provides incremental prognostic value to the CHA2DS2-Vasc score.

**Methods:** We performed a multicenter (5 hospitals in a single health system) retrospective analysis of 4,837,989 12-lead ECGs, obtained from 1,228,291 pts. IAB was defined as a P wave duration > 120msec in leads II, III, or aVF. Measurements were extracted as Extensible Markup Language (.xml) files from the GE MUSE system. After excluding pts without at least 1 year follow up from 2015 onward, or pts with AF diagnosed prior to the first ECG with IAB, there remained 241,450 pts with 945,837 ECGs. Outcomes included AF or flutter, CHF, MACE, stroke or systemic embolism, MI, hospitalization, and death at 1,000 day follow up.

**Results:** The cohort (M/F = 61.3% / 48.7%) consisted of 59,886 pts with IAB and 179,052 pts without IAB. Of IAB patients, 56.1% were men. During follow-up, the IAB group had a greater prevalence of hospitalization (35.7% vs 28.7%), MACE (9.9% vs 3.7%), AF (6.8% vs 3.3%), CHF (6.3% vs 1.9%), stroke (5.1% vs 2.9%), arterial thromboembolism (3.4% vs 1.8%), MI (1.5% vs 0.5%) and death (0.5% vs 0.2%) compared to the group without IAB. Despite having fewer women (43.7% vs 53.7%), the IAB group had a higher mean CHA2DS2-Vasc score (1.3 vs 1.2) than the group without IAB. Even after adjustment for baseline variables, AF, and CHA2DS2-Vasc score > 2, IAB independently predicted stroke during follow up. Patients who had both IAB and CHA2DS2-Vasc score >2 had worse stroke outcomes (OR 1.5, 95% CI 1.39-1.52, P<0.001).

**Conclusion:** IAB is associated with adverse cardiovascular outcomes and is an independent predictor of stroke, even after adjustment for AF and CHA2DS2-Vasc score. This study provides equipoise for further investigation into whether anticoagulation may be beneficial in patients with AF and IAB without other risk modifiers.

**ABSTRACT EN-728:**

**Towards Health Equity, presented by HRS DEI**

Sunday, May 1, 2022
10:30 AM - 11:30 AM

**EN-728-01**

**RACIAL AND ETHNIC INEQUITIES IN ORAL ANTICOAGULATION AND ASSOCIATED OUTCOMES FOR PATIENTS WITH ATRIAL FIBRILLATION - THE GET WITH THE GUIDELINES ATRIAL FIBRILLATION REGISTRY**

Utibe R. Essien; Lisa Kaltenbach; Tracy Wang; Gregg C. Fonarow; Kevin Thomas; Mintu P. Turakhia; Emelita J. Benjamin; Fatima Rodriguez; Margaret Fang; Jared Magnani and Jonathan P. Piccini

**Background:** Oral anticoagulation (OAC) is under-prescribed in racial/ethnic minority patients with atrial fibrillation (AF). Little is known of how OAC rates differ in hospitalized patients with AF and how differential prescribing relates to inequities in AF outcomes.

**Objective:** We compared OAC initiation and AF-related outcomes by race/ethnicity in Get With The Guidelines-AFib, a national quality improvement initiative for hospitalized AF patients.

**Methods:** Our primary outcome was the presence of OAC at discharge by race/ethnicity. We used Medicare linkage data to assess our secondary outcome of ischemic stroke, bleeding, or all-cause mortality at 1-year post-discharge by race/ethnicity. We used multivariable adjusted logistic regression with GEE to model the odds of our primary outcome and Cox proportional hazards regression with robust variance estimation to model secondary outcomes. Individuals with missing race/ethnicity (3.6%) were excluded from the analysis.

**Results:** Among 69,553 patients hospitalized with AF from 159 sites between 2014-2020, 85.6% were White, 7.3% Black, 5.8% Hispanic and 1.2% Asian patients. Overall, 48.8% were women; mean age was 68.6 years; mean CHADS2VA2Sc score was 3.8. Overall, 56,385 (78.5%) were discharged on any OAC. Black patients, adjusted odds ratio [aOR] 0.75; 95% CI 0.67-0.84, were less likely than White patients to be discharged on any OAC. Black patients discharged on OAC were less likely to receive direct oral anticoagulants (DOACs) vs. warfarin (aOR 0.82; 95% CI 0.65-0.96). At 1 year, bleeding (aOR 2.08; 95% CI 1.5-2.8) and stroke (aOR 2.07; 95% CI 1.34-3.20) rates were higher in Black than White patients (Table 2). Hispanic patients also had higher stroke rates (aOR 2.02; 95% CI 1.38-2.95). Mortality rates were higher in Black than White patients (aOR 1.22; 95% CI 1.02-1.47).

**Conclusion:** In a national registry of patients hospitalized with AF, Black compared to White patients were less likely to be discharged on OAC. Black patients also had higher rates of AF-related outcomes including stroke (also in Hispanic patients), bleeding, and mortality. Understanding the drivers of racial/ethnic differences in OAC prescribing, such as the higher cost of DOACs vs. warfarin, will help guide interventions to reduce OAC inequities and improve AF outcomes.
EN-728-02

QUANTIFICATION OF WOMEN AND UNDER-REPRESENTED MINORITY APPLICANTS TO CLINICAL CARDIAC ELECTROPHYSIOLOGY FELLOWSHIP

Uyanga Batnyam; David Chang; Jim W. Cheung; Jose A. Joglar; James P. Daubert; James P. Daubert and Usha B. Tedrow

Background: Prior to the institution of the Match, there have been no reliable data available regarding how many women or under-represented minority (URM) applicants for clinical cardiac electrophysiology (CCEP) fellowship there are in the United States.

Objective: To present the available data on women and URM CCEP applicants.

Methods: We reviewed three years (2019 - 2021) of ERAS data for CCEP fellowship applicants and their corresponding years for cardiovascular disease (CVD) fellowship. These data represent the applicants, and not the matched fellowship matriculants.

Results: Overall, 5-6% of the pool of CVD fellows chose CCEP in years 2016-2018 (Figure, Panel A). Women comprised 13-15% of that group and self-identified URM applicants comprised 7-10%. While there was a numerical increase in the absolute number of women applicants applying for CCEP fellowship (Figure, Panel B), this was not a statistically significant increase given the overall size of the applicant pool (P for trend 5 NS). The proportion of URM groups applying for CCEP fellowship was even lower. There were only 4 (3%), 6 (5%) and 7 (5%) self-identified Hispanic, Latino, or Spanish origin CCEP applicants in 2019, 2020 and 2021, respectively. Similarly, there were only 5 (4%), 6 (5%) and 7 (5%) self-identified Black or African American CCEP applicants in 2019, 2020 and 2021, respectively (Figure, Panel C). This trend starts early at CVD application level as women and URM CVD applicants comprised 21% and 10% in 2016, 24% and 9% in 2017, and 23% and 9% in 2018. (P for trend = NS in all above).

Conclusion: The number of women and URM applicants for CCEP is low with no increase observed between 2019 and 2021.

Identifying and addressing barriers for women and URM applying for CVD and CCEP training will be paramount to increase representation.

EN-728-03

A WIDENING DIGITAL DIVIDE: UTILIZATION OF VIRTUAL VISITS IS REDUCED OVER TIME FOR BLACK AND HISPANIC COMMUNITIES

Katherine Sauer; David Chang; Omar Kreidieh; Amy Leigh Miller; Usha B. Tedrow; Paul C. Zei; Thomas M. Tadros; Sunil Kapur; Melanie Maytin; Uyanga Batnyam; Esseim Sharma; Clinton J. Thurber; John Whitaker; Julie B. Shea; Nathaniel Steiger; Kenneth Comeiro; Lauren Ashley Rousseau; Tiffany Andrade; David T. Martin; Jorge Romero; Lindsay Harris; Patrice Hoskins; William H. Sauer and Bruce A. Koplan

Background: Social distancing restrictions resulted in increased utilization of virtual visits (VVs) for arrhythmia care in 2020. Over time, there has been a return to in-person visits (IPVs); however, utilization of VVs may continue to offer advantages for patients.

Objective: To assess characteristics of patients durably adopting virtual care.

Methods: All appointments in our arrhythmia clinics from March 2020 through November 2021 were analyzed. Completed appointments by EP providers were categorized as VVs or IPVs. The VV rate was calculated as number of VVs divided by total Visits (IPVs and VVs). Pt characteristics collected included self-identified race and ethnicity as well as age, gender, and insurance status. We also assessed enrollment in an internet-based patient portal that interfaces with the electronic medical record (EMR) and allows for communication with providers.

Results: A total of 6,084 VVs and 10,942 IPVs were included in the analysis. In 2020, 3,550 VVs comprised the majority (52.8% of 6,723) of all outpatient visits, whereas in 2021, this proportion dropped to 24.6% (2,534/10,303) as IPVs became more common. The largest reduction in VV utilization was amongst Black patients (65.2% reduction to a 19% VV rate) followed by Hispanics (62.3% reduction to a 15.8% VV rate). Both groups had a significantly reduced VV utilization rate compared to others in 2021 (P <0.01). There was no significant difference in VV rates for underinsured patients in 2020 or 2021, indicating social but not economic influence on telehealth adoption. Enrollment in the EMR patient portal during the study period was significantly higher in 2020 compared to 2021 (P <0.001).

Conclusion: The reduction in virtual visit utilization over time for Black and Hispanic patients is likely due to ongoing social distancing restrictions, a widening digital divide, and other barriers to telehealth adoption.