

015. Differences in the Management of Acute Coronary Syndromes by Race and Proximity to Care in an Integrated Healthcare Delivery System in Northern Nevada

Friday, October 26, 2018, 10:00 – 11:00 AM, 2:20 - 3:20 PM

Rowan C¹, Metcalf J², Grzymiski J², Mues KE³, Yedigiarova L³, Woo C³, Williams KA⁴

1. Renown Institute for Heart & Vascular Health, Reno, NV; 2. Desert Research Institute, Las Vegas, NV; 3. Amgen Inc, Thousand Oaks, CA; 4. Rush University, Chicago, IL.

Purpose

Differences in cardiovascular treatment patterns among underserved minority populations have been observed, however, the patterns of care following an episode of acute coronary syndrome (ACS) based on race and an urban/rural residence have not been well described. Among a cohort of individuals with an episode of ACS who sought care within the Renown Health integrated healthcare delivery system in northern Nevada, we sought to describe patterns of follow-up care for Caucasians, nonCaucasians, urban patients who reside less than 100 miles from the primary regional medical center, and rural patients who reside greater than 100 miles from the primary regional medical center.

Methods

Data from an 11-year Epic EMR record were utilized to identify 4,076 patients with an ACS event between 2007 and 2017 based on an inpatient ICD-9 or ICD-10 code. Patients were required to have at least one provider encounter in the year prior to and the year following the ACS index event. Baseline and follow up labs, medication prescriptions and clinic encounters were quantified.

Results

Among 3,527 (86.5%) Caucasians and 549 (13.5%) non-Caucasians, the mean age was 69 and 64 years, respectively. Comparing Caucasians to non-Caucasians, diabetes (29% vs. 41%) and chronic kidney disease (CKD) (33% vs. 37%) were less frequent among Caucasian patients prior to the ACS index event. The mean baseline LDL-C was 85 mg/dL and 88 mg/dL among Caucasians and non-Caucasians, respectively. Within the 1-year following discharge for the ACS event, 24% of Caucasians and 21% of non-Caucasians had a prescription for a high-intensity statin, with a mean reduction in LDL-C from baseline of 11 mg/dL and 13 mg/dL, respectively. In the 12 months post-index, the mean number of follow-up encounters with a cardiologist was 7 among Caucasians and 5 among non-Caucasians, and the mean number of in-person visits (any provider/visit type) was 19 and 16 among Caucasians and non-Caucasians respectively.

Among 3,367 (82.6%) urban and 709 (17.4%) rural patients, the mean age as of ACS was 68 and 65 respectively. The mean distance from a subject's home was 12 miles among urban patients and 142 miles among rural patients. The mean baseline LDL-C was 87 mg/dL among urban patients and 91 mg/dL among rural patients. Rates of high-intensity statin prescriptions in the 1-year following the ACS event were 28% among urban patients and 25% among rural patients, with a mean reduction in LDL-C from baseline to follow-up of 14 mg/dL and 16 mg/dL respectively. In the 12 months post-index, the mean number of follow up encounters with a cardiologist was 7 among urban patients and 5

among rural patients, and the mean number of in-person visits (any provider/visit type) was 19 and 15 among urban and rural patients, respectively.

Conclusions

Within a large integrated health delivery network in northern Nevada, prescription of high-intensity statin treatment following a hospitalization for ACS is sub-optimal and does not vary by race or by urban/rural residence. This, in combination with the moderate baseline LDL-C levels prior to the ACS suggest that significant residual risk and gaps in care exist among this population of patients.