NYC Coalition to End Racism in Clinical Algorithms
Meeting 11

Michelle E. 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

02 Patient Engagement Plans: Review of Deliverables to Date

03 CERCA Past & Future: Successes, Background on Race-Based Prescribing in Hypertension, and future sub-groups

04 Five-minute Break

05 Breakout Groups by Algorithm

06 Closing + Next Steps

We have received only one patient engagement plan. They are due.

Health System	Site	Work Plan	Evaluation Plan	Patient Engagement Plan
Health and Hospitals	Elmhurst	x	x	
Health and Hospitals	Kings County	x	x	
Health and Hospitals	Woodhull		x	
Maimonides		x		
One Brooklyn Health (OBH)	Interfaith	x	x	X
One Brooklyn Health (OBH)	Brookdale	x	x	
Saint Barnabas (SBH)		**x**		
Montefiore		x	x	
Mount Sinai		x	x	
Northwell		x	x	
NYP		x	x	
SUNY Downstate		x		

Please send them over to ajoseph4@health.nyc.gov. as soon as possible.

Patient Engagement Plan

[Name of System] — [Algorithm of Focus]

This template is designed to serve as a guide in the development of your institution's patient engagement plan. It is not required to be used in its exact format. CERCA members can develop any patient engagement plan that is most helpful to their work and teams. The table below allows you to describe increasing levels of patient engagement by initiative. For further details on the development and application of this patient engagement framework, please refer to the reference links provided.

The example below is the patient engagement initiative the CMO Office collaborated with NKF of Greater NY around Black kidney health.

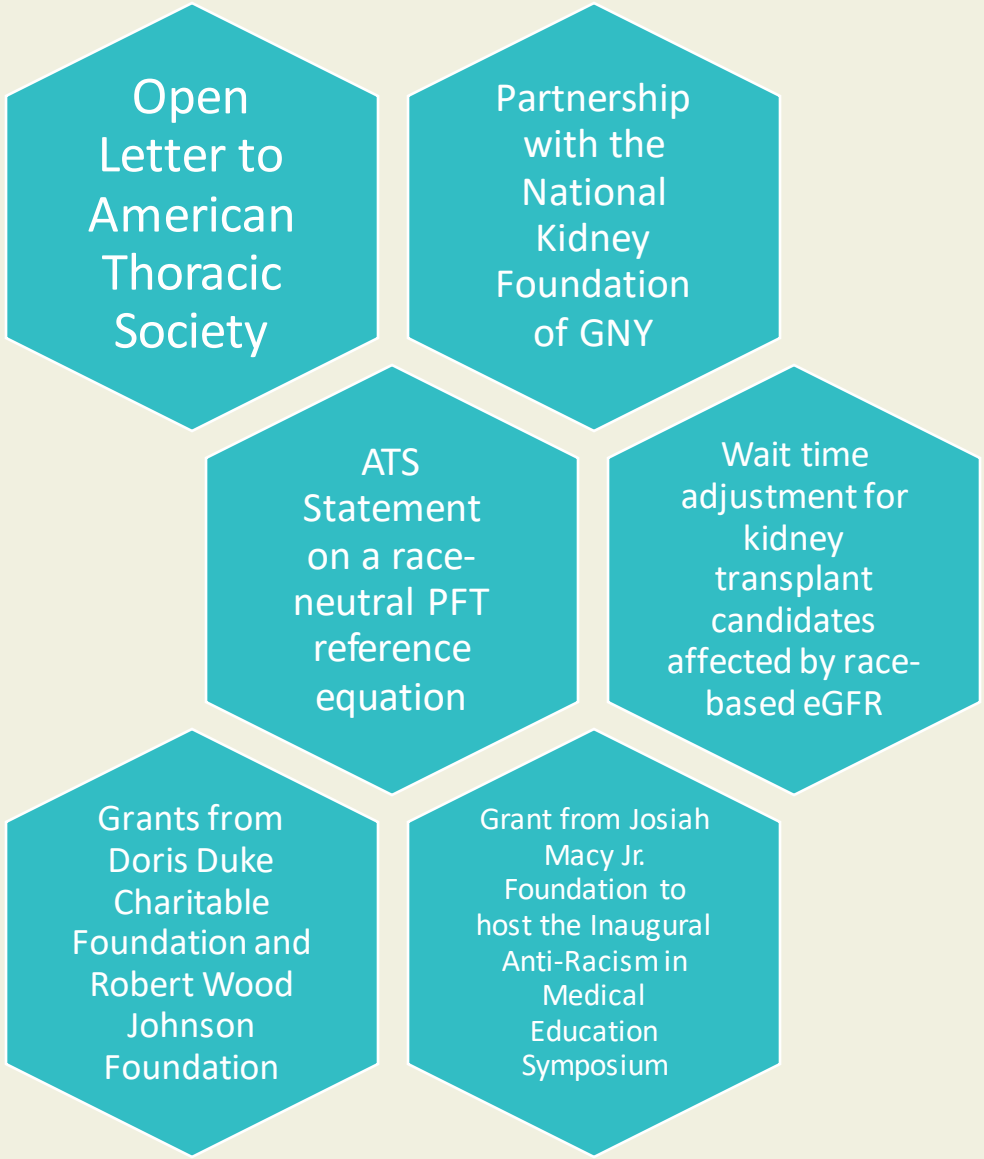
Initiative	**Inform Me** Share information on changes in algorithm and impacts on care.	**Engage Me** Discuss changes and impacts on care with patients during visits.	**Empower Me** Encourage patients to discuss care with other providers; share resources, checklists, etc.	**Partner with Me** Foster partnership with patients in developing appropriate care planning.	**Support Me** Connect patients with others who have similar experiences: provide space for patients to connect.
1. *Example:* NKF Black Kidney Health Matters	• Created website specifically focusing on kidney health of Black community • Educational webinar with patient and nephrologists discussing the meaning of changes in CKD diagnosis and how it affects them	• Developed patient-facing social media to engage priority population • Held pop-up events in partnership with NYC DOH to engagement community members in-person	• Created *Know Your Numbers* checklist that patients can take to appointments to facilitate conversation with kidney care provider • Created quiz for patients to determine risk for CKD	• Helpline for patients to ask questions regarding kidney diagnoses and care • Ongoing partnerships with CBOs (e.g., YMCA and DOH Action Center) for continued in-person visibility	• Patient events like cook-offs and citywide/ regional walkathons to build community and awareness

References:

https://ehrintelligence.com/news/national-ehealth-collaborative-releases-patient-engagement-framework

https://academic.oup.com/jamia/article/24/6/1088/3775742

CERCA Successes to Date



Racial Bias in Outpatient Clinical Algorithms:

HYPERTENSION TREATMENT

Toni Eyssallenne MD, PhD
Senior Medical Advisor
Office of the Chief Medical Officer
New York City Department of Health and Mental Hygiene

HTN: Race-based Prescribing for Black Patients

- Practice guidelines (i.e. JNC-8) recommend that Black patients with hypertension w/o co-morbidities initially be treated with a thiazide diuretic or a calcium channel blocker while non-Black patients are initially offered ACE-I .

How did we get here: Context for current guidelines

- Practice guidelines (i.e. JNC-8) were influenced by the results of the 2002 ALLHAT study
  - RCT that set out to determine the optimal 1st step in therapy for HTN
  - Can calcium channel blockers or angiotensin –converting enzyme inhibitors lower coronary heart disease or other cardiovascular events vs treatment with a diuretic

How did we get here: Context for current guidelines

- Practice guidelines (i.e. JNC-8) were influenced by the results of the 2002 ALLHAT study
  - The study reported that there was a 15% relative increase in stroke in lisinopril (ACEI) vs chlorthalidone group (diuretic)
  - Race stratification of the data found a 40% relative increase in stroke in Black vs non black and SBPs were 4mm Hg higher in Black vs non black
  - A similar study conducted in Sweden[1] did NOT show a difference in outcomes with lisinopril so ALLHAT researchers concluded that *race must be considered "in the context of the heterogeneity of race"*

[1]*Hansson L, Lindholm LH, Ekbom T et al Randomised trial of old and new antihypertensive drugs in elderly patients: cardiovascular mortality and morbidity: the Swedish Trial in Old Patients with Hypertension-2 study. Lancet.1999; 354:1751-1756*

HTN: Race-based Prescribing for Black Patients

- Practice guidelines (i.e. JNC-8) recommend that Black patients with hypertension w/o co-morbidities initially be treated with a thiazide diuretic or a calcium channel blocker while non Black patients are initially offered ACE-I .

Why are these guidelines problematic?

- **Treats Black race category as a monolith**
  - Descendants of slaves in America?
  - Caribbean and/or African Diaspora?
  - Light skin? Dark skin?
  - What about dark south Asians??
- **Guidelines came out in 2014 and 2017. We are overdue for a review**
  - New meds
  - Monotherapy is not great for controlling stage 2 HTN
- **The kidney analysis likely used an eGFR calculation that was outdated** (race-adjusted) and so positive effect of lisinopril on kidney disease for Black people was likely underestimated
- **Other nations reconsidering the merit of these guidelines**
  - Even the UK is considering a revision of the guidelines as it seems more likely that individualized therapy makes more sense in controlling BP than using Race incorrectly as a proxy for biology

What about genetics and race?

- While population descriptors have been used for genetic studies, they have not named individuals consistently or in a principled manner, often reflexively using race and ethnicity without great thought or justification
- "African descent" or "European ancestry" are often used to describe sweeping continental associations with disease alleles; these problematic generalizations are inaccurate
  - Black race/"African ancestry" and sickle cell disease risk, the genetic mutation causing this disease confers resistance to malaria and is concentrated in specific areas across the African continent, Middle East, Mediterranean, Southeast Asia, and Latin America.

Cerdeña JP, Grubbs V, Non AL. Genomic supremacy: the harm of conflating genetic ancestry and race. Hum Genomics. 2022;16(1):18. doi:10.1186/s40246-022-00391-2

Using Population Descriptors in Genetics and Genomics Research: A New Framework for an Evolving Field | The National Academies Press

HTN: Race-based Prescribing for Black Patients

- Though providers have been following these guidelines, greater use of race-specific monotherapy has actually coincided with a decline in hypertension control for Black patients. (Hypertension. 2021; 78:578–587, Hypertension. 2022;79:349–35)

- Moreover, guidelines may be limiting treatment options for Black patients (i.e. use of ACE/ARBS in treatment of chronic kidney disease)

Race-based Prescribing for Black Patients --> Differential Outcomes

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Differences in Hypertension Medication Prescribing for Black Americans and Their Association with Hypertension Outcomes

Hunter K. Holt, Ginny Gildengorin, Leah Karliner, Valy Fontil, Rajiv Pramanik and Michael B. Potter

The Journal of the American Board of Family Medicine January 2022, 35 (1) 26-34; DOI: https://doi.org/10.3122/jabfm.2022.01.210276

Article | Figures & Data | References | Info & Metrics | PDF

Abstract

Background: National guidelines recommend different pharmacologic management of hypertension (HTN) without comorbidities for Black/African Americans (BAA) compared with non-BAA. We sought to 1) identify if these recommendations have influenced prescription patterns in BAA and 2) identify the differences in uncontrolled HTN in BAA on different antihypertensive medications.

In this issue

The Journal of the American Board of Family Medicine
Vol. 35, Issue 1
January/February 2022
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Source: https://www.jabfm.org/content/35/1/26.abstract (2022)

An individualized approach to HTN therapy for all patients may be more important than race-based guidelines

*Study objectives:

Examined:

1) prescribing differences
2) HTN control

in Black vs non-black patients with HTN w/o co-morbidities

*Methodology:

- Linked retrospective observational cohort using 2 years of EHR data
- Patients aged 18 to 85 with HTN on 1- or 2-drug regimens (n=10,875)

*Findings:

- **Providers seem to follow race-based guidelines for HTN, but HTN control was worse in Black patients compared to non-Black patients**

Individualized approach to HTN treatment

According to the authors, other factors may be more important than considerations of race including:

- Dose
- Addition of second or third drugs
- Medication management
- Lifestyle changes
- Social and environmental factors (access to healthy food, unstable housing, etc.)
- Follow-up care (more clinical encounters for Black patients->better control)

Additionally, a Kaiser study found that cultural tailoring and a multi-level team-based approach reduced racial disparities for Black patients with hypertension.

CERCA subcommittee on race-based prescribing in hypertension

- We are interested in creating a new subcommittee on race-based prescribing in hypertension
- We are in the process of gauging interest in this subcommittee particularly in the primary care, cardiology and nephrology community for CERCA 2.0
- Thoughts and questions?

Thank you!

Questions?

Toni Eyssallenne, MD, PhD
Senior Medical Advisor
chiefmedicalofficer@health.nyc.gov

https://www1.nyc.gov/site/doh/providers/resources/coalition-to-end-racism-in-clinical-algorithms.page

CERCA 2.0: The Next Iteration

eGFR to Transplantation	• Building upon past eGFR activities, transition efforts to focus on kidney transplantation
VBAC to VBAC Patient Engagement	• Continue efforts on creating VBAC patient engagement videos
PFTs to PFT Implementation and Operationalization of Race-Neutral Eq.	• Continue efforts on the de-implementation of a race-based equation, incorporating new hardware/spirometers, etc.
Race-Based Prescribing in Hypertension	• Creation of a new subgroup that focuses on hypertension

Ending Disparities in CKD- Leadership Summit hosted by NKF GNY

Chelsea Tollner, MPH| Senior Director of Community Impact & Public Health

Friday, August 18th, 2023

The goal of the Ending Disparities in CKD Initiative is to develop a road map that will guide healthcare leaders in the Greater New York in driving a cultural shift in primary care, toward increasing the early diagnosis and management of CKD, especially in high-risk populations. Parties will come together to develop concrete recommendations and collaborations to advance them.

GNY Ending Disparities in CKD Leadership Summit

We are utilizing a Collective Impact strategy to develop and advance **equitable** solutions to improve CKD testing and diagnosis in primary care.

Meet our Summit Co-Chairs

Dr. Toni Eyssallenne
Senior Medical Advisor
NYC DOHMH

Dr. Susan Beane
Executive Medical Director
Healthfirst Partnerships and Medical Outcomes
Healthfirst New York Health Insurance

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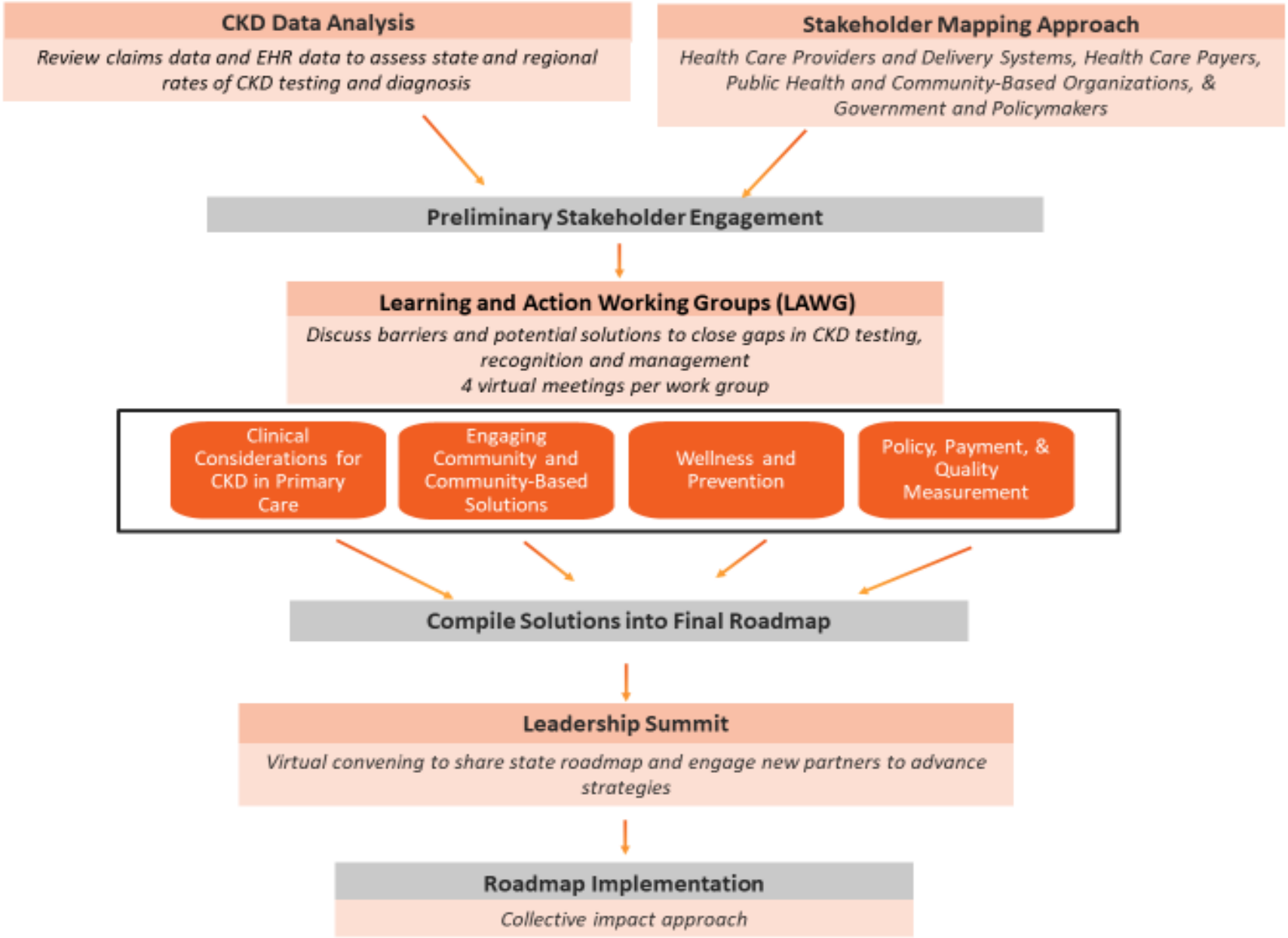


NATIONAL KIDNEY FOUNDATION®

Stakeholders

Health Care Providers

CMOs and quality offices, integrated health systems, FQHCs, medical societies,

Payers

Insurers, employers, Medicaid, Medicare

Community Organizations

YMCA, Faith Based organizations, community health organizations, foundations, human service organizations,

Patients and caregivers

Patients on Dialysis, kidney recipients, caregivers of those who have ESRD.

Government/Public Institutions

State lawmakers, state agencies (Departments of Health), Academic institutions.

Consensus Building Process

- 4 workgroups to develop consensus recommendations on key topics
- Recommendations will be the foundation to the roadmap

01

Clinical Considerations for CKD in Primary Care

Meeting Dates: 5/17, 5/31, 6/14, 6/28

Goal: To discuss strategies and approaches that can be employed to improve CKD recognition and care in primary care settings

02

Engaging Community and Community-Based Solutions

Meeting Dates: 5/24, 6/7, 6/21, 7/11

Goal: To develop strategies to advance CKD awareness through community engagement and to ensure that health care providers are aware of the community resources available to delay CKD progression

03

Policy, Payment, and HEDIS Measurement

Meeting Dates: 7/12, 7/26, 8/9, 8/23

Goal: To develop a strategy to streamline CKD testing in primary care from a policy and payment perspective

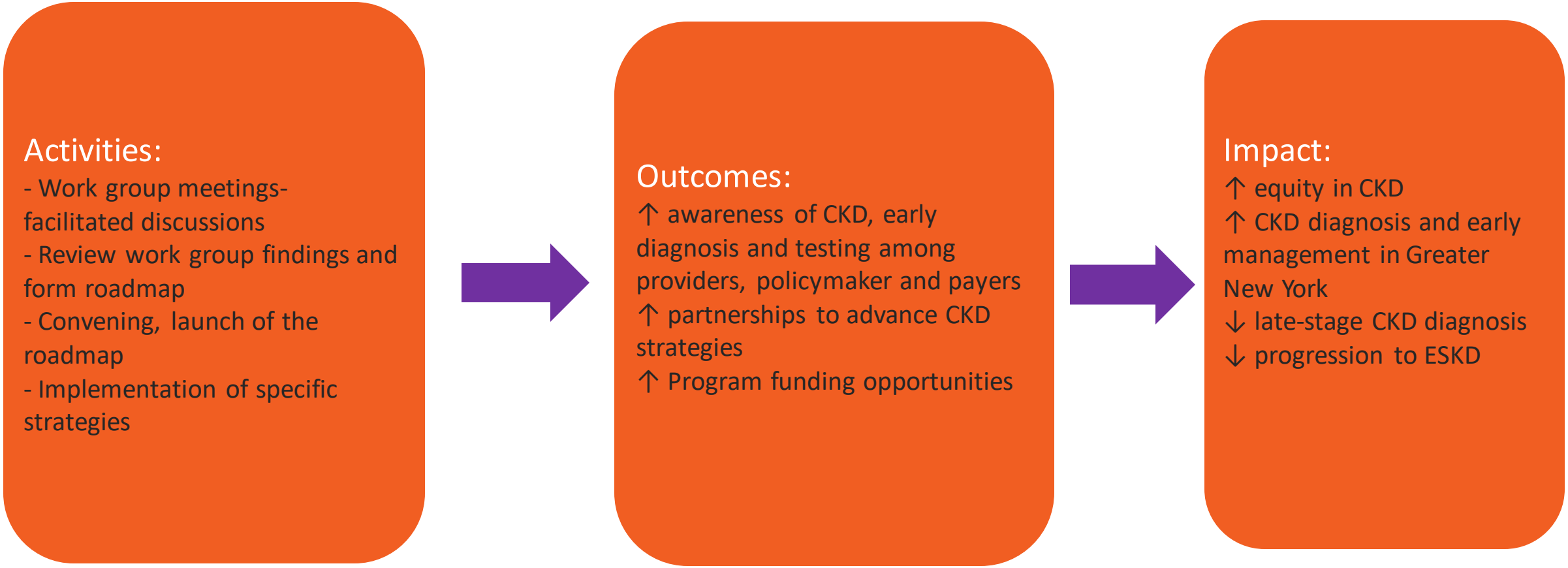
04

Wellness and Prevention

Meeting Dates: 7/19, 8/2, 8/16, 8/30

Goal: To develop a strategy to incorporate CKD testing and diagnosis into population wellness and prevention practices

Stakeholders Meeting Logic Model



NATIONAL KIDNEY FOUNDATION.

ENDING DISPARITIES & INEQUITIES

IN CHRONIC KIDNEY DISEASE

LEADERSHIP SUMMIT | OCT 19 2023

The National Kidney Foundation (NKF) is hosting a Virtual Leadership Summit focused on Ending Disparities and Inequities in CKD. As part of a national NKF Collective Impact Strategy, NKF in Greater New York is working on a groundbreaking initiative to develop a roadmap that will drive a cultural shift in primary care. Our overarching goal is to increase the early diagnosis and management of CKD, especially in communities disproportionately burdened by CKD.

The findings and recommendations of more than 50 thought leaders representing clinical care, public policy, payment models, and community-based organizations will be presented at a Virtual Leadership Summit on October 19, 2023 from 9:00 am – 11:00.

Questions? Contact Monique Hardin-Cordero,
Community Impact and Health Partnerships Director
212.889.2210 x228 | Monique.HardinCordero@kidney.org

T H A N K Y O U

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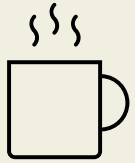
Break 

Reconvene to join your break-out groups in 5 minutes

Next steps:

- Continue to submit patient engagement plans, if further assistance is needed please reach out to Adriana Joseph ajoseph4@health.nyc.gov or Toni Eyssallenne aeyssallenne@health.nyc.gov
- CERCA Evaluation team will reach out regarding surveys and interviews starting in September
- Meeting 12 – Friday, October 20th from 1 to 2:30 EST
- CERCA Celebration – tentative in person for the first two weeks of December.

Thank You!