terms that I might be utilizing will have a daughter or son whose college educated could even be a nurse, an accountant, an attorney, you just don't know. And they will help partner in that person's care. As I mentioned in our opening remarks, we know it's more than just the physician. The advanced practice nurse and the pharmacist often also are very helpful in care. I would think most clinicians, if you have a busy practice, you should have some pharmacists whom you know on a first name basis and they'll be able to help you with barriers to access, especially to some newer therapeutics, which may not be covered by the person's insurance if it’s sub-optimal.

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Dr. Ferdinand: And in some cases, the person may have very limited insurance. Pharmacists know how to network and how to work around some of those barriers to getting medicines. You know, there are real disparities in our society based on race, ethnicity, socioeconomic status, geography, transportation. These things all come together in what's called the social determinants of health, where people work, live, play and pray. And it just doesn't make sense that in the magic 15 minutes of a routine doctor's visit that we can solve all of these.

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Dr. Ferdinand: So certainly, we should take the appropriate steps to address them.

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Dr. Haft: Yeah, I think that's ever so important to be able to identify how the social determinants of health impact patients and what their individual unmet social needs might be, as you pointed out. And it is very challenging because it's hard for a provider with the limited resources they have to fix all of society's ills. But there are some things that providers can do in terms of communications with patients. And I know you're very, very sensitive to this in terms of being able to identify implicit bias in some of the things that providers across the board have not been sensitive to in the past.

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Dr. Haft: How do you think we should address that going forward?

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Dr. Ferdinand: When you look at some of these disparities, they're found at multiple levels. The patient level—patient hesitancy, health literacy, which is not intelligence, it's just the ability to understand some of the complex concepts that we are forwarding. Health systems—payors, insurance, or lack thereof, and a lot of those things we can't correct, but one of the levels we can correct is the direct clinician-patient interaction, the doctor-patient interaction. Here, where we have the ability to help people help themselves, we have to recognize that all of us have bias. We bring into that exam room our past experiences. And it doesn't mean that you're mean or spiteful or hateful, but for instance, you may take it for granted that the person will not be able to understand the complexity of the disease, even while having a supportive person in the waiting room that you didn't inquire about who could help you navigate that. You may also take it for granted that if you electronically prescribe, that's going to lead to the patient getting access to medicine and to adherence.

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Dr. Ferdinand: And we now know that if patients don't believe that what's being prescribed is beneficial because many times it's not related to symptoms but related to risk, or as we've spoken of previously, if there are economic barriers, the medication will not be gotten. And if it's retrieved, there's some data with some chronic risk-reducing medicines, including antihypertensive, lipid lowering medicines, about half of people are no longer taking them or adherent at a year. So, we have to overcome our biases.

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Dr. Ferdinand: We have to believe that if there are apparent barriers to how the patient understands what we are trying to communicate, it's our job to do the right thing and make sure that they do understand. Sit down, eye level, culturally appropriate, literacy-appropriate level, use appropriate language, pictures, models, teach back, where you ask the patient, “Do you understand what I just said, and can you kind of explain it to me?” and give them a few minutes. Are there are any further questions? It's not a lot. It's not a long time that patients will require.

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Dr. Ferdinand: But what they will be able to now know is that this clinician, this physician, this nurse practitioner is interested in me as a person and is not just prescribing medication or suggesting interventions without paying attention to the person's individual needs and wants.

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Dr. Haft: Yeah, I think you're again exactly right. It goes to the factor of trust when you build that relationship by trying to meet people where they are, there's greater trust and more likelihood with greater trust that they'll adhere to the medications. If there's no trust, there's little belief that what you have conveyed to the patient is, in fact, valid. But even going beyond that and let's talk about one of the really, I think, important issue, and that's the differences that the different cultures or races have in terms of both their biology, which is probably small in terms of the differences, although it does exist, but also their outcomes in terms of cardiovascular disease and how that relates to therapies.

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Dr. Ferdinand: The disparities in outcomes based on race, ethnicity can be quite significant. Perhaps the population in the United States that has the highest risk are African-Americans. They have what I call the "white-black mortality gap." It was described very well by the Institute of Medicine in their landmark publication, *Unequal Treatment in 2002*. Black men have the shortest life expectancy. Black women have a short life expectancy such that their life expectancy is more similar to that of white men than white women.

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Dr. Ferdinand: And this white-black mortality gap has persisted, unfortunately, for decades. It narrowed a little bit around 2015, but it was widened again by the COVID-19 pandemic in which there was a disparate degree of severe disease, hospitalization and death in certain racial ethnic populations. I don't think this is driven by genes. There are some genetic factors: lipoprotein(a) is higher, for instance, in African Americans (the MESA study), and there's an apolipoprotein L1 that appears to place a person at more risk of kidney disease, which is fairly common in 3 to 5% of African Americans.

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Dr. Ferdinand: But those genetic nuances, those small changes in the genome, doesn't explain these huge mortality gaps. I think they're driven by a mixture of multiple factors, including patient-seeking behavior, access to care, suboptimal care, less application of evidence-based guidelines therapy and bias by us as clinicians and bias throughout the system. The social determinants of health: where people work, live, play and pray, in some estimation, may be as much as 80% of that burden, overwhelming what we can do as clinicians. So, what I do in my own practice is treat everyone as best I can, despite any nuances that I may see in their race, ethnicity, sex, gender, geography, or socioeconomic status, and overcome the bias that these differences that we see are somehow inherent. Because to a large extent they are not. They are driven by factors which often are not the fault of the patient himself or herself.

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Dr. Ferdinand: The fact, is that we, as clinicians, as I said, we can't change the health care system, but we can help address some of those factors.

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Dr. Haft: Thank you. I think that that was very well stated. And I think we often say that one's health outcomes and longevity are more dictated by their zip code than their genetic code. And I think what you just said really speaks to that, has everything to do with where people live, play, pray and work. And those things are factors of long-term policies and social norms that have developed over time, and it will take time to reverse and address many of those. But meanwhile, there are things that we can do in our everyday work, and I know you do many of those.

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Dr. Haft: Do they also translate to how you teach incoming students and fellows and residents?

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Dr. Ferdinand: Absolutely. I usually have a student or a resident who shadows me in clinic. And one of the first things that I will often help them understand is that as we move through the day's load of patients, it's not going to be a hypertensive or status post heart attack or heart failure. We're going to know the person's name. We're going to ask them how did they get here today, and if they have a significant other out there, we're going to see "Do you want them in the room?" And I often will often ask if it's an older person who maybe in their seventies or eighties and look quite debilitated: "What did you do previously?" I know one case I had where it was an elderly African American man who was in a wheelchair and for all purposes, he was a high risk ASCVD patient status post stroke, and I could have proceeded to look at some of the metrics the blood pressure, the lipids, temperature, oxygen saturation, medications, etc. But one of my first questions is, and I don't remember his last name. Well, let's say Mr. J. "What did you do previously?" He said he was in the military. "Oh." I say, "Great. My father was in the army. What branch were you in?" He was in the Air Force. I turned to the student and said, "This man is a hero." Most younger Americans are not aware that at one point the armed services were not integrated, and the Air Force was one of the ones that had the greatest barrier for African Americans to participate in. And I said, "The fact that this gentleman was able to serve in the Air Force and serve his country, he's a hero." And you can kind of see the guy straighten up in his chair and brighten up a little bit. Then we proceeded with the conventional doctor's visit.

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Dr. Ferdinand: So, what I was trying to pass on to the young doctors-to-be and those who already have their MD but are still in training is that we're not treating diseases. We're treating persons who happen to have conditions.

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Dr. Haft: Thank you so much for that. I think that Air Force analogy really rings true. We can think about both the unfortunate Tuskegee experiments that occurred and on the other hand, the brave heroes who were the Tuskegee Airmen. Both of those representing heroic people and disadvantages and cultural biases that have occurred through the years. So, is there a specific training program that you use for your students and residents in cultural humility or implicit bias? Or is it just the on-the-job training and the good examples that you provide for them on a day-to-day practice?

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Dr. Ferdinand: Tulane University is in New Orleans. It has a long history, one of the oldest medical institutions and participated in many of the unfortunate aspects of the segregated South. But we have taken the steps to have rigorous training much of it internet-based on bias, equity, inclusion and diversity. Most people were able to get through those seminars and take those tests. Sometimes I think internet learning is misleading because you can pay halfway attention and do the pre-test post-test and get credit for participating.

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Dr. Ferdinand: But what I try to do with my own personal life is with each patient interaction, whether the student or the residents in the room or not, is break through this concept that people are somehow inherently diseased, that African Americans are going to have worse hypertension and more heart failure,

more strokes, more heart attacks. We know that's what the data shows, but that it somehow is their fate, their lot, and that there's not much you can do about it. It leads to what we call “clinician inertia,” where the person comes in with an elevated blood pressure, an LDL that's suboptimal, an A1c that is well above seven, but we don't take the right steps to intervene. We may not even up-prescribe, we may not even add ezetimibe to a high intensity statin, or they may not even be on a high intensity statin. And if they're on a high intensity statin with ezetimibe we may not take the extra step to looking at more intensive therapy like the PCSK9 inhibitor. Or we won't even add more antihypertensive medication. What we know from the guidelines and from observational data is that most middle-aged and older persons need two or more medicines. But we'll tell a patient, "Your blood pressure's a little up, your cholesterol is not where I want it to be. You know, watch your diet. Make sure you're taking your medicine. I'm going to call in some refills. We'll see you in three months."

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Dr. Ferdinand: It's easy, it's quick. But it doesn't overcome those barriers. And it really doesn't give the type of rigorous risk reduction that's been shown in the randomized clinical outcomes trials to decrease heart attacks and strokes. So, I don't think it's a big mystery why we have the white-black mortality gap. Again, I don't think it's genetics that explains most of that.

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Dr. Ferdinand: It's how patients can get access, how patients have the application of evidence-based medicine, and how we as clinicians have our own bias. You talked about cultural humility. That's more than cultural competency. And it's not just knowing some of these facts, but being humbled that we are a part of a dysfunctional system and taking the steps as clinicians to modify our behavior to do a little bit more to achieve health equity.

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Dr. Haft: Again, so very well said. And I think that cultural humility and our fundamental importance as citizens to advocate for reductions in things that we know are wrong. Racism and the disparities that exist in our culture, I think, are part of our duty as health care providers, because we can't get better outcomes just by prescribing the newest medications. It needs to be a package of all of those things together. So, thank you so much. I'm just so glad we had the opportunity today to discuss this really important topic and health equity.

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Dr. Haft: And it's been a pleasure chatting with you and I really thank you for the great work that you've done for so many years as both a cardiologist and lipid specialist, but also in championing the cause of health equity. Thank you so much.

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Dr. Ferdinand: It's my pleasure.

00:18:28:04 - 00:18:58:07
Dr. Haft: And thank you all for joining us and remember to share this show with others. To learn more about the American Heart Association and its quality improvement efforts, you can visit www. Heart.org\changecholesterol. By visiting the website and joining Check Change Control Cholesterol Initiative, you'll gain access to informative resources and timely updates about cholesterol. Like our easy-

to-follow treatment algorithms. You can also receive special recognition for your efforts in supporting evidence-based care. Thank you. See you again next time.

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