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Health Equity Coverage Recommendation Form

Title:	**Health Equity in Heart Disease**
Date of Last Review:	6/1/24

Research Section

Background

The U.S. Centers for Disease Control and Prevention (CDC) explains that the term "heart disease" is not a diagnosis itself but instead refers to several types of heart conditions. The most common type of heart disease in the United States is coronary artery disease (CAD). CAD affects the blood flow to the heart. Decreased blood flow can cause a heart attack. Sometimes heart disease may be "silent" and not diagnosed until a person experiences signs or symptoms of a heart attack, heart failure, or an arrhythmia. High blood pressure, high cholesterol, and smoking are key risk factors for heart disease. About half of people in the United States (47%) have at least one of these three risk factors and about 1 in 5 people in the United States died from heart disease in 2022.[1]

Inequities discussed on the Office of Minority Health Website[2]

Heart Disease and Black/African Americans:[3]

- In 2019, African Americans were 30 percent more likely to die from heart disease than non-Hispanic white individuals.
- Although African American adults are 30 percent more likely to have high blood pressure, they are less likely than non-Hispanic white adults to have their blood pressure under control.
- African American women are nearly 50 percent more likely to have high blood pressure, as compared to non-Hispanic white women.

Heart Disease in American Indians/Alaska Natives:[4]

- In 2018, American Indians/Alaska Natives were 50 percent more likely to be diagnosed with coronary heart disease than their white counterparts.
- American Indian/Alaska Natives were 50 percent more likely to be current cigarette smokers, as compared to non-Hispanic white individuals, in 2018.

- American Indian/Alaska Native adults were 10 percent more likely than non-Hispanic white adults to have high blood pressure, in 2018.
- American Indians/Alaska Native adults are more likely to be obese, have high blood pressure, and be current cigarette smokers compared to non-Hispanic white adults - all risk factors for heart disease.

Review of current, peer-reviewed evidence from established sources

- Black/African Americans: Several studies have been published that encourage tailored, multidisciplinary approaches as well as increased community outreach to improve heart disease management and prevention. This includes prevention/management of comorbidities and risk factors such as blood pressure control, healthy diet and lifestyle factors, diabetes mellitus, etc.[5,6,7,8,9,10,11]

- American Indians/Alaskan Natives: Minimal data is available on the health disparities among American Indians/Alaska Natives and heart disease. However, there is an increased incidence of risk factors of heart disease also present among this vulnerable population (smoking, elevated blood pressure, poor diet, and inadequate physical activity) as well as a lack of access to care has been indicated as a barrier to preventing and management of heart disease. Researchers urge for additional studies and data on these populations to review for additional correlations (particularly regarding correlations in different lifestyles for Alaska Natives, where many continue to follow a subsistent and traditional lifestyle).[12,13,14]

Review of clinical practices guidelines from professional associations and societies in regard to these findings

***2019 ACC/AHA Guideline on the Primary Prevention of Cardiovascular Disease: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines*:**[15]

- To facilitate decisions about preventive interventions, it is recommended to screen for traditional ASCVD risk factors and apply the race- and sex-specific PCE (ASCVD Risk Estimator) to estimate 10-year ASCVD risk for asymptomatic adults 40 to 75 years of age[16]
- In the United States, hypertension accounts for more ASCVD deaths than any other modifiable ASCVD risk factor. The prevalence of hypertension (defined as systolic blood pressure [SBP] ≥130 mm Hg or diastolic blood pressure [DBP] ≥80 mm Hg) among US adults is 46%. Hypertension is higher in Black Americans than in white, Asian, and Hispanic Americans and increases dramatically with increasing age.

Do any of these findings relate to any of our current policies?

None of the above findings are applicable to any of our current medical policies at this time.

Summary

Medical Policy

Review of inequities among African Americans and American Indian/Alaska Native groups in heart disease prevention and treatment. Heart disease disproportionally affects these minority groups, mostly because these groups have an increased rate of risk factors- such as smoking and high blood pressure (which is also less likely to be controlled). Medication adherence and disparities in healthcare access have been indicated as some of the barriers that continue to affect these groups. Studies have indicated the importance of additional outreach into communities (especially increasing the usage of community partners) that focus on patient education to help reduce risk factors and prevalence of heart disease in ethnically vulnerable populations.

Pharmacy Policy

One area identified as a potential opportunity for improvement is access to medications that have established evidence of benefit in certain ethnic minorities. Currently, PHP offers preventive lists that are provided for PHP fully insured groups and offered as options for ASO and custom Large groups to opt in to. These lists include many preventive therapies offered either at no-cost to the patient or else they pay only their coinsurance/copay regardless of if they have met their deductible. Many commonly used medications for heart disease are on these lists, including ACE inhibitors, ARBS, statins, mineralocorticoid receptor antagonists, beta blockers, and diuretics. According to the 2022 AHA/ACC/HFSA Guideline for the Management of Heart Failure, the combination of hydralazine and isosorbide dinitrate is recommended for patients self-identified as African American with NYHA class III-IV HFrEF who remain symptomatic despite optimized medical therapy. While both drugs are generic and offered on low-cost generic tiers for Commercial and Medicare lines of business (they are covered in full for Medicaid), it was identified that they are not currently offered on the PHP preventive lists. A recommendation was made to our formulary team to consider adding these to the Core Preventive list to allow access to these medications at a lower cost which will improve access and medication adherence.

Recommendation:	The recommendation was made that the combination of hydralazine and isosorbide dinitrate be added to the PHP preventative list. UPDATE: Hydralazine and isosorbide dinitrate (all strengths EXCEPT the 40 mg strength) were added to the Core Preventive list effective 1/1/2025.

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CORE Revision History Section

DATE	SUMMARY OF CHANGES
06/10/2024	Initial review.