

Same Story, Different Disease

It Is Time to Change the Storyline for Racial Minorities and Patients of Lower Socioeconomic Status

See Article by Wayda et al

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Heat failure disproportionately affects African-Americans and individuals of lower socioeconomic status (SES).^{1,2} African-Americans have 2× to 3× higher prevalence of heart failure than Caucasians before the age of 75.¹ African-Americans have more hospitalizations for heart failure¹ and receive fewer advanced therapies for heart failure than expected.³ Similarly, individuals of lower SES have a 30% to 50% higher risk of developing heart failure² and lower likelihood of receiving heart transplant compared with individuals of higher SES.⁴ Furthermore, as illustrated in this issue of *Circulation: Heart Failure* in the article by Wayda et al,⁵ African-Americans and individuals of lower SES have worse outcomes post heart transplant.

Using the United Network for Organ Sharing database, Wayda et al⁵ studied the impact of race and SES on risk of composite death or retransplant after initial heart transplant. SES was measured by patient insurance, education, and neighborhood-level SES index. Results were adjusted for donor and graft characteristics. They found that African-Americans and individuals of lower SES have higher risk of composite death or retransplant after initial heart transplant compared with Caucasians and individuals of higher SES.

WHY IS THIS HAPPENING, AGAIN?

The interaction of race with SES contributes to adverse social determinants of health.⁶ SES is defined by an individual's income/wealth, health, education, occupation, political voice, social connections, environment, and physical insecurity.⁶ Although there are more Caucasians of lower SES than racial or ethnic minorities in the United States, a larger proportion of racial and ethnic minorities are of lower SES.⁷ The racial divide in SES is enlarging⁸ and factoring into racial disparities in health, including disparities in advanced heart failure.

Many factors that contribute to worse heart transplant outcomes in African-Americans and individuals of lower SES are entangled in social determinants of health. Medical nonadherence is perceived as present when an individual's medication regimen is unknown, not properly refilled, dosage is not taken as prescribed, therapeutic dose is not achieved, or appointments are missed. However, assessments of medical nonadherence are not standardized.⁹ Often medical nonadherence is secondary to low health literacy, underinsurance, or distrust of the health-care system.⁶ Patient-centered work reveals that appointments have been missed secondary to inability to obtain affordable transportation to appointments.¹⁰ Presumed nonadherence in African-American heart transplant recipients may also be secondary to genetic polymorphisms that lead to higher metabolism of

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immunosuppressive medications, which require higher dosage to attain therapeutic levels.¹¹

A stable social support network is important to achieve optimal heart transplant outcomes.⁹ Racial/ethnic minorities and individuals of lower SES often have social networks that are not equipped to take extended time from careers to provide caregiving.⁶ Their networks may have reduced health literacy and less wealth.⁶ Such social networks disadvantage recipients of advanced heart failure therapies who often require considerable assistance, particularly postoperatively.

It is important to acknowledge that unequal treatment may contribute to poor heart transplant outcomes of racial, ethnic minority, and lower SES patients. Healthcare providers treat patients differently based on race, ethnicity, and SES.^{12,13} Unconscious bias has a role in clinical decision-making and has contributed to racial minorities and patients of lower SES not receiving the standard of care.^{12,13} African-Americans and individuals of lower SES have higher mismatch by human leukocyte antigen and race.⁵ Multiple factors must be considered when selecting a donor organ, but an untoward effect of bias may include selecting less ideal donors or managing rejection and infection less aggressively in vulnerable populations.

HOW DO WE CHANGE THE STORYLINE?

The article by Wayda et al¹⁵ increases awareness of existing racial and socioeconomic disparities in advanced heart failure. Healthcare providers and patients must unite to systematically address social determinants of health present in advanced heart failure. This will require action through multiple spheres of influence. At the innermost layer, patient-centered care has to be first. Care should be provided at the individual level and not generalized by racial or socioeconomic stereotypes. This may take the form of identifying barriers to optimal disease outcomes in each patient, and when appropriate engaging more intense resource utilization such as increased clinic visits, home nursing care visits, and travel vouchers for appointments. Challenges related to sociodemographic factors may also be relieved with focused visits with health educators, social work, and financial advisors. Equitable postheart transplant survival has been observed with this approach in diverse racial and socioeconomic populations.¹⁴ In addition, as healthcare providers, we must be aware of our implicit biases that may unconsciously impact decision-making for vulnerable populations. Promotion of views that treat all patients as equal, encourage consideration of the patient's perspective, and support adherence to guidelines may assist in building trust in the patient-physician relationship.¹³ Overall, these patient-centered approaches may improve medical adherence and social support networks.

The next layer of influence includes our hospital systems. Healthcare providers are responsible for putting patient care first, followed by promoting research and education. Healthcare providers are also charged with providing fiscally sound health care. Healthcare providers must strategize with healthcare system administrators to allocate resources (appointment duration and location, allied health support) and seek quality improvement for all patients, including the most vulnerable.

The final sphere of influence includes society's role in reducing health disparities by race, ethnicity, and SES. Changing society will require collaborations with patients and like-minded stakeholders in other occupations.^{13,15} This includes being vocal about healthcare policies that increase access to heart failure therapies³ and other government policies that disproportionately affect racial and ethnic minorities and patients with lower SES such as district zoning, housing, education, and penal system policy.¹⁵ Addressing structural inequalities in society may be one of the most difficult steps in changing the storyline, but our engaged population of patients, healthcare providers, and societal stakeholders have the power to change healthcare in the United States one page at a time.

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FOOTNOTES

Circ Heart Fail is available at <http://circheartfailure.ahajournals.org>.

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