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Invited Commentary | Equity, Diversity, and Inclusion

Zooming in to Advance Health Equity for Heart Failure—Disaggregating Race, Ethnicity, and Social Data

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One of us (A.P.) was born in the US with a Cuban-born father and a Mexican American mother and was acutely aware of the different social and economic success achieved by Latinx subpopulations. The Cuban migration in the 1950s and 1960s was predominantly a middle-class exodus and is likely why economic and health trajectories of older Cubans in the US have been more favorable than the courses of Latinx ethnic subpopulations with poorer and less educated immigrants. Caring for patients with heart failure on Chicago's south side, we also recognize the increased challenges of Black patients from the Englewood neighborhood (median income 2018-2022, $27 317) compared with Black patients from Chatham (median income 2018-2022, $39 952).[1] Historically, our systems for analyzing ethnic and racial categories in the US have not recognized the heterogeneity of Latinx and Black populations. Similarly, the article by Cheng et al[2] demonstrates how an aggregate Asian ethnicity category makes important inequities in heart failure across ethnicities invisible. Specifically, Cheng et al found that Southeast Asian individuals have higher incidence and prevalence of heart failure compared with East Asian individuals.[2]

Heart failure is a model chronic condition for improving health inequities with state of the art, multidisciplinary team–based care. As clinicians, we need to tailor our care to the medical and social needs of individual patients. Overall, cardiologists do a good job determining how patients' guideline-based care should be based upon their heart failure class and medical features. However, the health care system does a worse job addressing the social needs of patients and implementing care plans that successfully provide evidence-based care. How can we, as individuals and health care systems, address the social barriers to care experienced in the clinic such as miscommunication, mistrust, health literacy, and limited English proficiency? Also, how can we address the barriers patients face obtaining medications, following exercise guidelines, and improving dietary habits?

The ethnicity category Southeast Asian encompass diverse ethnicities including Vietnamese, Cambodian, and Laotian. We describe Vietnamese history to illustrate why it is important to understand specific histories and lived experiences to tailor care, health systems, and policies to improve health equity.[3] Among Asian American individuals in the California Health Interview Survey,[4] Vietnamese individuals have worse health outcomes compared with Asian individuals overall for measures such as reporting fair or poor health (36.4% vs 17.8%), disability rates (30.1% vs 21.0%), and rates of heart disease (4.8% vs 4.4%). Vietnamese individuals reported higher rates of lacking a usual source of care than Asian individuals overall (18.4% vs 17.4%).[4]

To tackle these health inequities, we must understand the context of the Vietnam War, waves of immigration, and resettlement policy.[5] The first wave of immigration occurred in 1975 before the fall of Saigon, favoring advantaged and privileged groups with ties to the US government. The second wave of immigration beginning in 1978 consisted of political refugees (ie, boat people) who frequently experienced extreme hardships and trauma at sea and in refugee camps before resettlement to the US. The third wave was family reunification efforts in the 1980s and 1990s. The Vietnam War forced people to migrate with little preparation and give up most of their possessions. Resettlement efforts were usually underresourced. Many Vietnamese immigrants obtained low-paying jobs below their training. Thus, compared with Asian individuals overall, Vietnamese individuals have high rates (21.3%) of being at or below 0% to 99% of the federal poverty level and fewer financial assets, both of which are associated with health inequities.[5] In addition, racial

discrimination and limited English proficiency are associated with increased odds of poor self-reported health for Vietnamese people.[6] Thus, programs to care for and prevent heart failure must account for diversity of Vietnamese experiences; interventions to improve health equity should address trauma, discrimination, limited English proficiency, and insufficient economic resources.

To identify risk factors and create solutions for health inequities among Latinx populations, it is also critical to disaggregate ethnicity and social data to understand lived experiences, such as immigration history. Following the Cuban revolution of 1959, approximately 250 000 mostly highly educated, middle class Cuban individuals emigrated to the US in the Golden Exile.[7] However, 650 000 less advantaged Cuban Americans emigrated between 1995 and 2015 following the fall of the Soviet Union.[7] These later emigrants were primarily unskilled, semiskilled, and service workers, similar to generations of Mexican immigrants to the US.

Clinicians caring for Cuban American patients must account for their economic and cultural diversity. According to the Pew Research Center,[8] English literacy is lower among Cuban Americans (61%) than Mexican Americans (72%). Research has also demonstrated that health care mistrust is higher in patients with limited English proficiency. While clinicians might assume higher health literacy in a population with higher levels of formal education, a substantial proportion of Cuban Americans speak predominantly Spanish and would greatly benefit from language-concordant care. In addition, scales used to quantify and understand acculturation have mainly been validated in the Mexican American population and cannot be readily applied to other Spanish-speaking peoples. As new Cuban American concentrations arise in places like Nebraska, clinicians must understand their complex historical narratives.

It is critical to collect detailed social demographic data to identify inequities without otherizing patients into stereotypical aggregate wholes that do not make sense for heterogeneous populations. Thus, we applaud the Office of Management and Budget March 2024 revised standards for federal race and ethnicity data that "require the collection of detailed race and ethnicity categories as a default" and that create a new Middle Eastern or North African category separate from the White category.[9] However, efforts to collect, analyze, and act upon granular race and ethnicity and social data must be supported. For example, the Centers for Medicare & Medicaid Services is financially rewarding the collection of health-related social needs data.[10] More support and stronger incentives are needed from both public and private payers to advance health equity.

Health care delivery organizations, health plans, and policymakers need to use disaggregated race and ethnicity and social data to improve care. Heart failure care demands more than pulmonary artery catheter monitoring, inpatient titration of guideline-directed medical therapy, and organ transplantation when patients are at the end of the road. It should entail targeted preventive and maintenance measures, adjusted clinic hours for patients to come after work, and best practice alerts that monitor prescription refills for patients at risk for heart failure readmissions . Geospatial analysis of race and ethnicity data should identify access deserts and help prioritize outreach activities to patients and community members. It should help identify where to place new health care facilities and pharmacies. It should also identify what neighborhoods community-based organizations should partner with to improve access to food markets and safe green spaces. Just as importantly, detailed demographic data can assist clinicians in providing culturally sensitive and language-concordant care.

We can meet patients where they are when we understand the complete picture of their lives. Disaggregating race and ethnicity and social data may seem removed from patient care, but it represents a fundamental effort to see the humanity in each patient. Disaggregating data allows health care professionals to wield our full skill as clinicians caring for patients. It allows us to be institutional change agents improving systems of care and advocate for policies that meet each person's medical and social needs. We deepen our relationships with patients when we zoom in on the individual and work collectively toward advancing health equity.

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