NYC Coalition to End Racism in Clinical Algorithms

Michelle Morse, MD, MPH
Chief Medical Officer
Deputy Commissioner, Center for Health Equity and Community Wellness
New York City Department of Health and Mental Hygiene

Agenda

01 Welcome to CERCA – Dr. Michelle Morse

02 Remarks - Prof. Dorothy Roberts | Q&A

03 H+H implementation of eGFR and institutional change – Drs. Nichola Davis & Lou Hart

04 Break

05 Breakout Groups by Algorithms

06 Closing + Next Steps

12 CERCA Pledgees

Mount Sinai

SUNY Downstate Medical Center

Wyckoff Heights Medical Center

SBH Health System Bronx

Maimonides Medical Center

NYU Langone Medical Center

Northwell Health

NewYork-Presbyterian

Montefiore Health System

NYC Health + Hospitals

One Brooklyn Health

Cortelyou Medical Associates

Goals

1. To raise awareness amongst health system partners on how race correction contributes to racial health inequities.

2. To eliminate race correction in at least one clinical algorithm at institutions that have pledged to join the coalition within 2 years of the launch of the coalition.

3. To measure institutional and citywide impacts of eliminating race correction on racial health inequities at coalition.

4. To elevate and communicate the commitments to racial and ethnic health equity of the members of the coalition

5. To avoid the potential impact race correction may have on the provision of timely care and referrals.

Algorithms in Focus

- **Vaginal Birth after Caesarean (VBAC)**
  - "…a 30-year-old woman with a BMI of 35 and one prior cesarean for arrest of labor is assigned a 46% chance of successful VBAC if she is identified as white and a 31% chance if she is identified as African American or Hispanic."[1]

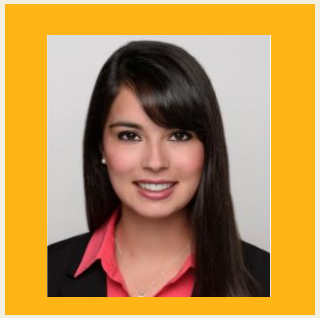
- **Estimated Globular Function Rate (eGFR)**
  - The "correction" factor for Black race calculates level of kidney function for "Black" patients that appear healthier than White patients for the same measured lab result.[2]

- **Pulmonary Function Tests**
  - In recent study evaluating the impact of race correction on PFT, Moffett et al. interpreted over 14,080 PFTs and the removal of race correction resulted in "diagnosis of obstruction for an additional 414 patients", an 1.7% (22.1% to 23.9%) increase of prevalence of obstructive lung disease, "diagnosis of restriction for an additional 665 patients" an 4.7% (8.8% to 13.5%) increase in the prevalence of restrictive lung disease, and there was an increase in any pulmonary defect by 20.8% (59.5% to 81.7%).[3]

1. Zelnick LR, Leca N, Young B, Bansal N. Association of the Estimated Glomerular Filtration Rate With vs Without a Coefficient for Race With Time to Eligibility for Kidney Transplant. *JAMA Netw Open*. 2021;4(1):e2034004. doi:10.1001/jamanetworkopen.2020.340
2. Vyas DA, Jones DS, Meadows AR, Diouf K, Nour NM, Schantz-Dunn J. Challenging the use of race in the vaginal birth after cesarean section calculator. Womens Health Issues 2019;29:201-204.
3. Moffett AT, Eneanya ND, Halpern SD, Weissman GE. The Impact of Race Correction on the Interpretation of Pulmonary Function Testing Among Black Patients. In: A7. A007 IMPACT OF RACE, ETHNICITY, AND SOCIAL DETERMINANTS ON INDIVIDUALS WITH LUNG DISEASES. American Thoracic Society; 2021:A1030-A1030. doi:10.1164/ajrccm-conference.2021.203.1_MeetingAbstracts.A1030

NYC Health

Advisory Council



Arielle Elmaleh-Sachs, MD
Department of General Internal Medicine
Columbia University Medical Center

Duncan Maru, MD, PhD
Assistant Commissioner for the Bureau of Equitable Health Systems at NYCDOHMH

Ayrenne Adams, MD MPH
Primary Care Physician and Clinical Director on Social Determinants of Health at NYC H+H

Jennifer Tsai, MD, M.Ed
Emergency Medicine Physician
Yale School of Medicine

Leo Eisenstein, MD
Resident Physician Internal Medicine at NYU and Bellevue Hospitals

Marie Plaisime, PhD, MPH
Medical sociologist and a Joint FXB Health and Human Rights Fellow Harvard University

Nwamaka D. Eneanya, MD, MPH
Assistant Professor of Medicine Hospital of the University of Pennsylvania

Salman Ahmed, MD, MPH
Nephrologist and Assistant Professor Baylor College of Medicine

Sophia Kostelanetz, MD, MPH
Internal Medicine and Pediatrician Physician Liaison for Health Equity at Tennessee Department of Public Health

CERCA Microgrants

- NYC Health Department has $10,000 microgrants available to CERCA members who fit the following criteria:

    1. Safety Net Hospitals not associated with a private or public health system
    2. Institutional commitment and interest in ending race correction in at least one clinical algorithm
    3. Support from institutional leadership to end race correction in at least one clinical algorithm

- Please reach out to Adriana Joseph (ajoseph4@health.nyc.gov) if you are interested in learning more

Poll 1:

Does your institution practice race adjustment in the following clinical algorithms? (choose all that apply)

- ❑ eGFR
- ❑ VBAC
- ❑ PFT

Poll 2:

If you are a clinician, do you practice race adjustment in the following clinical algorithms? (choose all that apply)

- ❑eGFR
- ❑VBAC
- ❑PFT

eGFR Update

Nwamaka D. Eneanya, MD, MPH
Assistant Professor of Medicine
Hospital of the University of Pennsylvania

Agenda

01 Welcome to CERCA – Dr. Michelle Morse

02 Remarks by Dr. Dorothy Roberts | Q&A

03 H+H implementation of eGFR and institutional change – Drs. Nichola Davis & Lou Hart

04 Break

05 Breakout Groups by Algorithms

06 Closing + Next Steps

Prof. Dorothy E. Roberts, J.D.

George A. Weiss University Professor of Law and Sociology & the Raymond Pace and Sadie Tanner Mossell Alexander Professor of Civil Rights

University of Pennsylvania Carey Law School

Agenda

01 Welcome to CERCA – Dr. Michelle Morse

02 Remarks by Dr. Dorothy Roberts | Q&A

03 H+H implementation of eGFR and institutional change – Drs. Nichola Davis & Lou Hart

04 Break

05 Breakout Groups by Algorithms

06 Closing + Next Steps

On the Road to Health Equity
Eliminating Race-Based Medicine at NYC H+H

Nichola Davis, MD, MS
Vice President, Chief Population Health Officer
NYC Health + Hospitals

Lou Hart, MD
Medical Director of Health Equity
Office of Health Equity, Yale New Haven Health System

NYC HEALTH + HOSPITALS

“Medical Eracism” Initiative Aims to Abolish Race-Based Assessments Used for Medical Decisions

Public health care system will eliminate common diagnostic tests for kidney disease and pregnancy that are based on biased assumptions and can negatively impact quality of care for patients of color

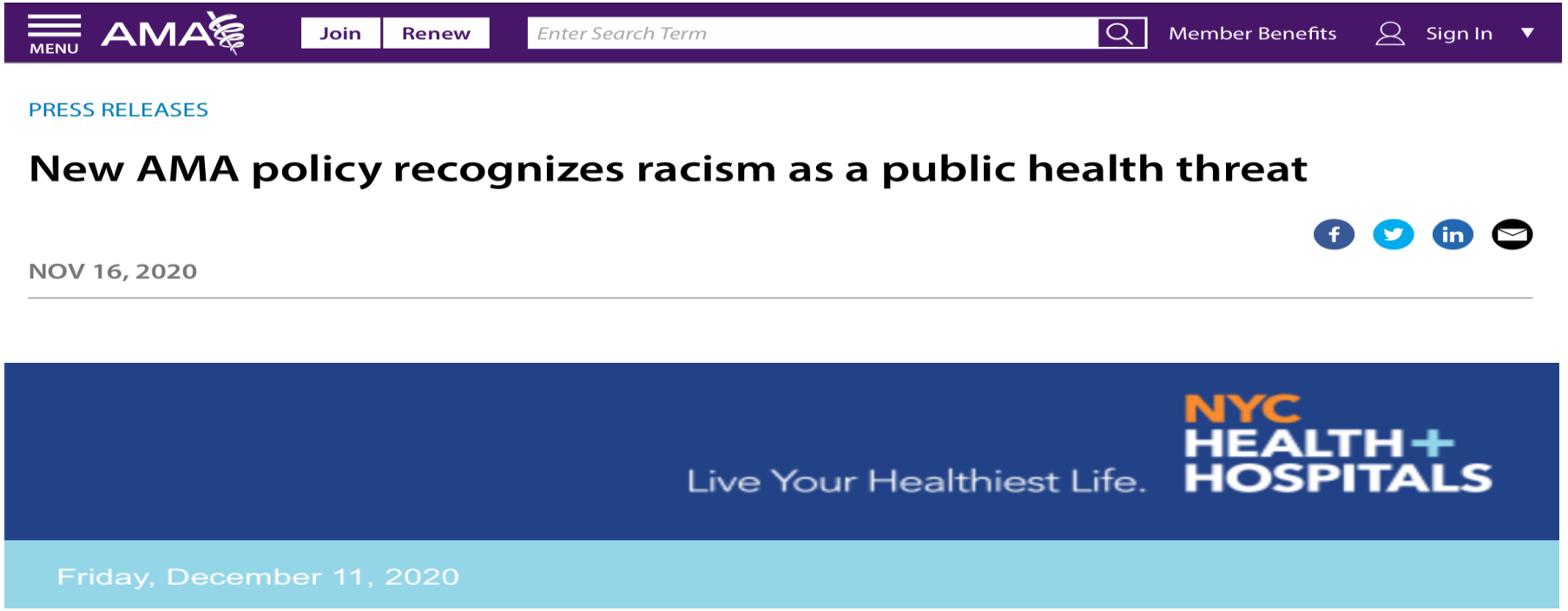
Initiative builds on the health system’s commitment to eliminate implicit bias in health care and provide equitable, quality care to all patients

NYC HEALTH + HOSPITALS

Kotter Model for Change

(Source: Adapted from Kotter 1996)

#1 - Create Sense of Urgency



MENU AMA Join Renew Enter Search Term Member Benefits Sign In

PRESS RELEASES

New AMA policy recognizes racism as a public health threat

NOV 16, 2020

Live Your Healthiest Life. NYC HEALTH+ HOSPITALS

Friday, December 11, 2020

Attacking Racism at NYC Health + Hospitals as a Public Health Threat

This past month, the American Medical Association (AMA) declared racism "an urgent public health treat." NYC Health + Hospitals wholeheartedly agrees, and we are glad to see the AMA take this important and necessary step forward in declaring racism a key driver of health inequity.

#2 - Gather Your Coalition

- Social / Political will to change
  - Office of Quality & Safety, System CQO
  - Equity and Access Council, System CDIO
  - Office of Population Health, System CPHO
  - System CMO, Hospital CMOs / Presidents
  - Clinical Councils - Internal Med, Nephrology, Critical Care, Clinical Laboratories
  - EMR
  - CEO / Board

#3 - Develop Steps to Eliminate Race-Based GFR

- Identification of the problem
- Framework to review Race-Based Medicine (RBM)
- Provide data of current problem
- Provide patient perspective
- Tailor message for various audiences
- Communication strategy

#4 - Strategic Clinical Approach

- Comprehensive lit review
  - Researching the origin of the algorithm
  - Rationale for the inclusion of race
  - Effects of race on the algorithm's recommendations.
- Identify clinical and operations subject matter experts to partner with
- Create 1-pagers to provide the rationale for removing race from the algorithm
- Socialize 1-pager infographic and other tailored content broadly and often to patients, clinicians, and staff

Medical Eracism: Removing Race-Based eGFR

Context

- When calculating a patient's kidney function (GFR), we often use a set of calculations based on various factors to estimate their glomerular filtration rate or eGFR
- Traditionally, these risk factors include serum creatinine, age, sex and **race (Black vs. non-Black)**
- The equation reports out two values. For Black patients it increases the estimated GFR by 16-21% to account for their "increased muscle mass", though no robust scientific evidence exists to support this claim
- **The unintended consequence is to assert and propagate a biological cause for Black bodies being different from all non-Black bodies, a popular eugenicist view**

Contributing Factors

- ❑ African Americans have a **3x** and Hispanics **1.5x higher risk** of developing kidney failure than White Americans[1]
- ❑ By having higher eGFRs, Black patients might have delayed referral to specialty services, dialysis and transplantation

Key Takeaways

- ❑ The inclusion of race is fraught with bias and has lasting deleterious implications for our Black patients. **For a multitude of social and scientific reasons, the Nephrology workgroup feels strongly that the inclusion of subjective race (a social construct) as an objective (biologic) proxy for creatinine generation / clearance in the biomedical environment does not meet the scientific rigor required at NYC Health + Hospitals for our diagnostic screening tools.**

Plans for Corrective Action

- ❑ Lab Services - Standardize all eGFR calculations to use CKD-EPI eGFR(Cr) where results will be reported without race adjustment based on serum creatinine, age, sex, and is normalized to 1.73m2 body surface area
- ❑ Epic – Work to ensure raced based eGFR is no longer reported out as 2 different values to our clinicians and patients
- ❑ **Approved by Nephrology Workgroup, IM Council, ICU & OB/GYN leadership, Quality & Safety, Medical & Professional Affairs, Equity & Access Council, Clinical Lab Council, CMO Council**

1. https://www.kidney.org/news/establishing-task-force-to-reassess-inclusion-race-diagnosing-kidney-diseases

#5 - Overcoming Challenges

- There's no biological basis for race, remind people of the history of race in medicine
- It limits and corrupts knowledge production as a lazy and shameful crutch/proxy
- It is an ecological fallacy
- Leads to medical bias and healthcare stereotyping as well as racially tailored care.
  - Separate and unequal
- Racializing disease and management forces our providers to determine differential treatments for their patients based on race (a socio-political category) → **racially discriminate in our care**

#6 - Tailoring Your Message for Buy-In

- Financial – violation of federal Civil Rights law, which may lead to lawsuits and liability
  - (Civil Right Act – Title 6) & (Affordable Care Act – Section 1557)
- Ethical – may be contributing to racial health inequities which are contrary to our moral mission in healthcare
- Clinical – not based in sound science, free of bias, with universally justifiable reasons for its inclusion. Also, hard to actualize in practice without the undue influence of implicit and explicit bias

NYC HEALTH+ HOSPITALS

#7 - Communicate your vision clearly and often

- Race is not a biological category that produces health disparities due to genetic differences, rather it is a socio-political system based on hierarchical phenotypic categorization used to support and propagate structural racism

- Race is not the risk factor for inequitable disease outcomes, but rather RACISM is, through its explicit and insidious grave biological consequences on human bodies and environmental living conditions

8 - Launch your Campaign!

Medical Eracism - eGFR

Medical Eracism - VBAC

Live Your Healthiest Life.

Thursday, February 11, 2021

Abolishing Race Based Medicine for Kidney Function, VBAC and More

NYC Health + Hospitals Office of Quality & Safety, in partnership with the Equity & Access Council, has embarked on an effort to abolish race based medicine from our medical practices across our health system.

NYC Health + Hospitals is proud to be leading the nation in removing race based practices in the delivery of care. We stand resolute in treating our patients as individuals and targeting our treatments and guidance based on their specific biology and unique social and life experiences, not simply their race or ethnicity.

Agenda

01 Welcome to CERCA – Dr. Michelle Morse

02 Remarks by Dr. Dorothy Roberts | Q&A

03 H+H implementation of eGFR and institutional change – Drs. Nichola Davis & Lou Hart

04 Break

05 Breakout Groups by Algorithms

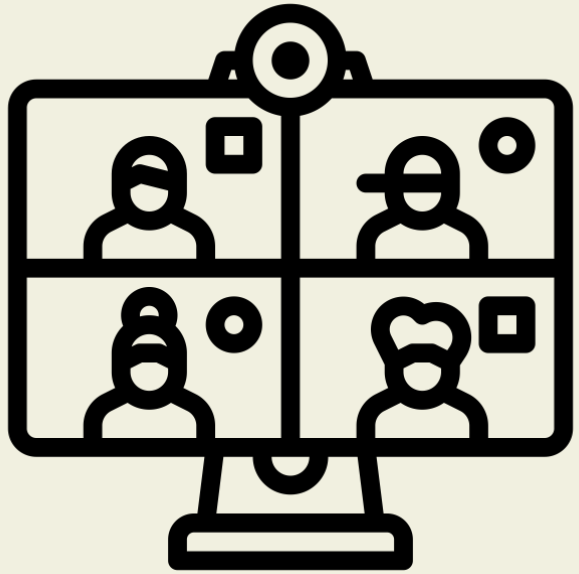
06 Closing + Next Steps

Breakout Groups by Clinical Algorithm

CERCA teams will be broken out by chosen clinical algorithm (eGFR, VBAC, PFT)

Members of advisory council and CHECW staff will facilitate each breakout:
Dr. Sophia Kostelanetz – eGFR
Dr. Michelle Morse – VBAC
Dr. Duncan Maru – PFT

CERCA members will:
1) Introduce themselves
2) Share reasons for chosen algorithm
3) Discuss what members hope to get out of CERCA



Breakout rooms are timed for 20 minutes

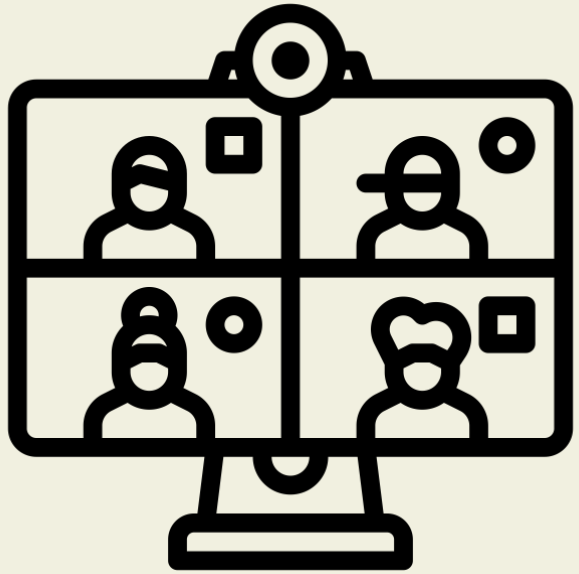
We'll reconvene in 5 minutes

Breakout Groups by Clinical Algorithm

CERCA teams will be broken out by chosen clinical algorithm (eGFR, VBAC, PFT)

Members of advisory council and CHECW staff will facilitate each breakout:
Dr. Sophia Kostelanetz – eGFR
Dr. Michelle Morse – VBAC
Dr. Duncan Maru – PFT

CERCA members will:
1) Introduce themselves
2) Share reasons for chosen algorithm
3) Discuss what members hope to get out of CERCA



Breakout rooms are timed for 20 minutes

Agenda

01 Welcome to CERCA – Dr. Michelle Morse

02 Remarks by Dr. Dorothy Roberts | Q&A

03 H+H implementation of eGFR and institutional change – Drs. Nichola Davis & Lou Hart

04 Break

05 Breakout Groups by Algorithms

06 Closing + Next Steps

***Next steps*:**

- The second meeting for CERCA will be **Friday, January 21st, 2022**
- Please email Adriana Joseph (ajoseph4@health.nyc.gov) if interested in learning more about the CERCA Microgrants
- Homework for CERCA members in preparation for meeting #2
    1. For those who have made changes to selected algorithm(s), bring a description to next meeting. For those who have not made changes to selected algorithm(s), bring an outline of steps to implement changes.
    2. Read relevant algorithm one-pager and references.

Thank You!