recommended VAD over transplant for all racial/sex groups. Surveys demonstrated similar final recommendations.

Conclusions: Despite identical clinical vignettes, the decision making process varied by patient sex and race. Women patients were judged more harshly by their appearance and adequacy of social support, particularly the African American woman.

Implications for Policy or Practice: Future research should investigate whether objective assessments of social support lead to equity in advanced therapy allocation.

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Patient-Physician Race/Ethnicity Concordance Improves Adherence to Cardiovascular Disease Guidelines

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Research Objective: Studies have found that race/ethnicity concordance between patients and providers improves medication adherence among patients with hypertension and single CVD outcomes (eg, blood pressure control). Our objective was to examine the association of patient-physician race/ethnicity concordance on adherence to the Million Hearts "ABCS" CVD guidelines: (A) aspirin when indicated, (B) blood pressure control, (C) cholesterol management, and (S) smoking screening and cessation. To the best of our knowledge, this is the first study to examine the impact of race/ethnicity concordance on guideline adherence to multiple CVD outcome measures.

Study Design: This study was part of HealthyHearts NYC, a stepped-wedge cluster randomized controlled trial funded through AHRQ's EvidenceNOW initiative to test the effectiveness of practice facilitation on helping primary care practices adhere to CVD guidelines. The main outcomes were the Million Hearts' ABCS measures. Two additional measures were created: (a) proportion of patients who use tobacco who received a cessation intervention (smokers counseled) and (b) a composite measure that assessed the proportion of patients meeting treatment targets for A, B, and C (ABC composite). Practice-level outcome data were extracted for thirteen quarters from practices' electronic health record (EHR) systems, encompassing the control, intervention, and follow-up periods of the intervention. Patient-physician race/ethnicity concordance was calculated using patient race/ethnicity data extracted from the practices' EHR and physician race/ethnicity data collected via a Provider Survey. The concordance measure was calculated as the proportion of patients with the same race/ethnicity as the physician, for example, if practice is led by an Asian physician, and patients are 33% non-Hispanic white, 5% non-Hispanic black, 5% Hispanic, and 57% Asian, the concordance is 0.57.

Population Studied: 211 small primary care practices in NYC.

Principal Findings: 57.7% of Hispanic, 53.6% of black, 73.6% of Asian, 74.2% of non-Hispanic white, and 24.1% of Hawaiian/Pacific Islander patients had the same race/ethnicity as their physicians. 44.7% of physicians had the same race/ethnicity as at least 70% of their patients. Patient-physician race/ethnicity concordance was associated with adherence to four of our six outcome measures: aspirin (IRR = 1.08, 95% CI: 1.03-1.14, $P < .001$); blood pressure (IRR = 1.09, 95% CI: 1.07-1.12, $P < .001$); smoking screening and cessation (IRR = 1.06, 95% CI: 1.04-1.08, $P < .001$); and ABC composite (IRR = 1.42, 95% CI: 1.33-1.52, $P < 0.001$). We did not find an association for race/ethnicity concordance with Cholesterol and Smokers Counseled.

Conclusions: Increasing opportunities for patient-physician race/ethnicity concordance may improve adherence to CVD guidelines. The largest improvement was observed in the ABC Composite measure, suggesting that patient-physician race/ethnicity concordance is particularly important for managing medically complex patients who have multiple chronic diseases.

Implications for Policy or Practice: Health policy should fund programs that support the recruitment and retention of a wide diversity of students and faculty to increase the level of concordance in patient-clinician encounters. Policy makers may also want to consider legislation to help support or protect small practices that predominantly serve communities of color, where a large proportion of the physicians may be racially/ethnically concordant with the patient population. Medical education programs should incorporate patient-physician communication training to minimize gaps potentially created by race/ethnicity discordance.

Primary Funding Source: Agency for Healthcare Research and Quality.

Minimizing Defensiveness in Clinician Education about Implicit Bias: Lessons Learned from a Community-Engaged Randomized Clinical Trial

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Research Objective: Clinicians' implicit bias can affect quality of healthcare delivery and contribute to healthcare disparities. How