Good morning, everyone, and thank you, Dr. Holter-Chakrabarty, for that kind introduction. I am delighted to be here.

I am particularly delighted because our conversation gives me the opportunity to thank you ... the members of the American Society of Hematology ... for your years of steadfast partnership with CDC.

When we needed to offer a public health workshop on hospital-acquired venous thromboembolism, which partner did our Division of Blood Disorders call on? Our colleagues at ASH.

When data were showing that the Johnson & Johnson COVID vaccine might be associated with rare cases of VTE, who did we turn to for help in understanding the data? Again, our colleagues at ASH.

As CDC works to reduce maternal mortality both in the United States and around the world, your advocacy for those living with sickle cell disease is making a difference .... going beyond providing health care ... going right to addressing the racism that likely plays a part in this staggering fact: compared with healthy pregnant women, someone with sickle cell disease is 10 times more likely to die during, or following, pregnancy ... and these women with sickle cell disease have an increased risk for stillbirth, high blood pressure, and preterm delivery.

Indeed, for every blood disorder CDC addresses .... hemophilia, hereditary hemorrhagic telangiectasia, sickle cell disease, thalassemia, Von Willebrand disorder, and VTE .... ASH is there as our invaluable partner.

When I received the invitation to speak today, I was asked to focus on the important role hematologists can play in addressing health disparities and racism as a threat to our nation’s health.

I would start by saying ASH is already in the forefront of these efforts.
Your commitment to diversity, equity, and inclusion in health care has been shared for the world to see.

You have published reflections on the anti-Semitism, homophobia, and violence directed against individuals in the hematology community ... former ASH president Dr. Stephanie Lee issued a June 2020 message on dismantling disparities, reminding all that ASH’s Committee on Promoting Diversity has been working to support scientists from backgrounds underrepresented in medicine for almost two decades.

Just this past May, current president Dr. Martin Tallman published a letter to the editor in the New York Times stating unequivocally that “the use of sickle cell trait to cover up the deaths of Black people while in police custody is abhorrent and has no scientific or medical merit.”

And ... I could not agree more.

And the letter published in the Atlanta Journal-Constitution this August ... cosigned by ASH with 16 other medical associations ... highlighted how Georgia’s newly passed voting law would disproportionately affect people of color.

With such strong statements, policy recommendations, and other advocacy positions ... from physicians and pharmacists like yourselves ... and with such clear values ... ASH is out in front on these issues.

And here we are here today for the luncheon as part of the ASH Grassroots Network, each of you advocating for equity and access to quality health care.

I am delighted to add my voice to this conversation and suggest we consider these four actions for addressing health disparities and racism: recognize, educate, advocate, and listen.

Recognize instances where structural or interpersonal racism exists in the healthcare setting and decide you will take steps to combat it.

Educate yourself, colleagues, and the institutions you work with about the specialized needs of people with blood disorders including how racism is a barrier to better health.
Advocate for your patients by representing their interests and sharing resources with them to access care.

And ... listen to your patients to better understand their needs and desires as you support them on their journey to better health.

Let me expand a bit on that last point .... listening.

I think listening is one of the most important things we can do for our patients ... especially for those who are underserved and those who may not always access or receive care. As clinicians, we must strive to understand the lived experiences of others and the obstacles they face. Truly ... listening is never a waste of time.

By listening, we learn what our patients value .... where they come from .... and what they dream. We learn their stories and the barriers that have stood in their way.

We cannot treat them or address their concerns unless we first ... listen. I learned this lesson at my patients’ bedsides .... I suspect this rings true for you as well.

Before we get to your questions, let me highlight some of the work CDC is doing to address health inequities in sickle cell disease and bleeding and clotting disorders through our Division of Blood Disorders. And touch on ways you can help.

For the first time, CDC has a small, dedicated funding line for the Sickle Cell Data Collection program, currently active in 11 states. Administrative and clinical data sources include state Medicaid and Children’s Health Insurance Program databases, death certificates, newborn screening programs, hospital discharge and emergency department medical records, and clinical records or case reports ... and we will expand to more states as resources become available.

In these same states, we are developing county-level maps on the 15 items in CDC/ATSDR’s social vulnerability index. This new project will add important ... and novel ... data on socioeconomic status,
household composition and disability status, minority and language status, and housing type and transportation status ... providing us with evidence for policies that can reduce and improve those stresses ... those social determinants of health ... and in turn improve the health and health outcomes of people living with sickle cell disease.

While hematologists understand sickle cell disease and its manifestations, we recognize that people living with sickle cell disease often find themselves seeking care in a hospital emergency room where their condition is poorly understood. Our Division of Blood Disorders developed a fact sheet for healthcare providers ... "The 3 Tips About Sickle Cell Disease Every Emergency Provider Needs to Know" ... addressing barriers patients report facing when they seek treatment in emergency rooms and explaining the necessity for prompt treatment for pain. I hope you have seen the fact sheet and I encourage you to share it in your communities.

For people living with bleeding disorders, we are establishing national reporting of disability status and gender identity. Having these data will help identify health status and service needs, promote early identification of disability and gender identity, and reduce stigma.

While this information will be valuable in understanding people with all types of bleeding disorders, gender identity and its intersection with clinical care for bleeding disorders is particularly important for people with X-linked bleeding disorders, such as hemophilia.

This is some of what CDC is doing. So, what can you do to help?

You are doing much of it already. In our hospitals and practices we can:

**Treat all patients with respect and dignity** .... meeting their needs through accurate diagnosis ... with providers listening to patients and understanding that risk factors may vary by race.

**Develop formal, hospital-based reporting systems**, similar to those for safety events and quality improvement, to document and respond to racist behavior.

**Include patients with sickle cell disease, or their advocates, on antiracism task forces.**
Institute sickle cell disease-specific pain-management protocols to reduce the time to opiate administration and to improve health outcomes.

Provide the means for patients with sickle cell disease to safely report concerns about racism or inequity.

Develop partnerships with patients and recognize their ability to educate providers about the impact of race and racism on their healthcare experiences.

Provide psychosocial support for patients including the services of social workers, patient navigators, psychologists, and community health workers.

Practice mindfulness and self-reflection in the care of patients with sickle cell disease, recognizing that everyone has biases.

Listen to understand the lived experience of marginalized and minority populations and engage in active partnership with communities of color, being aware of cultural sensitivities.

Implement mandatory racial implicit bias training for all clinicians ... in a supportive environment.

Use language appropriately and teach others to do the same, no longer using words like “sickler” or other demeaning terms to describe patients.

Pursue training programs to increase knowledge and competence about the use of evidence-based guidelines for the treatment of diseases among minority populations.

And address interpersonal racism by speaking explicitly about race within and across medical teams and creating safe spaces for all healthcare workers to discuss race and racism and to report events when they happen.
In research, we can:

**Reflect on how racism manifests in the research settings**, analyzing the effect of race and racism on funding for disease research.

**Conduct research and surveillance to learn about risk factors in populations that have been traditionally underrepresented** in research studies ... including, for example for VTE, women, racial and ethnic minorities, and transgender individuals.

**And we can offer patients information about and access to clinical trials**, when appropriate, during the course of that patient’s treatment. A lack of diversity in clinical trials leads to health inequities in medical research and, ultimately, practice.

I believe ... as does ASH .... that we are at the infection point.

Now is our moment ... long overdue. It took centuries to get here. What we do now ... our collective ... intentional ... work ... can start to undo that history.

Let me stop here so we have time for your questions. There is so much for us to discuss.

I turn the floor back over to you, Dr. Holter-Chakrabarty.