

Summit on Heart Failure in African Americans
Plan to End Treatment Disparities and Improve Patient-Centered Care and Outcomes

Arlington, VA
June 7, 2018

Summit Report

Introduction

A recent summit held by the National Minority Quality Forum; its wholly owned subsidiary Healthy Communities, LLC; and Aetna, Inc., focused on ways to address widely accepted racial and ethnic disparities in the identification and treatment of cardiovascular disease in African Americans.

Cardiologists, cardiology nurse practitioners, other health care providers and patient advocates from across the U.S. gathered during the “Summit on Heart Failure in African Americans: Plan to End Treatment Disparities and Improve Patient-Centered Care and Outcomes,” June 7, 2018, in Arlington, Virginia.

Dr. Keith Ferdinand, professor of medicine at the Tulane University School of Medicine, and Dr. Elizabeth Ofili, director and senior associate dean at the Morehouse School of Medicine, served as co-chairs. Participants focused on the goal of developing an action plan that would measurably propel improved care and outcomes for African Americans with heart failure (HF).

At the onset, it was clarified that the meeting’s purpose was not to reiterate the [existing health disparities between African Americans and Caucasian Americans](#). This was a public health conversation of the 20th century that had been largely accepted. Having recognized this deeply rooted inequality, the new task is to create an action plan that alleviates these disparities. The Summit’s objective was practical action rather than theoretical discussion.

Environmental Scan

**For presentation slides and audio recordings of summit:*

<https://drive.google.com/open?id=1vMOJq4GEY-div7nCW60gHbA4Xr9hC7JC>

The summit began with an environmental scan, in which the recommended care and current gaps in heart failure treatment for African Americans were reviewed. Five presenters offered distinct perspectives and expertise. Dr. Sunny Ramchandani, deputy chief medical officer for Aetna, provided a leadership perspective, explaining Aetna’s role in the fight against heart failure in African Americans. Aetna, a Fortune 50 health care company, serves approximately 23 million medical members in the United States. Given this large potential for impact, the company is looking for a cost-effective, practical, sustainable model that includes several interventions in heart failure treatment. Dr. Ramchandani said that Aetna is committed to actualizing the action plan to come out of the Summit.

Dr. Gary Puckrein, President and CEO of the National Minority Quality Forum, discussed the impact of heart failure on African Americans. He offered several studies that analyzed factors such as access to medications, medication adherence and hospitalization. He noted that the Forum’s access to a database of over five billion patient records with zip code-specific analytics can assist in developing local strategies to combat heart failure in African Americans.

In short, geography matters. Seventy percent of African Americans live in 2,500 zip codes; 80 percent of African Americans with heart failure live in 1,800 zip codes. If the primary care physicians and cardiologists in these communities were better educated on risk factors and high-impact treatment modalities, outcomes for African Americans with heart failure would likely improve. Given the higher hospitalization and rehospitalization rates for African Americans with heart failure, Dr. Puckrein also noted the cost savings associated with improved treatment. While the guidelines for evidence-based treatment of heart failure have been widely recognized, actual usage is not consistent. He asserted that the first step in improvement will be to ensure that the proper standard of care for African Americans with heart failure is more effectively implemented by the providers serving this population.

Dr. Keith Ferdinand offered a cardiologist's perspective and provided evidence-based care recommendations for African Americans. His discussion of key health practitioners in this practice area, medication adherence barriers, and rates of re-hospitalization provided a critical foundation for the Summit's actionable items. He explained that many African Americans with heart failure are first seen in the emergency room when it is already too late. Furthermore, African Americans are less likely to receive care by a cardiologist during an intensive care unit admission for heart failure. Primary care, family medicine and internal medicine must be educated on how to care for these patients, considering that they are the individuals most responsible.

Additionally, Dr. Ferdinand listed factors that negatively affect prescription adherence, including insufficient resources, limited English, low health literacy and lack of social support networks. Even more fundamentally, many of these patients do not have an adequate understanding of why the prescriptions are necessary or how they will be beneficial, resulting in a lower likelihood of adherence. In order to better educate patients, providers need to provide information in the patient's language and at their level of health literacy. Finally, Dr. Ferdinand noted that minority-serving hospitals tend to have a higher rate of hospital readmission, primarily due to poor diagnosis in the emergency room. Initiatives in which a hospital was penalized if a patient with heart failure was readmitted within 30 days of discharge resulted in a decrease in readmission rates for both minority and non-minority serving hospitals, clearly illustrating the need for wide scale reform of the discharge process.

Haley Stolp next provided an overview of her work with Million Hearts[®], an initiative co-led by the Centers for Disease Control and Prevention and the Centers for Medicare & Medicaid Services. The program's goal is to prevent one million heart attacks, strokes and other cardiovascular events over five years. Cardiac rehabilitation (CR) was added to the Million Hearts[®] framework in 2017 to prevent recurrent cardiovascular events and improve the overall health and well-being of people with heart disease, including women, people of color, those with geographic and socioeconomic obstacles and those with heart failure.

Stolp shared the five objectives of the program's CR action plan, acknowledging that particular attention is needed to improve cardiac rehabilitation participation among African Americans to: (1) Increase awareness of the value of CR to improve medication adherence, quality of life and outcomes; (2) Increase use of best practices for referral, enrollment and participation; (3) Build equity in CR referral, participation and program staffing; (4) Increase sustainability, affordability and accessibility, and; (5) Measure, monitor and report progress. The Million Hearts' national target is 70 percent participation in cardiac rehabilitation, which would save an estimated 25,000 lives and prevent 180,000 hospitalizations every year. Cardiac rehabilitation would be an important action item proposed by the

experts later on in the Summit, and Million Hearts serves as an informative model of an action-oriented solution.

Rhonda Monroe, a HF survivor and the chair-elect of WomenHeart: The National Coalition for Women with Heart Disease, gave the final presentation of the Summit. Monroe's experience as an African American heart failure patient was a unique and invaluable part of the day's conversation. In recounting her story, she critiqued the health care system and offered insights into several setbacks she experienced that she believes should be addressed in the broader approach to CR prevention and treatment. For example, when Monroe visited a physician for the first time and complained of chest pain, her heart-related symptoms were not taken seriously, resulting in misdiagnosis. While Monroe credits her persistent personality as the reason she was able to finally be diagnosed properly and receive the necessary care, she recognizes that not every person has the same ability to self-advocate. Monroe noted that health care providers must ensure that every patient with heart failure who comes through the system has someone advocating for them. Additionally, she reiterated the lack of health literacy in the African American community and stressed the importance of culturally tailored education, citing her own campaigns in barber shops and beauty salons as successful examples. Finally, Monroe asserted that faith is a valuable source of strength and hope in the face of overwhelming adversity. Monroe pointed out that even the term "heart failure" is inherently discouraging, making it more difficult to believe in a positive outcome for oneself.

Action Proposal

Following the five presentations, the experts referred to a draft six-point action plan to end treatment disparities and improve outcomes in African Americans with heart failure. The participants take turns offering their experience and knowledge to refine the proposal. Below are the action plan items accompanied by corresponding expert discussion:

1) Target, through geospatial analysis and mapping, education and quality improvement support for primary care practices

The ideas and proposals discussed focused primarily on educating stakeholders in high-stake zip codes and making medication costs more transparent. With access to geographical statistics, health program planners could direct their efforts toward the zip codes in which most African Americans with heart failure live. An effective solution for one of these zip codes will likely be successful in others due to the similar characteristics of the areas. Additional discussion centered on the importance of the following:

- Creation of a taskforce of health practitioners to send educators into primary care practices and improve care in these specific communities.
- Application of technology to facilitate engagement with primary care physicians in these communities without having to physically send personnel.
- Development of a network to connect primary care physicians with cardiologists, so that they might receive guidance and improve their diagnosis and treatment of heart patients.
- Development of an electronic template to guide primary care physicians in their assessments of patients who have CR risks and/or symptoms as well as a tool to help clinicians prioritize the same.

- Increase awareness of patient medication out-of-pocket costs so providers can promote adherence.
- Better leadership in primary care that prioritizes quality care for African Americans at risk for CR.

Participants then reviewed the Sustainable Healthy Communities' practice transformation model, an evidence-based approach to engaging practice-leading physicians and allied health care workers. The model trains and supports the implementation of rapid cycle quality improvement projects that can produce more efficient, patient-centered, team-based and evidence-based care, including optimal prescribing habits, improved adherence and stronger patient engagement. This approach also includes community engagement based on both the Collective Impact (<http://collectiveimpactforum.org/>) and the Asset-based Community Development (ABCD, <https://resources.depaul.edu/abcd-institute/Pages/default.aspx>) models. The committee endorsed moving forward with such a program, prototyping it in one community and expanding nationally.

2) Disseminate best practices for successfully discharging patients using team-based approaches

There was significant overlap between the original action points two and three, due to the popular belief that a team-based approach is necessary in order to successfully discharge patients. For this reason, the two points from the original action plan have been synthesized. Patients with recent hospitalizations represent the population at highest risk for future hospitalizations, and thus deserve special attention. The experts generally agreed on the following regarding improving the discharge process:

- A quick and personal follow up is critical, usually within days by a health care coordinator.
- A post-discharge follow-up appointment, which should be scheduled prior to discharge, should occur within seven days of discharge.
- The patient should already know the provider with whom they will follow up, to increase a sense of comfort and improve care quality and outcomes.
- The use of same-day or transition clinics can be very valuable for patients who do not have a stable place of residence. At these types of clinics, overall care coordination should be provided by a health practitioner.
- Technology can improve the discharge process. A text message system—currently in use in various hospitals—could improve medication adherence and the overall discharge experience. Hospital systems should be committed to providing these models to reduce cost, reduce hospitalizations and improve quality of care.
- Ideally, the provider responsible for seeing the patients in the post-discharge clinic should participate in the discharge process to ensure continuity of care. This person would be able to evaluate the patients in a very high-risk period, track progress and provide the care necessary to directly prevent rehospitalization.
- “Virtual huddles,” in which all providers involved in the patient’s care (pharmacists, physicians, nurses, social workers, etc.), must sign off to assure that they have completed their role in the discharge process, would be helpful.
- Hiring personnel to run a post-discharge clinic would likely save the hospital/health system money over time.

- Post-discharge visits should focus on optimizing prescription of and adherence to guideline-directed medical therapy for heart failure.
- Finally, it is important to recognize that the team members in this care process could exist outside of a given system or institution. Communities are often rich with volunteer services and programs that are not utilized. Aetna specifically could play a pivotal role in connecting team members throughout the community and providing the funding necessary for them to collaborate. Adoption of this approach using SHC's Quality Improvement-Education (QIE) model, with champion training, community engagement, and rapid cycle improvement, would be an important prototype for supporting implementation before widespread dissemination.

3) Promote cardiac rehabilitation among African Americans with heart failure

While the benefits of cardiac rehabilitation (CR) have been statistically demonstrated, it is not currently sustainable. In addition, there are several barriers to program participation that must be alleviated for the sake of universal patient access, especially among African Americans. Barriers include the following:

- African-Americans are often younger when they are diagnosed with HF, leading to challenges related to balancing employment, child care and other unique issues.
- Patients often desire to attend cardiac rehab but cannot afford it due to the copay or the facility fee that hospitals charge.
- Young people in cardiac rehab often do not see anyone who looks like them in the space, so it is not a comfortable environment.
- Often, rehab sessions occur during regular work hours, making it impossible for individuals to attend.
- Additionally, even if attendance barriers are removed, cardiac rehabilitation should not just be exercise. It should be an all-encompassing program that educates on nutrition, stress reduction and other healthy lifestyle components.

The following proposed solutions are just a few that could be effective in alleviating the above mentioned barriers to cardiac rehab: developing communication materials that depict young African Americans participating in cardiac rehabilitation to debunk preconceived notions, disseminating messages about the value and safety of CR through organizations and institutions that serve African Americans and helping health care systems and employers make a business case for CR.

4) Promote health-literate and culturally appropriate patient education and engagement materials

In the same way that primary care practices should be better educated, patients should be better educated so that they can recognize their own symptoms and care for themselves. A patient who understands his or her own condition will better adhere to prescribed medications, and a culturally appropriate education is necessary to ensure this understanding. A majority of the literature on heart failure is too advanced for most patients, but many patients are embarrassed to admit that they do not

understand. Generally, video and virtual content is more effectively absorbed than print. Finally, the information should be disseminated in environments where African Americans are most comfortable. Whether it be barber shops, fraternities/sororities or faith-based organizations, the messenger can often be as or even more important than the message.

5) Promote attention and accountability

The final action item requires a communications plan to inform those who have the ability to effect change in treatment of heart failure in the African American population. Participants at the Summit supported discussions with the Congressional Black Caucus and/or other elected and policy leaders, educating them about this need and engaging their attention to the issue. It would be beneficial to ask government officials to sponsor educational initiatives around heart failure, similar to what has been done nationally for diabetes. A campaign led by a spokesperson, ideally a former patient and survivor, could also be impactful in inspiring hope among the target population. State legislators could be petitioned to support the plan as well.

Conclusion

Ultimately, the data speaks for itself. Not only are there disparities in care for African Americans with heart failure, but there is a significant disparity in outcomes as well. The disproportionate hospitalization and mortality rate of African Americans from heart failure and the high proportion of national health care spend dedicated to this specific patient population provides a powerful incentive for change. Primary care providers play the most critical role in improving these outcomes, but team-based approaches in which hospital and health systems collaborate with communities are necessary to provide cardiac rehabilitation, ensure medication adherence and prevent hospital readmission and optimal patient functioning and quality of life.

Appendix A: Expert Panel

<p>Keith Ferdinand, MD – Co-chair <i>Professor of Medicine, Tulane University School of Medicine & Tulane Heart and Vascular Institute</i></p>	<p>Alanna Morris, MD <i>Assistant Professor of Medicine, Division of Cardiology, Emory University School of Medicine Director of Heart Failure Services, Atlanta VA Medical Center</i></p>
<p>Elizabeth O. Ofili, MD, MPH – Co-chair <i>Professor of Medicine, Director & Senior Associate Dean Clinical Research Center & Clinical and Translational Research Morehouse School of Medicine</i></p>	<p>Anekwe E. Onwuanyi, MD <i>Professor of Medicine, Morehouse School of Medicine Chief of Cardiology, Morehouse School of Medicine Medical Director, Heart Failure Program, Grady Memorial Hospital</i></p>
<p>Nancy M Albert, PhD <i>Associate Chief Nursing Officer, Office of Nursing Research and Innovation Clinical Nurse Specialist, Kaufman Center for Heart Failure Cleveland Clinic Health System</i></p>	<p>Gary A. Puckrein, PhD <i>President & CEO, National Minority Quality Forum</i></p>
<p>Lisa Benton, MD, MPH <i>Medical Director, Aetna</i></p>	<p>Sunny Ramchandani, MD, MPH <i>Deputy Chief Medical Officer, Aetna</i></p>
<p>Luther T. Clark, MD <i>Deputy Chief Patient Officer Global Director, Scientific, Medical and Patient Perspective, Office of the Chief Patient Officer Merck</i></p>	<p>Kevin B. Sneed, PharmD <i>Senior Associate Vice President, University of South Florida Health Dean and Professor, University of South Florida College of Pharmacy</i></p>
<p>Alisahah Cole, MD <i>Vice President/System Medical Director, Community Health Atrium Health</i></p>	<p>Felix O. Sogade, MD <i>CEO, Georgia Arrhythmia Consultants and Research Institute</i></p>
<p>Patricia Davidson, MD <i>Preventive Cardiologist, MedStar Washington Hospital Center</i></p>	<p>Haley Stolp, MPH <i>Public Health Analyst, IHRC Inc.</i></p>
<p>Karol Harshaw-Ellis, DNP, MSN <i>Nurse Practitioner, Duke Clinic</i></p>	<p>Hector Ventura, MD <i>Professor of Medicine, Ochsner Clinical School The University of Queensland School of Medicine</i></p>
<p>Barbara Hutchinson, MD, PhD <i>President, Chesapeake Cardiac Care</i></p>	<p>Gretchen C. Wartman <i>Vice President for Policy and Program, National Minority Quality Forum</i></p>
<p>Suja Mathew, MD <i>Chair of Medicine, Cook County Health and Hospitals System Governor, Northern Illinois Chapter, American College of Physicians</i></p>	<p>Marcus L. Williams, MD <i>Physician, Cardiac Associates Assistant Clinical Professor of Medicine, Division of Cardiology, University of Medicine & Dentistry of New Jersey</i></p>
<p>Rhonda E. Monroe, MBA <i>Heart Champion, Mayo Clinic Chair-Elect, WomenHeart</i></p>	<p>Alanna Morris, MD <i>Assistant Professor of Medicine, Division of Cardiology, Emory University School of Medicine Director of Heart Failure Services, Atlanta VA Medical Center</i></p>

Appendix B

Summit on Heart Failure in African Americans
Plan to End Treatment Disparities and Improve Patient-Centered Care and Outcomes

Arlington, VA
June 7, 2018

Meeting Goal: Advance an action plan that will measurably propel improved care and outcomes for African Americans with heart failure.

Objectives:

- *Environmental scan:* Briefly review recommended care and current gaps in treatment and outcomes experienced by African Americans; and,
- *Specify actions:* Review and identify specific actions that stake-holders should implement to measurably improve heart failure treatment and outcomes among African Americans.

Agenda:

* For presentation slides and audio recordings of summit:

<https://drive.google.com/open?id=1vMOJg4GEY-dIV7nCW60gHbA4Xr9hC7JC>

8:00 am: Continental Breakfast

8:30 am: Welcome and Introductions – Co-Chairs: Drs. Ferdinand and Ofili

8:40 am: Review of Meeting Objectives and Agenda - Dr. Ofili

8:50 am: A Leadership Perspective from Aetna- Dr. Ramchandani

9:00 am: Measuring the Impact of Heart Failure in the African American Community
Dr. Puckrein will review NMQF's work to understand and reverse the impact of heart failure on African Americans, reviewing data analytics and geomaps concerning the epidemiology, access to medications, medication adherence, hospitalization, costs, and mortality.

9:30 am: Clinical Portrait of Heart Failure in African Americans
Dr. Ferdinand will summarize evidence-based care recommendations and the toll suffered by African Americans.

10:00 am: Million Hearts, Cardiac Rehabilitation, and Racial Disparities
Dr. Wright will review the Million Hearts Cardiac Rehab Collaborative's efforts to promote cardiac rehabilitation access for African Americans, including in heart failure.

10:20 am: Patient Perspective
Rhonda Monroe from WomenHeart will provide the perspective of an African American patient with cardiovascular disease navigating the health care system.

10:45 am: Break

11:00 am: Action Plan Review – Dr. Ofili

The advisory group will review suggested actions, providing feedback and making additional suggestions.

12:15 pm: Lunch

12:45 pm: Continued Action Plan Review – Dr. Ofili

The advisory group will review suggested actions, providing feedback and making additional suggestions.

3:00 pm: Break

3:15 pm: Summary and Next Steps – Drs. Ferdinand and Ofili

The chairs will provide a summary of the recommended actions and moderate a discussion of the next steps for translating the action plan into meaningful improvement.

4:00 pm: Adjournment

Appendix C

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Cardiac Rehabilitation Infographic – Million Hearts

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