

Call to Action: Structural Racism as a Fundamental Driver of Health Disparities: A Presidential Advisory from the American Heart Association

Thursday | March 18, 2021 | 1:00pm – 2:00pm ET

Guest Speakers:

**Eduardo Sanchez, MD, MHP, FAAFP | Anjail Z. Sharrief, MD, MPH, FAHA
Paul C. Walker, PharmD, FASHP | Terri Wiggins, MS**

AC Forum Moderators:

Tracy Minichiello, MD | Sara Vazquez, PharmD, BCPS, CACP

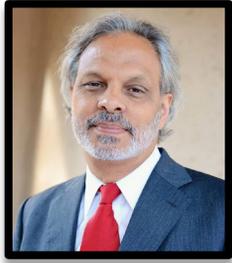


**Anticoagulation
FORUM**

Webinar ▶

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Presenters



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- Chief Medical Officer for Prevention, American Heart Association



Terri Wiggins, MS

- Vice President of Science, American Heart Association



Anjail Z. Sharrief, MD, MPH, FAHA

- Associate Professor of Neurology, McGovern Medical School
- Founder & Director, STEP Clinic
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- Health Equity Response Task Force, City of Houston



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Paul C. Walker, PharmD, FASHP

- Clinical Professor and Assistant Dean of Experiential Education and Community Management, College of Pharmacy, University of Michigan



Sara Vazquez, PharmD, BCPS, CACP

- Clinical Pharmacist, University of Utah Health Thrombosis Service



American
Heart
Association.

Call to Action: Structural Racism as a Fundamental Driver of Health Disparities

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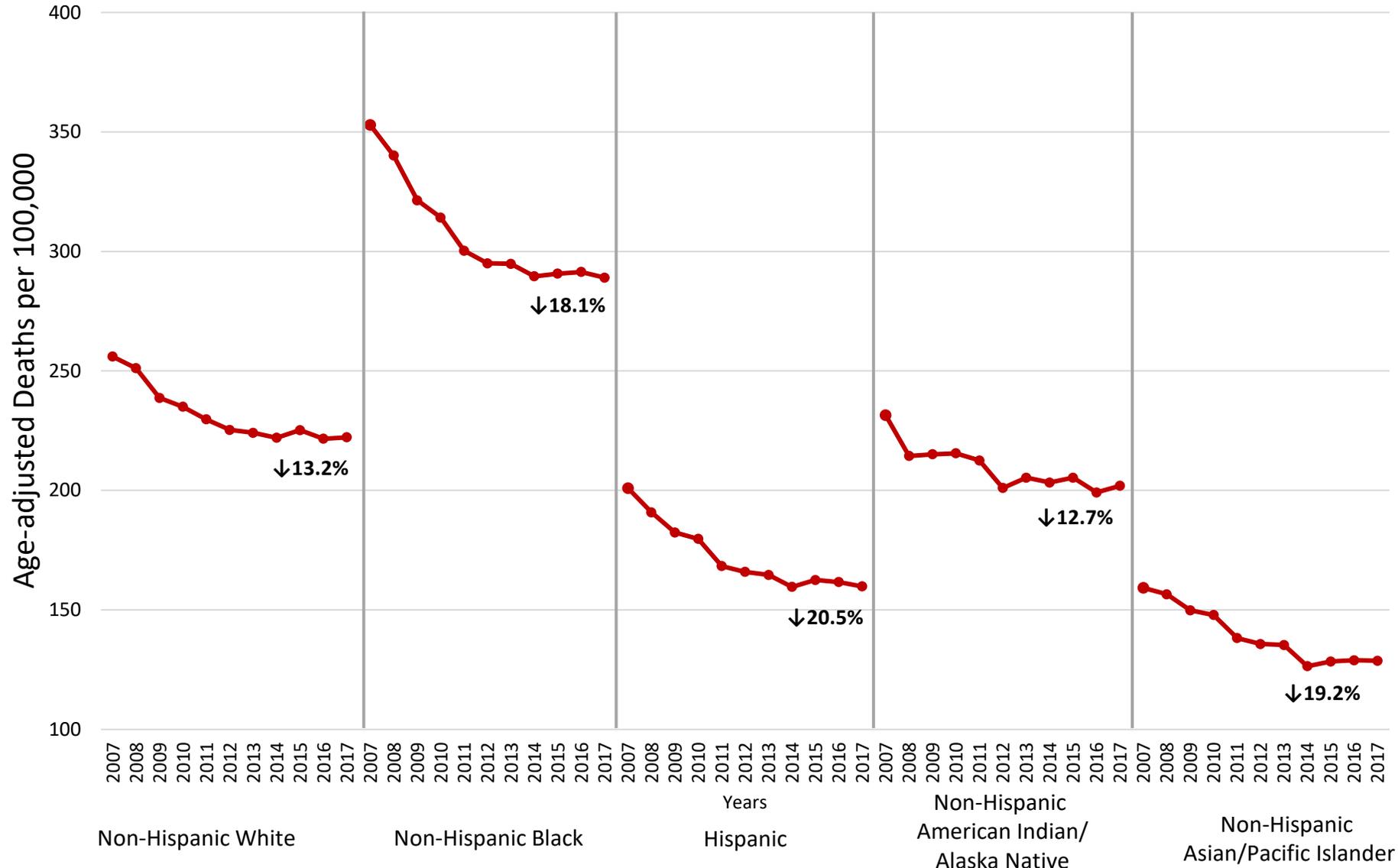
Causes of Death: USA (2019)

Rank	Cause	Number	Percent
	Total – all causes	2,854,838	100%
1	Heart diseases	659,041	23.1%
2	Cancer	599,601	21.0%
3	Accidents	173,040	6.1%
4	Chronic lower resp. disease	156,979	5.5%
5	Stroke	150,005	5.3%
6	Alzheimer’s disease	121,499	4.3%
7	Diabetes mellitus	87,647	3.1%
8	Kidney disease	51,565	1.8%
9	Influenza/pneumonia	49,783	1.7%
10	Intentional self harm (Suicide)	47,511	1.7%

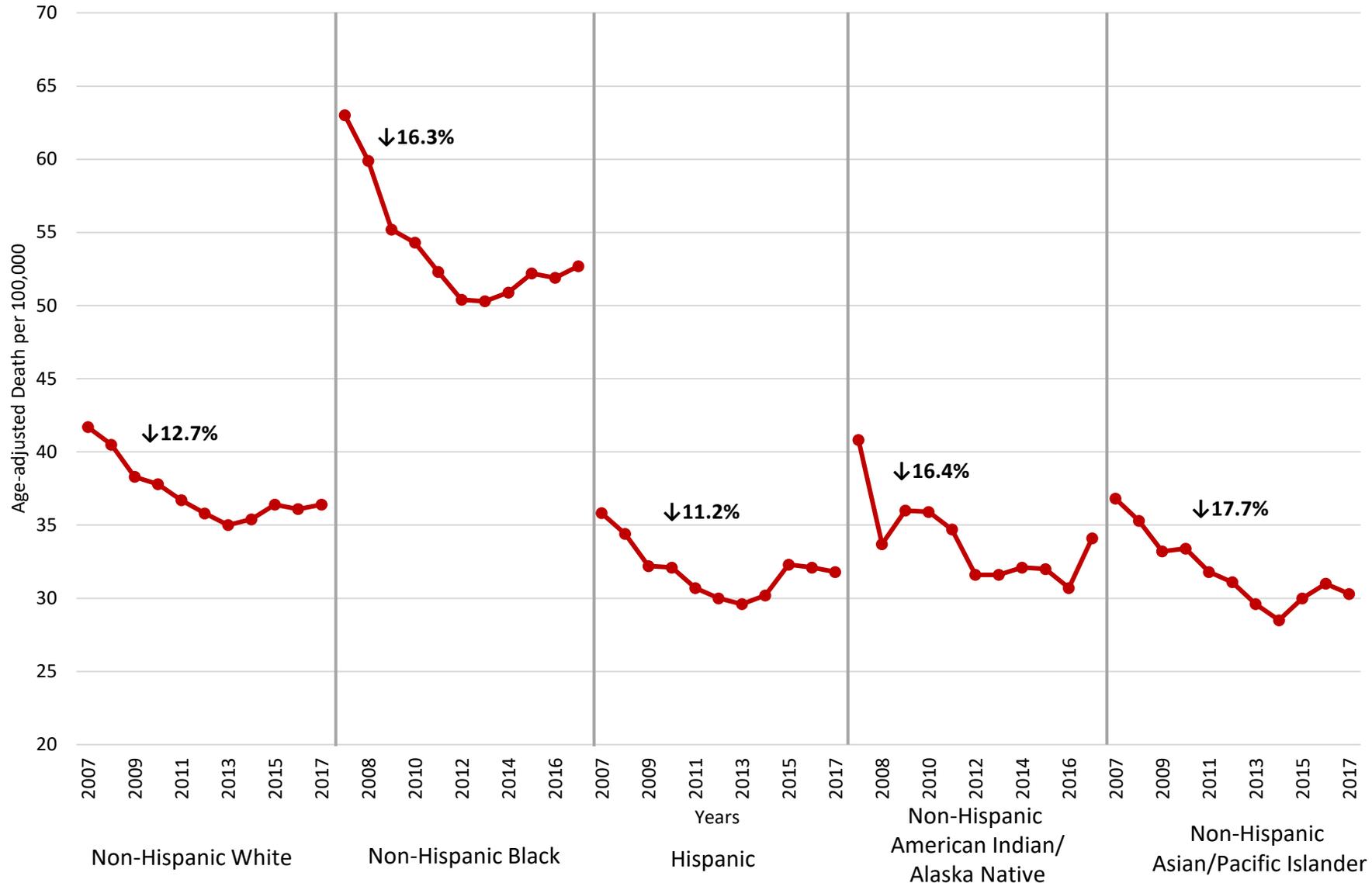




Age-Adjusted Total CVD Mortality Rates 2007-2017 by Race and Ethnicity



Age-Adjusted Stroke Mortality Rates 2007-2017 by Race and Ethnicity



Hypertension Control among Adults in the United States (2017-2018)

Characteristic	Prevalence
Overall	43.7%
Female/Male	48.5%/45%
Non-Hispanic White	48.2%
Non-Hispanic Black	41.5%
Non-Hispanic Asian	41.1%
Hispanic	40.5%
Health Insurance	>40%
No Health Insurance	24.1%
No health care visit in past year	8.0%

Hypertension Control among Adults in the United States (2017-2018)

Characteristic	Prevalence (%)
Less than high school graduation	40.5
High school and some college	46.2
College graduation	48.0
< \$20,000 annual household income	39.4
\$20,000 - \$44,999 annual household income	45.1
\$45,000 - \$74,999 annual household income	49.2
> \$75,000 annual household income	50.2

AHA PRESIDENTIAL ADVISORY

Call to Action: Structural Racism as a Fundamental Driver of Health Disparities

A Presidential Advisory From the American Heart Association

ABSTRACT: Structural racism has been and remains a fundamental cause of persistent health disparities in the United States. The coronavirus disease 2019 (COVID-19) pandemic and the police killings of George Floyd, Breonna Taylor, and multiple others have been reminders that structural racism persists and restricts the opportunities for long, healthy lives of Black Americans and other historically disenfranchised groups. The American Heart Association has previously published statements addressing cardiovascular and cerebrovascular risk and disparities among racial and ethnic groups in the United States, but these statements have not adequately recognized structural racism as a fundamental cause of poor health and disparities in cardiovascular disease. This presidential advisory reviews the historical context, current state, and potential solutions to address structural racism in our country. Several principles emerge from our review: racism persists; racism is experienced; and the task of dismantling racism must belong to all of society. It cannot be accomplished by affected individuals alone. The path forward requires our commitment to transforming the conditions of historically marginalized communities, improving the quality of housing and neighborhood environments of these populations, advocating for policies that eliminate inequities in access to economic opportunities, quality education, and health care, and enhancing allyship among racial and ethnic groups. Future research on racism must be accelerated and should investigate the joint effects of multiple domains of racism (structural, interpersonal, cultural, anti-Black). The American Heart Association must look internally to correct its own shortcomings and advance antiracist policies and practices regarding science, public and professional education, and advocacy. With this advisory, the American Heart Association declares its unequivocal support of antiracist principles.

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On behalf of the
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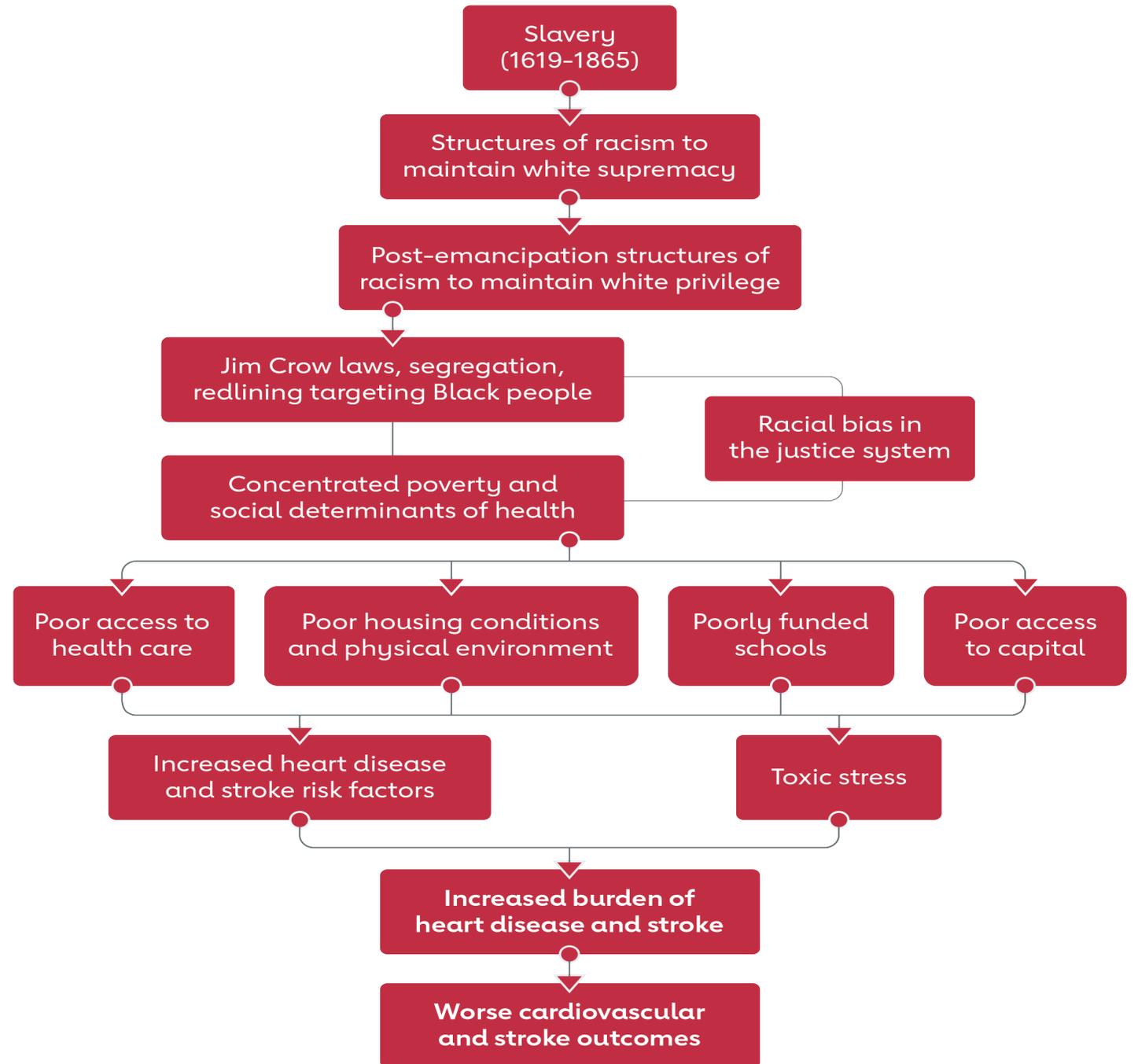
Abstract Summary

The American Heart Association is committed to go beyond words and help accelerate social equity by declaring racism as a major cause of poor health and premature death.

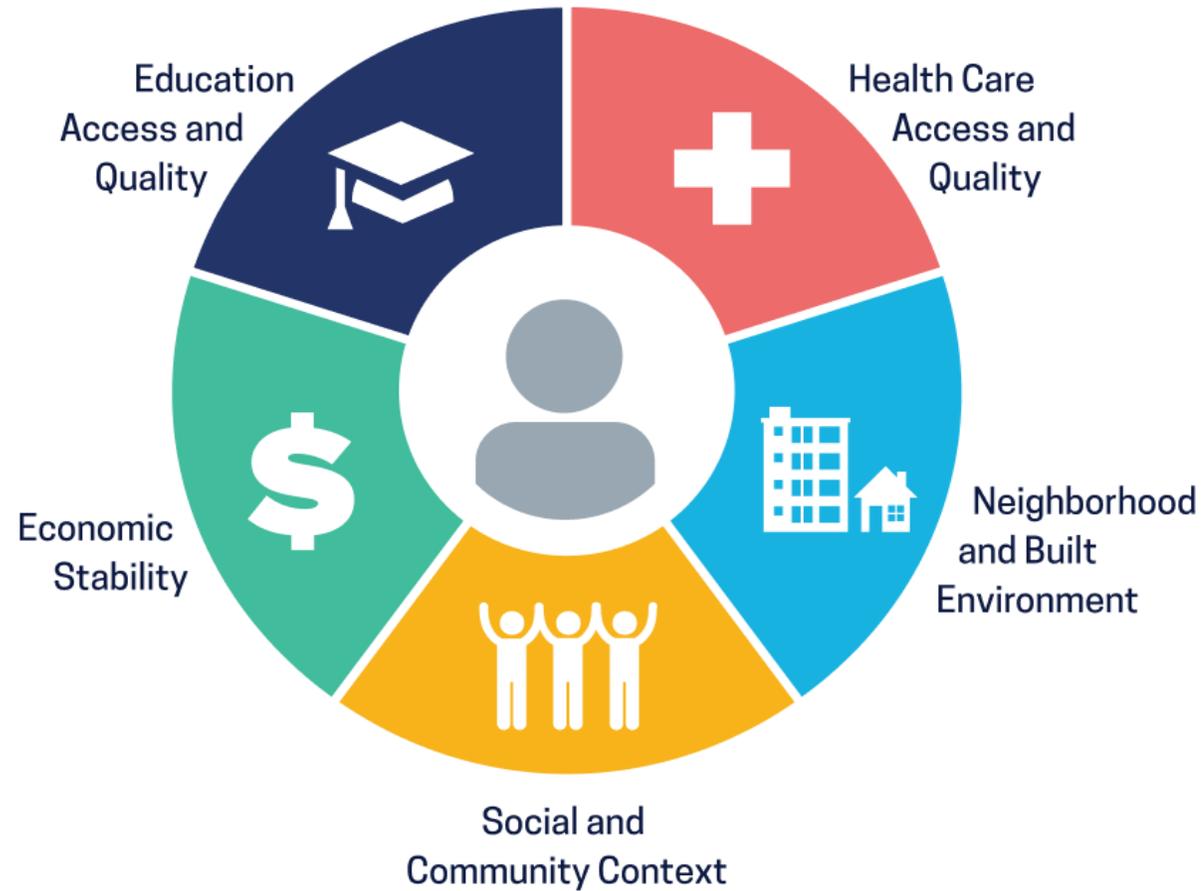
- Structural racism contributes significantly to the disproportionate burden of cardiovascular risk factors (including high blood pressure, obesity and type 2 diabetes) in Black, Asian, American Indian/Alaska Native, and Hispanic/Latino people compared with white people in the U.S.
- Structural racism is manifest in current systems and laws related to housing, education, criminal justice, health and healthcare and economic opportunities. These systems and laws have a negative effect on people of color based on their race.
- Structural racism is a significant impediment to the American Heart Association's goal to equitably achieve cardiovascular health for all people.

Historical Context

Linking Anti-Black Racism to Poor Health Outcomes



Social Determinants of Health



How Does Structural Racism Impact Health?

Leads to a set of **historically-influenced**, persistent (**maintained**), structures **across an array of systems** (educational, housing, healthcare, economic) that result in unequal access to opportunities for social and economic advancement resulting in a complex interplay between social determinants of health, race, and health outcomes.



CASE STUDY

CASE STUDY

- Mr. JB is a 58 year-old gentleman employed as a mechanic with a history of high blood pressure.
- He is taken to the local hospital by a coworker after complaining of mild right arm and leg weakness and slurred speech. The "stroke alert" is not activated, but instead, a neurologist is called in to evaluate him. By the time he is evaluated, he cannot be treated with tPA and is admitted for evaluation.

CASE STUDY

- His workup demonstrates atrial fibrillation as the cause of his stroke. He is discharged home after 2-3 days with a walker. He does not have medical insurance for inpatient rehabilitation.
- He is instructed to go to the local community clinic for outpatient treatment and to obtain a primary care doctor to initiate anticoagulation therapy.

CASE STUDY

- At a clinic visit two weeks later, the provider reviews his medical record and recommends initiation of anticoagulation. He is given a prescription for a direct oral anticoagulant and told to follow-up in 3 months for continued care.
- When he goes to pick up the medication, he realizes that it costs \$300. He pays for a one month prescription.
- He cannot afford to pay for physical therapy. His strength does not improve, and he is not able to return to work.

CASE STUDY

- He moves in with his brother. He cannot afford to go to the doctor or pay for his medications, so he stops the DOAC and starts taking aspirin.
- Within the year, he is admitted with a recurrent ischemic stroke that leaves him paralyzed and completely dependent on care. His medical record states “recurrent stroke due to non-compliance with anticoagulant medications.” He is discharged to a nursing home.

Consider the factors that
contributed to the poor outcome
for Mr. JB

CASE STUDY

- Social determinants of health have a major impact on the development of cardiovascular disease and disease outcomes.
- Structural racism contributes to the distribution of social determinants that adversely impact historically marginalized communities and contribute to health disparities.
- In order to achieve health equity, structural racism and the resulting inequities must be addressed.



Structural Racism Presidential Advisory

Key Areas to Address

- Transform historically marginalized communities by restructuring systems to improve conditions that affect health in workplaces, neighborhoods and schools.
- Implement policies to improve the quality of education, housing and neighborhoods, especially in residentially segregated areas.
- Eliminate inequities in access to and quality of health care.



Structural Racism Presidential Advisory

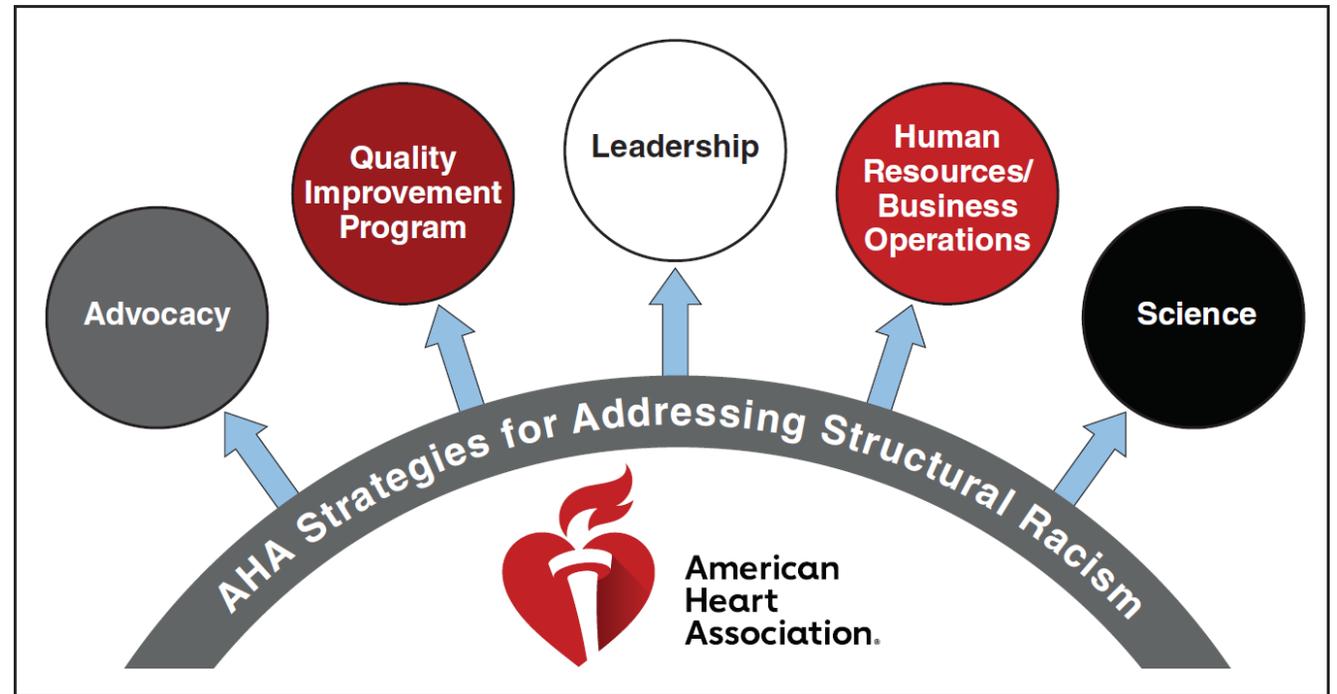
Key Areas to Address

- Foster allyship between racial and ethnic groups to transform changes in individual cultural attitudes, garner political support for change and grow public empathy that change needs to occur.
- Support research on racism to investigate the joint effects of multiple domains of racism (structural, interpersonal, cultural and anti-Black) and their effects on health outcomes and health disparities.

AHA/ASA Focus Areas

External Focuses

- Science
- Quality Improvement Programs
- Business Operations
 - ✓ Increase contracts with historically underserved businesses
- Advocacy
 - ✓ Expand Medicaid



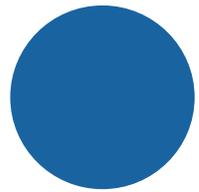
Thank You

Practical Steps To Implementing Change: A Call to Action

Paul C. Walker, PharmD, FASHP

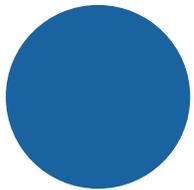
Clinical Professor and Assistant Dean of Experiential Education
The University of Michigan College of Pharmacy
Chair, ASHP Task Force on Racial Diversity, Equity and Inclusion

“Be the Change You Wish to See”



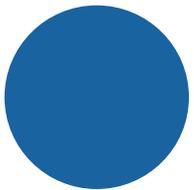
Educate ourselves about health disparities and SDOH*

- Apply what we know/learn to patient care



Identify our unconscious (implicit) biases

- Work consciously and deliberately to reduce their impact



Personal Advocacy

- Policies that address health disparities and promote health equity

**SDOH = Social Determinants of Health*

Area	AHA Call To Action ¹	ASHP Task Force Recommendations ²
Governance and committees	<ul style="list-style-type: none"> • Examine how to <i>leverage volunteer membership to recruit and develop members from underrepresented racial and ethnic groups</i>, with the goal of enhancing diversity and broadening perspectives within leadership positions and roles. 	<ul style="list-style-type: none"> • <i>Change its bylaws</i> for approval by the ASHP House of Delegates in 2021 to <i>make all active members of ASHP eligible to serve on the ASHP Committee on Nominations</i>.
		<ul style="list-style-type: none"> • <i>Appoint more racially diverse Committee on Nominations and ASHP Membership Sections Committee on Nominations</i>.
		<ul style="list-style-type: none"> • Identify and implement ways to increase the racial diversity, including Black, Indigenous, and People of Color (BIPOC), in all committee appointments.
		<ul style="list-style-type: none"> • Identify and implement ways to <i>increase the presence of Black, Indigenous, and People of Color (BIPOC)</i>, including those who practice in diverse or smaller institutions, <i>in ASHP awards and other member recognition programs</i>.
		<ul style="list-style-type: none"> • Seek ways to help ASHP state affiliates prioritize and align their diversity, equity, and inclusion efforts with those of ASHP, with the goal of increasing BIPOC in hospital and health-system pharmacy at the state and local levels. • <i>Encourage its members to continue to recruit BIPOC candidates for all positions, including leadership positions, in hospitals and health-systems</i>.

¹Call to Action: Structural racism as a fundamental driver of health disparities. *Circulation*. 2020; 142:e454-e468. ²Recommendations of the ASHP Task Force on Racial Diversity, Equity, and Inclusion

Area

AHA Call To Action¹

ASHP Task Force Recommendations²

Education and Training

- Provide consistent education and training of AHA staff

- Encourage *colleges of pharmacy* and *accredited residency programs* to provide ongoing education to appreciate diversity of the populations we serve and the value of cultural competence in improving health outcomes of underrepresented minorities.
- The ASHP *residency accreditation guidance and standards* should include specific language that encourages ongoing education and training to reduce implicit bias to help accredited residency programs assess and enhance racial diversity and foster a more inclusive environment.
- identify opportunities and implement efforts to *encourage ASHP-accredited residency programs to encourage increased numbers of applications from Black, Indigenous, and People of Color (BIPOC) pharmacy students.*
- ASHP should *provide guidance on how to reduce bias in residency application screening tools* and should encourage residency programs to update their recruitment processes to include more BIPOC candidates.
- Increase and refine its efforts to collect demographic data to understand specific disparities between pharmacy residency applicants and positions granted.
- Refine the current student and practitioner *mentorship program* and *ensure BIPOC students and practitioners have equal access to mentors* that can guide them on obtaining a residency or a career in hospital and health-system pharmacy.

¹Call to Action: Structural racism as a fundamental driver of health disparities. *Circulation*. 2020; 142:e454-e468. ²Recommendations of the ASHP Task Force on Racial Diversity, Equity, and Inclusion

Area

AHA Call To Action¹

ASHP Task Force Recommendations²

Research

- Build an antiracism research agenda
 - Seek to study interventions that can mitigate or eliminate the adverse health effects of structural racism
 - Seek to understand ways in which structural racism can be eliminated as a fundamental cause of disease.
 - Insist on both inclusion of diversity in clinical trial recruitment and inclusivity in patient engagement in research design.
 - Ensure diversity and inclusiveness of investigators funded by the AHA;
 - Support more early and midcareer investigators from historically marginalized groups.

- Collect data to understand specific disparities among ASHP Foundation research grant applicants, recipients, and the grantees' institutions.
- Partner with schools and colleges of pharmacy with a high enrollment of Black, Indigenous, and People of Color (BIPOC) students and healthcare organizations that serve BIPOC communities to study issues surrounding BIPOC pharmacists and their impact on healthcare and patient outcomes, including whether healthcare outcomes of BIPOC patients are improved by care by a BIPOC pharmacist, the effects of institutional and systemic racism on social determinants of health, and trust among BIPOC communities regarding aspects of healthcare.

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Next Steps

- Make a personal commitment to *“Be the change you wish to see!”*
- Work individually and within your organizations to *“advance the science to understand structural racism and its effects on health, how to eliminate its adverse consequences, and how to offer concrete, science-informed solutions, and actionable steps and programs to improve health and well-being, to achieve equitable health for all.”*¹



Call
to
Action

¹*Call to Action: Structural racism as a fundamental driver of health disparities. Circulation. 2020; 142:e454-e468.*

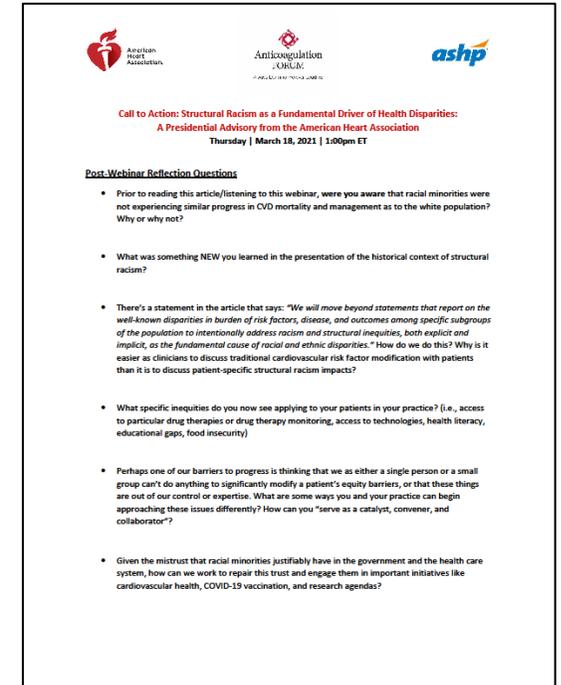
Post-Webinar Discussion Questions

Visit our website to download the post-webinar discussion questions and continue the conversation

- *What was something new you learned in the presentation of the historical context of structural racism?*
- *Why is it easier as clinicians to discuss traditional cardiovascular risk factor modification with patients than it is to discuss patient-specific structural racism impacts?*
- *What specific inequities do you now see applying to your patients in your practice?*

and more...

<https://www.surveymonkey.com/r/ACFIDEA>



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Webinar Series – Structural Racism & Health Disparities

Continuing the Conversation

**Part 1: Call to Action: Structural Racism as a Fundamental Driver of Health Disparities:
A Presidential Advisory from the American Heart Association**

March 2021

Part 2: Patient Stories – Experiencing Racism in Health Care

June 2021

Part 3: How I Got Here – Clinicians’ Journeys Experiencing Racism

August 2021

Part 4: Implementing Changes – Ways we are Addressing Health Disparities in Practice

October 2021



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How to Claim Credit



- 1) Go to: <http://acf.cmecertificateonline.com/>
- 2) Select **“Structural Racism as a Fundamental Driver of Health Disparities”**
Evaluate the program
- 3) Print certificate for your records

This program is accredited for Providers, Pharmacists, and Nurses for 1.0 hours

Claim Credit:
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AC Forum IDEA Committee

Inclusion, Diversity, Equity, and Allyship (IDEA) Committee

Goals

- Engage in active anti-racist efforts that will create meaningful change
- Be intentional about diversity in AC Forum leadership, membership, and programming
- Expand access to opportunities for Black and other clinicians of color in anticoagulation and related fields
- Increase awareness of structural racism and its impacts on health inequities/disparities

By working together with partners and allies, we can expand our reach and increase our impact

Learn more at <https://acforum.org/web/education-idea.php>



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AC Forum IDEA Scholarships

Abstract Research Award and Conference Scholarship

- Complementary registration to National Conference (minimum \$345 value)
- Travel stipend of \$1500

Boot Camp Scholarship

- Complementary registration to virtual Boot Camp (\$249 value)

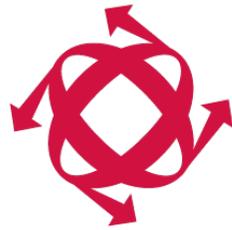
Eligibility:

- Applicants must be clinicians from underrepresented racial and ethnic groups within the field of antithrombotic therapy

OR

- A clinician conducting research on racial health disparities (Abstract Research Award)





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