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## Leaving the Social Vacuum: Expanding Cardiovascular Guidelines to Embrace Equity

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The limits of my language are the limits of my world.

—Ludwig Wittgenstein,<sup>1</sup> *Tractatus Logico-Philosophicus*

The 2022 American Heart Association/American College of Cardiology/Heart Failure Society of America Guideline for the Management of Heart Failure<sup>2</sup> marks the first occurrence to our knowledge that social determinants have been explicitly prioritized in guideline-based care. Heretofore, guidelines generally ignored the complex array of social factors that obstruct their equitable implementation and have been constructed, in short, in a social vacuum. In contrast, the heart failure (HF) guidelines acknowledge the contributions of social factors on disease management. Although the HF guidelines assert a broader, contemporary perspective, we have concerns about how they address social disadvantage, direct care in vulnerable patient populations, and approach health literacy. Our consideration is that the HF guidelines are a first step toward integrating social determinants of health into professional society guidelines. However, as outlined here and summarized in the accompanying Table, our expectation is that they can do more to depart from their social vacuum and embrace health equity.

A clear treatment principle of the HF guidelines is polypharmacy, the prescribing of multiple medications given the demonstrated benefit of combination therapies for outcomes in HF. Our argument is not with the evidence of the approach, but with the presumption that it is realistic and achievable. Long-term health care and copays compete with mundane financial burdens, such as housing, food security, child care, and transportation. Financial insolvency and poverty are common in our society and have been exacerbated by the COVID-19 pandemic. We recently participated as coauthors in work that demonstrated the effect of household income and copayments on access and adherence to the HF medication sacubitril/valsartan.<sup>3</sup> The primary solution to financial barriers proposed by the HF guidelines is to call in a multidisciplinary team. We consider it presumptive to assume that such resources

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None.

are widely available, particularly in the health care systems that patients living in socially disadvantaged conditions are likely to use. For cardiovascular disease guidelines to promote health equity, they must more explicitly address the dissonance between the treatments promoted by our evidence and their affordability.

We would advocate that the HF guidelines acknowledge and address the real financial barriers to medication and treatment within their scope of the provision of care. We suggest that guidelines (1) present evidence-based roadmaps for successful programs that improve longitudinal access and equity, (2) situate understanding patients' financial resources as a priority to patient-centered care, demonstrated by straightforward tasks such as running test scripts, reporting copays to patients, and working with them to prescribe the medications that they can afford, and (3) include those with multidisciplinary expertise as part of guideline writing committees, such as social workers and social epidemiologists, who have the expertise to measure, assess, and address financial obstacles. Patients who are disadvantaged socioeconomically cannot afford for clinicians to abdicate understanding of the raw effects of financial and social realities on their lives and medical care experiences.

Cardiovascular guidelines have largely presumed rather than articulated processes and standards for communication. In contrast, the HF guidelines' emphasis on health literacy is commendable, particularly as the document references validated measures for health literacy assessment and screening. As clinicians, we direct National Institutes of Health-funded programs that situate health literacy as an obstacle to equitable cardiovascular care. Positioning health literacy as an individual-level barrier, as do the HF guidelines, is myopic when most of the US population has less than basic general literacy.<sup>4</sup> Furthermore, a clinician or team conducting one-off health literacy assessments and tailoring communication accordingly is not sustainable. We advocate that guidelines (1) approach health literacy as an institutional-level barrier, (2) cite programs that have effectively implemented strategies to overcome health literacy challenges, and (3) promote attributes of what has been termed a "health literate organization."<sup>5</sup> Systematic approaches to reducing health literacy barriers make care more accessible and equitable for everyone being served.

Guideline-based practice has the potential to widen rather than narrow disparities. The causes are three-fold. First, those with social disadvantage, historical marginalization and distrust, low health literacy, limited English proficiency, or other barriers to equitable care are less likely to participate in clinical trials. The result is a skewed demographic of the trials that inform the guidelines. Second, such individuals are less likely to receive guideline-based care because of structural barriers and are therefore more likely to experience health inequities. Third, an iterative literature develops, one that ignores the realities of structural obstacles to care as studies parade the successful outcomes attained when patients adhere to guideline-based care and the failures when they do not.

To address this cycle of widening disparity, we advocate that clinical trials and observational studies collect and report individual- and neighborhood-level social factors. We expect this approach would provide opportunity to gauge generalizability and promote transparency of social diversity and provide incentive for studies to enhance their collection of social measures. Such data are essential for subgroup analyses and to elucidate focused

interventions and strategies for higher risk populations. Diversifying clinical trials by race and ethnicity is paramount. However, we likewise issue a call to augment and report diversity by income, educational attainment, neighborhood composition, and social environment. Guidelines can report such data—or their absence—and thereby both enhance our understanding of guideline-based evidence and provide incentive for studies to enhance collection of social measures.

Two conjoint aims of the American Heart Association are to (1) promote the cardiovascular health of individuals, neighborhoods, and society and (2) advance health equity. These cannot exist as independent endeavors. Guidelines reflect our priorities and focus, our context, and the temporal legacies of the studies that informed them. They do not exist in a social vacuum, and their implementation without consideration of fundamental social realities perpetuates disparities. The guidelines are not static; we can expand their content and perspective and thereby recognize and address how social risks limit and obstruct their implementation. We owe our collective medical professional communities and the communities of patients we serve guidelines that pursue the promise of health equity.

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**Table.**

## Avenues for Expanding American Heart Association and Professional Society Guidelines to Embrace Health Equity

Domain	Strategies for implementation
Social disadvantage	<ul style="list-style-type: none"> <li>• Acknowledge the prevalence of financial barriers to medication, including both copays and insurance challenges.</li> <li>• Situate understanding patients' financial resources as a priority to patient-centered care.</li> <li>• Identify and present programs that have fostered equitable access to pharmacologic therapies.</li> <li>• Integrate strategies for ascertaining medication affordability and accessibility.</li> <li>• Include essential multidisciplinary collaborators (eg, social workers) in guideline authorship.</li> </ul>
Health literacy	<ul style="list-style-type: none"> <li>• Avoid consideration of health literacy solely as an individual-level barrier.</li> <li>• Approach health literacy as a population-based challenge, given the prevalence of limited literacy overall in the United States.</li> <li>• Promote system-level strategies for addressing health literacy (eg, "health literate organization" attributes<sup>3</sup>) to articulate uniform approaches to reduce health literacy barriers.</li> <li>• Identify and describe programs and interventions that have successfully improved outcomes in individuals with low health literacy.</li> </ul>
Standards of evidence, guideline reporting	<ul style="list-style-type: none"> <li>• Describe fundamental study composition (sex, race, ethnicity) in guidelines.</li> <li>• Identify social composition, including factors such as individual- and neighborhood-level disadvantage, educational attainment, health literacy, and other SDOH.</li> <li>• Summarize gaps in evidence as pertinent to social disadvantage.</li> <li>• Identify RCTs and studies appropriate for guideline inclusion that have successfully included diverse social composition.</li> </ul>
Standards of evidence, guideline implementation	<ul style="list-style-type: none"> <li>• In RCTs and observational registries (eg, GWTG), assess SDOH and social factors.</li> <li>• Avoid biased confirmation of guideline-based evidence by ignoring SDOH and barriers to treatment access.</li> </ul>

GWTG indicates Get With The Guidelines; RCT, randomized clinical trial; and SDOH, social determinants of health.