Patient-Centered Care in Cardiovascular Disease
credo: Why, What and How

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American College of Cardiology

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Nothing to disclose
Acknowledgment

• First *credo* sponsor:
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<thead>
<tr>
<th>Advisory Group Members, continued</th>
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<tr>
<td>Gordon L. Fung, MD, MPH, PhD, FACC</td>
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<tr>
<td>UCSF</td>
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<tr>
<td>Governor, Northern CA, ACC</td>
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<tr>
<td>President, California Chapter, ACC</td>
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<tr>
<td>Center for Healthy Families and Cultural Diversity</td>
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<td>UMDNJ-Robert Wood Johnson Medical School</td>
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<td>Ileana L. Piña, MD, FACC, FAHA</td>
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<td>Case Western Reserve University</td>
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<tr>
<td>Louis Stokes VA Medical Center</td>
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<td>Sarah H. Scholle, DrPH, MPH</td>
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<tr>
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<td>Chapter President/ACC Governor-Arizona</td>
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credo: Why, What and How

- CVD disparities exist and lead to avoidable, premature morbidity and mortality
- Trends in general population and cardiology compound CVD disparities
- Evidence-based approach to reducing disparities available for further testing and implementation
Three key themes emerge in the 2009 NHDR:

- Disparities are common and uninsurance is an important contributor.
- Many disparities are not decreasing.
- Some disparities merit particular attention, especially care for cancer, heart failure, and pneumonia.

Table H.2. Core measures that are getting worse for more than one racial and ethnic group compared with reference group

<table>
<thead>
<tr>
<th>Topic</th>
<th>Measure</th>
<th>Blacks</th>
<th>Asians</th>
<th>AI/ANs</th>
<th>Hispanics</th>
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<tbody>
<tr>
<td>Heart disease</td>
<td>Hospital patients with heart failure who received recommended hospital care</td>
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</tbody>
</table>
Age-Adjusted High Blood Pressure in Adults ≥ 20 Years of Age

Hypertension Death Rates, 2006

- **Whites**: 6.5
- **Blacks**: 17.7
- **Hispanics**: 6.2
- **Asians**: 6.1
- **Native Americans**: 5.8

**Age-adjusted Death Rate (per 100K), Men and Women**

Age-Adjusted Death Rates for White and Black Females, 2006

STEMI Reperfusion by Race/Ethnicity

ACTION Registry®-GWTG™ 2008 data
From Now to 2050: A Much More Diverse Nation

2008

- Non-hispanic, Single-race White
- Black
- American Indian/Alaska Native
- 2+ Races

2050

- Hispanic
- Asian
- Native Hawaiian/Other Pacific Islander

Figure 3.
Percent Black or African American Alone or In Combination: 2000

For information on confidentiality protection, nonresponse error, and definitions, see www.census.gov/prod/2000/doc/p23-171.pdf

People indicating one or more races including Black or African American as a percent of total population by state

![Color legend](image)

People indicating one or more races including Black or African American as a percent of total population by county

![Color legend](image)

Supply and Demand for General Cardiologists

Distribution of Hispanic Cardiologists and Population

## Recommendations of Cardiovascular Workforce Report Relevant to Disparities

<table>
<thead>
<tr>
<th>Recommendation</th>
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<tbody>
<tr>
<td>Expand team-based care</td>
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<td>Identify and implement best practices for effective and efficient care to these underserved communities</td>
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<tr>
<td>Develop outreach programs to target underrepresented minorities in medical school and internal medicine programs and provide financial support</td>
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<tr>
<td>Resources for cultural proficiency education in medical school, residency, and continuing education should be increased</td>
</tr>
</tbody>
</table>

Do Clinically Similar Patients Receive Different Care Based on Race/Ethnicity?

Web-based survey of 344 cardiologists

While nearly half of U. S. physicians identify language or cultural communication barriers as obstacles to providing high-quality care, physician adoption of practices to overcome such barriers is modest and uneven.
Evidence-based Reduction in Health Disparities

Data show:

- Across health conditions QI and cultural competency training can increase quality, provider knowledge/attitudes, and patient satisfaction/health
- In CVD, physician education necessary but not sufficient; team care and patient education can be effective
- In acute hospital ACS care, QI can improve quality and reduce disparities

Information about a patient’s race or ethnicity:

- Should NOT be used to infer information about health-related values or beliefs;
- Should be used for detecting disparities, optimizing the effectiveness of quality-improvement, and reaching out to local community.
What Are the Keys to Reducing Disparities?

- Performance measure-based quality improvement
- Provider/patient education
- Team care
Proposed *credo* Pathway to CVD Outcome Equity

- Obtaining race/ethnicity data
- Stratified reporting of quality measures
- Targeting/testing interventions
IOM Recommended Standardized Collection of Race, Ethnicity, and Language Need

**Race and Ethnicity**

- **OMB Hispanic Ethnicity**
  - Hispanic or Latino
  - Not Hispanic or Latino

- **OMB Race** (Select one or more)
  - Black or African American
  - White
  - Asian
  - American Indian or Alaska Native
  - Native Hawaiian or Other Pacific Islander
  - Some other race

**Granular Ethnicity**

- Locally relevant choices from a national standard list of approximately 540 categories with CDC/HL7 codes
- “Other, please specify:___” response option
- Rollup to the OMB categories

**Language Need**

- **Spoken English Language Proficiency**
  - Very well
  - Well
  - Not well
  - Not at all

(Limited English proficiency is defined as “less than very well”)

- **Spoken Language Preferred for Health Care**
  - Locally relevant choices from a national standard list of approximately 600 categories with coding to be determined
  - “Other, please specify:___” response option
  - Inclusion of sign language in spoken language need list and Braille when written language is elicited

Institute of Medicine, *Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement*, 2009.
<table>
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<tr>
<th>Drug Type</th>
<th>Last Qtr</th>
<th>Last 12 mo</th>
<th>Hospitals</th>
<th>Nation</th>
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<tr>
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Acute STEMI-NSTEMI Care by Gender

- Clopidogrel: 80% Male, 76% Female
- GP lib-IIIa Inhibitor: 45% Male, 23% Female
- Reperfusion: 94% Male, 80% Female
- Time to PCI < 90 min: 77% Male, 45% Female
credo Initiatives: Next Steps

- Training for NCDR® sites on collecting race, ethnicity, and language data
- *Keeping PACE*: ACS PI-CME Initiative
- Dissemination of educational tools and resources to ACC members
- Development of *credo* website
- Development of patient education tools/advisory group
- Hypertension PI-CME and research initiative
Program Support

• Major independent educational grant support for *Keeping PACE* provided by Bristol-Myers Squibb/sanofi Pharmaceuticals Partnership

• Additional independent educational grant support provided by Daiichi Sankyo, Inc. and Lilly USA, LLC, Pfizer, and Schering Corporation
Stage A: Review performance data stratified by race/ethnicity from associated hospital participating in ACTION-GWTG Registry

Stage B: Implement Educational Plan – Live local meeting reviewing performance measures and tools for improving clinical care and redressing disparities

Stage C: Re-examine performance data from associated hospital
We must not see any person as an abstraction. Instead we must see in every person a universe with its own secrets, with its own treasures, with its own sources of anguish, and with some measure of triumph.

Elie Wiesel from *The Nazi Doctors and the Nuremberg Code*
Questions
For more information about *credo*,
Contact me:

lhall@acc.org

Thanks!!