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September 24, 2020

The Honorable Richard E. Neal  
Chairman  
Committee on Ways and Means  
U.S. House of Representatives  
Washington, DC 20515

Dear Chairman Neal:

Thank you for your leadership in elevating racial equity as a priority in the delivery of health care nationwide. We welcome your interest in learning more about our commitment and efforts in this critical area, and we look forward to continuing this conversation with you and your committee.

As a nearly 100-year-old organization devoted to public health that serves as a relentless force for a world of longer, healthier lives, the American Heart Association has long advocated for racial equity in the medical profession and throughout the health care system. While much progress has been achieved through our science and programs, much more remains to be done. We are committed to continually adding to, analyzing and applying the latest and best scientific evidence to achieve our shared goal of ensuring equitable health care as an essential cornerstone of a truly equitable society. Toward that end, we work to strengthen the public health infrastructure to effectively engage diverse stakeholders, prioritize transparency and employ a diverse workforce with cultural and linguistic competency necessary to serve all U.S. populations.

The medical community has long recognized that disparities in treatment and care leave Black, Hispanic/Latino and Native American communities at greater risk for cardiovascular disease and other life-threatening conditions. Importantly, scientific research has found that race, a socially constructed term, is not itself a risk factor for heart disease. A [study](#) presented at the American Heart Association's Epidemiology and Prevention | Lifestyle and Cardiometabolic Health Scientific Sessions in March found that heart disease risk differs among African Americans,

Black people from the Caribbean and African immigrants – with African Americans having a higher level of cardiovascular risk than the others. These findings, and many others, support the widely accepted conclusion that systemic inequities in income, housing, food security, access to health care and other social determinants of health threaten historically under-resourced communities throughout our nation<sup>1</sup>.

Health equity, diversity and inclusion are foundational to the American Heart Association's mission and are relentlessly pursued by staff, volunteers and partners throughout the United States and around the world. Our signature quality improvement program, [Get With The Guidelines®](#), empowers medical professionals to apply the most up-to-date, evidence-based treatment guidelines to improve clinical care and health outcomes for all patients. Our [Get With The Guidelines® - Heart Failure](#) program engages a broad spectrum of hospitals across the country to ensure we reach and impact diverse patient populations. The result is a robust, nationally representative clinical registry data set that is improving awareness and understanding of disparities in care.

The Get With The Guidelines® - Heart Failure risk score, which you queried us about in your Sept. 3 letter, was developed, validated and published more than a decade ago to predict in-hospital mortality in patients with heart failure, using the best statistical and analytical approaches in place at the time. The risk model was based on clinical literature and derived from more than 20 patient variables. The data include a patient's medical history, vital signs and laboratory results collected upon admission to a hospital. The demographic variables include a patient's age, sex and self-identified race/ethnicity. It is important to note that while race was included as a variable in the publication, Get With The Guidelines® clinical thought leaders elected not to include race in the model programmed into the registry. Thus, race is not included in the heart failure risk score used by hospitals in Get With The Guidelines® - Heart Failure.

The risk score was intended to serve as a tool to inform clinicians about a patient's mortality risk during hospitalization for heart failure. The goal was to facilitate patient-centered considerations and discussions about the best course of care considering social determinants of health and other important factors. By numerous measures, Get With The Guidelines® - Heart Failure has achieved that goal. Over the past decade, the program has been shown to demonstrably improve quality and outcomes for patients, and to reduce or eliminate disparities by race and ethnicity in care quality<sup>2</sup>. Among the proven results are

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<sup>1</sup> Warner, JJ., Benjamin, IJ., Churchwell, K., Firestone, G., Gardner, TJ., Johnson, JC. Ng-Osorio, J., Rodriguez, C.J., Todman, L., Yaffe, K., Yancy, C>, Harrington, RA., Advancing healthcare reform: The American Heart Association's 2020 principles for adequate, accessible, and affordable healthcare: A presidential advisory from the American Heart Association. *Circulation*. 141(10): e601-e614.

<sup>2</sup> Al-Khatib, SM., Hellkamp, AS., Hernandez, AF., Fonarow, GC., Thomas, KL., Al-Khalidi, HR., Heidenreich, PA., Hammill, S., Yancy, C., Peterson, ED., Trends in use of implantable cardioverter-defibrillator therapy among patients hospitalized for heart failure: have the previously observed sex and racial disparities changed over time? *Circulation*. 2012. 125(9): 1094-1101.

reductions in 30-day readmissions, a measure now used by the Centers for Medicare and Medicaid Services to determine provider reimbursement rates.

We are enormously proud of these results, but success has never interrupted our drive for continuous improvement. Since the Get With The Guidelines® - Heart Failure algorithm was first developed in 2009, clinicians and scientists have identified variables other than race that better define in-hospital risk – including ZIP code, income and other social determinants of health. Recognizing these advancements, in early 2019 the American Heart Association began the methodical process of adding elements to improve hospitals' understanding of the social needs of their patient populations, and how those needs may relate to health outcomes. More recently, we convened a team of experts to reexamine and revise the Get With The Guidelines® - Heart Failure risk score. This process draws upon new research, science and global clinical data to ensure the algorithm incorporates variables and patient characteristics widely recognized as the most current, relevant and accurate indicators of in-hospital risk.

The American Heart Association's longstanding commitment to addressing racial equity extends beyond Get With The Guidelines® to include all of our policies, programs and initiatives. This commitment is deeply rooted in our history of funding research and translating scientific discoveries into clinical care improvements that benefit patients. In our nearly century-long history, we have invested more than \$4.5 billion in cardiovascular research – more than any U.S. nonprofit organization and second only to the U.S. government. We require funded research grants involving human-subject studies to include under-represented racial and ethnic groups and women. We also [invest in researchers who are adding to the diversity of the scientific community](#). In addition, our 16 scientific councils each include volunteer leaders who ensure diversity, equity and inclusion are at the forefront of our scientific endeavors.

We are also making enormous strides in addressing equity at the community level through social impact. Our impact investment efforts, which include the [Bernard J. Tyson Impact Fund](#), named in honor of the late chairman and CEO of Kaiser Permanente who served as an American Heart Association national board member, raise private funding to invest in evidence-based, innovative and inclusive local solutions that are breaking down social and economic barriers to health equity in communities across the country. To date, our impact funds have invested a total of \$4.6 million and driven \$16 million in new funding for 33 community organizations creating health equity. An additional five investments will be announced by December. Our [EmPOWERED to Serve Business Accelerator™](#) addresses health disparities by empowering social entrepreneurs to build partnerships that promote community-centered solutions to help people and families overcome poverty and improve long-term health.

Our multi-faceted response to the COVID-19 pandemic is anchored by a focus on populations that, because of endemic inequities including lower income,

lower levels of education, use of public transportation, difficult housing situations, “essential” jobs, lower quality environments, decreased availability of health care and lower likelihood of health insurance, have experienced a devastating and disproportionate impact of the novel coronavirus. We fast-tracked a multi-million-dollar fund for [rapid-response scientific research projects](#) on the cardiovascular implications of the coronavirus. Funded grants include those focused on the cardiovascular effects of COVID-19 on Black women. We also created a national [COVID-19 CVD Registry](#) that captures data on clinical characteristics, medications, treatments, biomarkers and outcomes for adult COVID-19 patients at more than 150 participating hospitals and health systems across the country. Approximately 50 percent of the registry are Black or Hispanic/Latino patients, making the registry representative of communities disproportionately affected by the pandemic. At the same time, we have spoken out forcefully and unequivocally against [incidents of police brutality and racial violence](#). In response to concerns among consumers, including Black and Hispanic/Latino communities, about going to the hospital during the pandemic when experiencing a heart attack or stroke, we launched [Don't Die of Doubt](#), a national public awareness campaign to dispel fears and myths about calling 9-1-1.

The American Heart Association’s public policy work profoundly reflects our commitment to racial equity. Whether working to improve access to quality health care, prevent tobacco and nicotine use, fund cardiovascular disease research and prevention programs, or pass policies that encourage healthy eating and active living, we support federal, state and local policies that address systemic racial and economic inequities in our country. We are fortunate to have worked with you and members of your committee on these and other shared priorities.

Thank you again for the opportunity to provide this important information. We look forward to answering any additional questions you may have, and we would welcome the opportunity to further discuss our ongoing work to enhance Get With The Guidelines® and address health equity and disparities in care. Please feel free to contact Emily Holubowich, our Vice President of Federal Advocacy, who could arrange follow-up conversations about our relentless pursuit of longer, healthier lives for everyone, everywhere. Emily can be reached at [emily.holubowich@heart.org](mailto:emily.holubowich@heart.org).

Sincerely,



Nancy Brown  
CEO, American Heart Association



Mitchell Elkind, MD, FAHA  
President, American Heart Association