Wide-ranging strategies needed to eliminate racial and ethnic inequities in stroke care, say researchers

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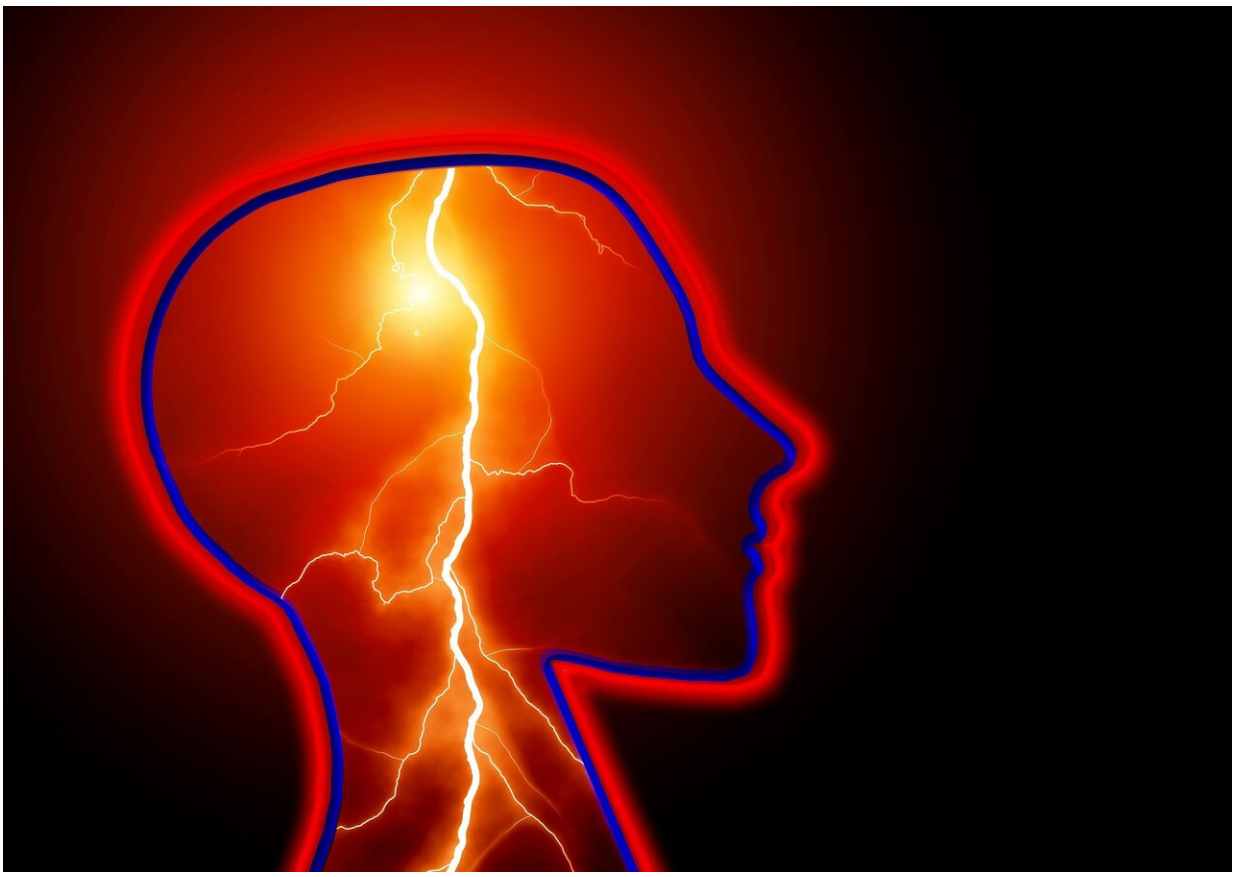

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"Upstream" causes of health inequities related to stroke, such as

structural racism and structural conditions of the places where people live, learn, work and play, have not been studied well, according to a new American Heart Association scientific statement.

The statement, published today in *Stroke*, reviews the most recent research on racial and ethnic inequities in stroke care and outcomes; as well as identifies gaps in knowledge and areas for future research.

"There are enormous inequities in stroke care, which lead to significant gaps in functional outcomes after stroke for people from historically disenfranchised racial and ethnic groups, including Black, Hispanic and Indigenous peoples," said Amytis Towfighi, M.D., FAHA, chair of the scientific statement's writing group. "While research has historically focused on describing these inequities, it is critical to develop and test interventions to address them."

Stroke disproportionately affects historically disenfranchised communities, yet the disproportionate risk among these communities is not well understood. Historically disenfranchised populations are vastly underrepresented in stroke clinical trials, which contributes to the lack of understanding and reduces the generalizability of research findings, which in turn exacerbates inequities that lead to poorer outcomes, according to the statement.

To reduce the lasting effects of a stroke caused by a blood clot—the most common type of stroke—medication to dissolve the clot should be administered within three hours (or up to four-and-a-half hours in some people) after symptoms begin. Mechanical removal of the clot (also called endovascular therapy) may be safe for some people up to 24 hours after stroke symptoms start. However, not all people experiencing a stroke have rapid access to these treatments.

"Time is vital for stroke treatment, however, people from historically

disenfranchised populations are less likely to get to an emergency room within the time window for acute intervention," Towfighi said.

"Although Black people are more likely to participate in a post-stroke rehabilitation program, research indicates they are more likely to have poor functional outcomes. In addition, there are persistent racial and ethnic inequities in post-stroke risk factor control, and studies specifically addressing these inequities have not found the optimal method to mitigate the disparities."

Most studies reviewed addressed individual, patient-level factors, such as health literacy, stroke preparedness, medication adherence and lifestyle behaviors.

Few addressed upstream factors, such as structural racism (including racist policies that led to residential segregation) or environmental factors, often referred to as social determinants of health, such as community deprivation; economic stability; health insurance; housing; neighborhood walkability and safety; the availability and affordability of healthy food options; education quality; and employment, the authors noted.

"Combating the effects of systemic racism will involve upstream interventions, including policy changes, place-based interventions and engaging with the health care systems that serve predominantly historically disenfranchised populations and the communities they serve, understanding the barriers, and collaboratively developing solutions to address barriers," according to the statement.

A 2020 American Heart Association presidential advisory, "Call to Action: Structural Racism as a Fundamental Driver of Health Disparities," declared structural racism as a major cause for poor health and premature death from heart disease and stroke for many and detailed the

Association's immediate and ongoing actions to accelerate social equity in health care and outcomes for all people.

Previous studies indicate that careful attention to stroke preparedness among patients, caregivers and emergency medical personnel may reduce inequities in getting people suspected of having a stroke to the emergency room quickly and prompt treatment.

However, there has not been sufficient attention on reducing inequities in rehabilitation, recovery and social reintegration, which includes information such as assessing the impact of neighborhood/city-level interventions like improved sidewalks, and access to physical, occupational and speech therapy, according to the statement.

The statement acknowledges that racial and ethnic identity are complex, and race is a social construct, rather than a biological one. In addition, research has often oversimplified and/or misclassified race. For example, in the U.S., ethnicity has been long categorized as Hispanic or non-Hispanic, which arbitrarily combines the myriad of ethnicities into only two categories.

Native Hawaiians and Pacific Islanders are frequently grouped together with Asian Americans, ignoring the disproportionate impact of stroke within Indigenous communities.

"In our review, we used the race and ethnicity categories typically supported by governmental research funding agencies that drive how data are collected. However, we are cognizant that these categories are inadequate to describe the nuances of lived experiences and to fully illuminate inequities that are entrenched in societal structures including health care," said Bernadette Boden-Albala, Dr.P.H., M.P.H., vice chair of the statement writing group.

Further research is needed across the stroke continuum of care to tackle racial and ethnic inequities in stroke care and improve outcomes.

"It's critical for historically disenfranchised communities to participate in research so that researchers may collaborate in addressing the communities' needs and concerns," Boden-Albala said. "Opportunities include working with community stakeholder groups and community organizations to advocate for partnerships with hospitals, academic medical centers, local colleges and universities; or joining community advisory boards and volunteering with the American Heart Association."

"Health care professionals will need to think outside the 'stroke box;' sustainable, effective interventions to address inequities will likely require collaboration with patients, their communities, policy makers and other sectors," Towfighi added.

More information: Amytis Towfighi et al, Strategies to Reduce Racial and Ethnic Inequities in Stroke Preparedness, Care, Recovery, and Risk Factor Control: A Scientific Statement From the American Heart Association, *Stroke* (2023). DOI: 10.1161/STR.0000000000000437

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