MedicalXpress

# African-Americans hospitalized for heart failure less likely to see cardiologist

April 30 2018

African-American patients were less likely than Caucasian patients to be treated primarily by a cardiologist when admitted to the intensive care unit for heart failure, according to a study published today in *JACC: Heart Failure*. Previous studies have shown that in-hospital survival is higher when patients of any race receive primary care from a cardiologist, compared to other specialties.

Heart failure is a condition in which the heart does not pump enough blood to meet the body's needs. By 2030, it is expected that 8 million people will be diagnosed with heart failure in the U.S. According to the researchers, a collaboration between hospitalists, intensivists and cardiologists will be necessary to effectively treat these patients, particularly ones requiring higher level care.

Previous studies have shown care by a cardiologist leads to improved outcomes after a heart failure hospitalization, including increased receipt of evidence-based treatments, reduced readmissions and increased survival. Despite having the highest risk of heart failure compared to other races and ethnicities—and the highest overall mortality—African-Americans are less likely to be treated with advanced therapies or receive medical device therapies for heart failure, according to the new study.

"Both patients and physicians should know that racial disparities exist in health care. Patients must be their own advocates and not fear getting a second opinion, especially when they believe they are not being heard,"

said Khadijah Breathett, MD, MS, assistant professor of medicine in the division of cardiology at the University of Arizona College of Medicine - Tucson, and the study's lead author. "Physicians should adhere to guideline recommendations, advocate for underserved populations and be aware of implicit biases that may adversely affect clinical management. Bias in clinical decision-making has contributed to disparate treatment in racial and ethnic minorities. We must consider that it may be present."

Using data from the Premier Healthcare Database, a national observational database, researchers analyzed 104,835 patients at 497 U.S. hospitals admitted to an ICU with heart failure from 2010 to 2014. Researchers determined race through hospital administrative data; primary care by a cardiologist was determined by billing as cardiovascular disease or cardiac electrophysiology.

Of the 104,835 patients, 19.7 percent were African-American and 80.3 percent were Caucasian. Approximately half were male and Caucasian patients were 11 years older than African-American patients on average. The majority of patients had some form of health care insurance. Researchers found racial differences in the comorbidities of the two populations. African-Americans were more likely to have diabetes, chronic kidney disease, end stage renal disease or obesity while Caucasian patients had more atrial arrhythmias, chronic obstructive pulmonary disease and depression.

After adjustments, researchers found Caucasians were more likely to be admitted and receive primary care by a cardiologist compared to African-American patients. The relationship also differed by sex—Caucasian women were 30 percent more likely to be admitted by a cardiologist when compared to African-American women. The disparity was greatest for African-American men, as Caucasian men were found to be 50 percent more likely to receive care by a cardiologist than African-

American men.

Researchers found primary ICU care by a cardiologist led to higher in-hospital survival regardless of race, however, overall, Caucasians were 40 percent more likely to receive care by a cardiologist compared to African-Americans.

"Racial and ethnic disparities in health care delivery remains a persistent systematic problem, and drastic steps are needed to reduce the racial/ethnic and gender health disparities that persist in contemporary care," Breathett said. "We could consider rewarding centers that reduce disparities in their respective centers, use innovative techniques to reduce disparities and provide high quality care. We could also consider penalizing centers that provide poor quality care. It is time to change the operations of the U.S. health care system."

"This important paper by Breathett and colleagues highlights the need for more research on why we continue to observe racial differences with the receipt of optimal care in the U.S. health care system," said Christopher O'Connor, MD, MACC, editor-in-chief of *JACC: Heart Failure* and Chief Executive Officer of Inova Heart and Vascular Institute.

In an accompanying editorial, Ileana L. Piña, MD, MPH, Professor of Medicine, Epidemiology/Population Health at Albert Einstein College of Medicine, said it is important to raise awareness for patients and providers of the racial/ethnic disparities in care, expand health insurance coverage and increase the number of providers in underserved communities.

Piña said, "Given a significant percent of African-American patients either with private insurance or Medicare, can we continue to blame the disparity in care to lack of access or insurability? Is it not time to

consider preconceived notions of access and inherent, although unrecognized racial bias and stereotyping that lead to racial health disparities?"

Study limitations include the lack of physician details, including source of admission, type of physician caring for the patient prior to the ICU and informal consultations with cardiology. As an observational study, the researchers noted there are possible unmeasured confounders.

**More information:** *JACC: Heart Failure*, DOI: 10.1016/j.jchf.2018.02.015

Provided by American College of Cardiology