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Fellow's Voice

## Overcoming clinical inertia to improve the use of cardiovascular risk reducing therapy: A Fellow's Voice



While on the Cardiology service my intern year, I cared for a middle-aged cattle rancher from rural Wyoming admitted with an acute myocardial infarction and new onset heart failure with reduced ejection fraction. Despite a detailed discussion of pathology and care planning, he fixated on the word “failure.” In that moment his world collapsed, and his greatest concern was his ability to maintain his cattle which had provided his family’s livelihood for multiple generations. As had been done for me decades earlier, I tried to help him understand the context of his disease and how “failure” was not indicative of fault or a sealant of fate. Though premature cardiovascular disease and hyperlipidemia ran in his family, he had minimal interactions with the healthcare system, as the nearest clinic was nearly 50 miles from his home. Had medical access been more available, much of his cardiovascular disease might have been averted. Cases like his helped to shape my interest in cardiovascular disease prevention, leading me to pursue a longitudinal clinical experience in the Lipids Clinic at the University of Utah. I found my passion in preventive Cardiology caring for adults at high risk for atherosclerotic cardiovascular disease, whether from long-standing diabetes, necessary polypharmacy, or familial inheritance.

We are at a time of great wealth in our options to treat cardiovascular disease and prevent progression. Despite this, I often see patients not on safe, effective, and available therapies proven to provide benefit. This is undoubtedly a multifaceted problem, but one relatively common barrier to this is clinical inertia, the act of not intensifying therapy despite medical indication [1]. From a prevention space, clinical inertia comes into play with many of my patients with hypertension and hyperlipidemia. In community practice we see clinical inertia prominently contribute to disparities in blood pressure control by race and ethnicity, as well as for older adults [2,3]. This begs the question of whether a structured approach that involves a protocolized care pathway for titration of antihypertensive medication and co-managed with pharmacists and nurses can overcome clinical inertia and consequent disparities in care. This model has been implemented with success in the care of patients with heart failure, and there is compelling evidence that adapting this for the management of hypertension and hyperlipidemia can improve uptake of appropriate preventive interventions with reduction in blood pressure and low-density lipoprotein cholesterol [4, 5]. While we have seen success of multidisciplinary and protocolized care for cardiovascular prevention in controlled and integrated care settings, larger efforts are needed on how to implement this approach in a fragmented care infrastructure that does not use consistent blood pressure measurement techniques [6].

Management of hyperlipidemia and global atherosclerotic cardiovascular disease risk with statin therapy is often considered an “easy”

decision based on indication. Yet, undertreatment is prevalent for high-risk primary and secondary prevention patients. For example, among 5006 adults with atherosclerotic cardiovascular disease registered in the Getting to an Improved Understanding of Low-Density Lipoprotein Cholesterol and Dyslipidemia (GOULD) Management study, only 17.1 % received lipid lowering therapy intensification over two years, even though nearly two-thirds had an LDL-C  $\geq 70$  mg/dL [7]. Part of this is driven by hesitation and concerns of statin-associated risks. Misinformation about statin therapy plays prominently in patient willingness to initiate and remain on therapy [8]. While we do have multiple non-statin options now for lipid lowering which we can offer in the appropriate clinical context, many patients are amenable to statin therapy and simply need more time to talk through the evidence and indications. On a local level, we know that increased clinical encounter time is associated with a small increase in appropriate statin initiation [9]. It may be that though we are limited in our ability to lengthen an individual clinic visit, we can use telehealth and remote monitoring interventions to improve medication optimization and allow for more in-between visit discussions [5]. Much like the patient I cared for intern year, many US adults in rural areas live far from their local healthcare, let alone specialty care. The limited access to healthcare contributes to worsening health disparities; US adults living in rural areas have a greater risk of incident cardiovascular disease with poorer outcomes compared to adults living in urban areas [10,11]. Studying and implementing approaches that enable clinicians to spend more time with patients in the clinic, as well as in between visits, may offer powerful tools to overcome clinical inertia for preventive therapies.

While we grow our options of therapeutics to reduce cardiovascular risk, addressing clinical inertia that leads to undertreatment and propagates disease for high-risk patients to improve the use of tried-and-true therapies should not take a back-seat. It is with this framework that I hope to use my career in Preventive Cardiology as a clinician-investigator to improve access for cardiovascular prevention and caring for patients with high-risk of cardiovascular disease.

### CRediT authorship contribution statement

**Alexander R Zheutlin:** Conceptualization, Project administration, Writing – original draft, Writing – review & editing.

### Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence

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the work reported in this paper.

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