NYC Coalition to End Racism in Clinical Algorithms
Meeting 6

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 Institute for Healing and Justice in Medicine

03 National Kidney Foundation

04 5-minute Break

05 Breakout Groups by Algorithm

06 Closing + Next Steps

Updates:

- New Senior Medical Advisor: Toni Eyssallenne, MD, PhD

- CERCA Report is out!

- Status of CERCA deliverables:
  - 5 members submitted final evaluation plans
  - 5 members submitted final work plans
  - OBH only member to submit both final deliverables!

- ATS letter and petition

Institute for Health and Justice in Medicine

INSTITUTE FOR HEALING AND JUSTICE IN MEDICINE

THE HUB

Our Origin Story & Positionality

3 students of medicine and public health at the UC Berkeley-UCSF Joint Medical Program who wrote a report that blossomed into an interdisciplinary grassroots organizing and advocacy network.

Noor Chadha

Bernadette “Bernie” Lim

Madeleine “Maddy” Kane

Othering & Belonging Institute

Center for Race & Gender

INSTITUTE FOR HEALING AND JUSTICE IN MEDICINE

POLICY BRIEF

Toward the Abolition of Biological Race in Medicine

Transforming Clinical Education, Research, and Practice

Noor Chadha, Bernadette Lim, Madeleine Kane, and Brenly Rowland

BELONGING.BERKELEY.EDU | INSTITUTEFORHEALINGANDJUSTICE.ORG

Core Organizers











INSTITUTE
FOR HEALING
AND JUSTICE
IN MEDICINE

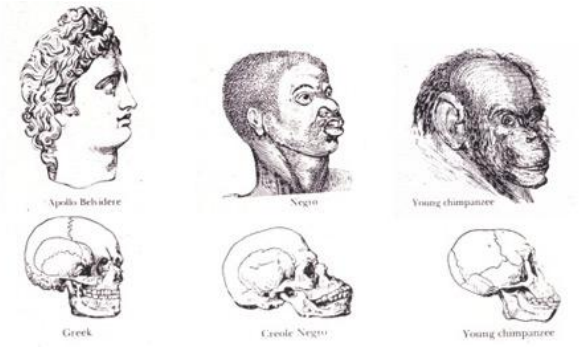
THE HUB

Our Mission

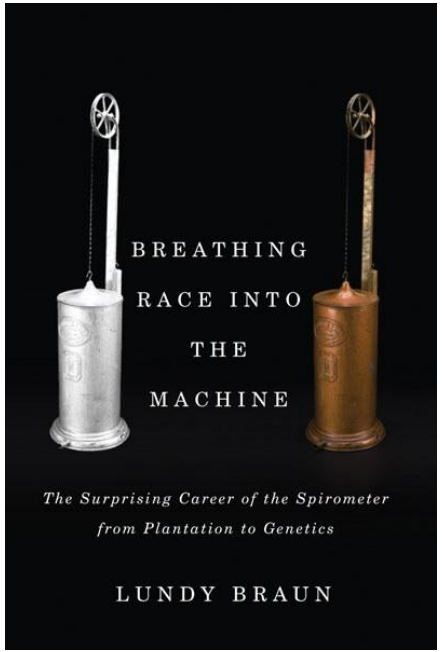
We center around **sharing and uplifting perspectives** (narratives, experiences, research, and other works) **related to healing, social justice, and community activism in Western medicine and public health**.

We foster space for **vibrant dialogue and debate**, consciousness-raising, and movement building, seeking to sharpen our collective analysis and develop methods to critique structures of power in medicine through community scholarship and solidarity.

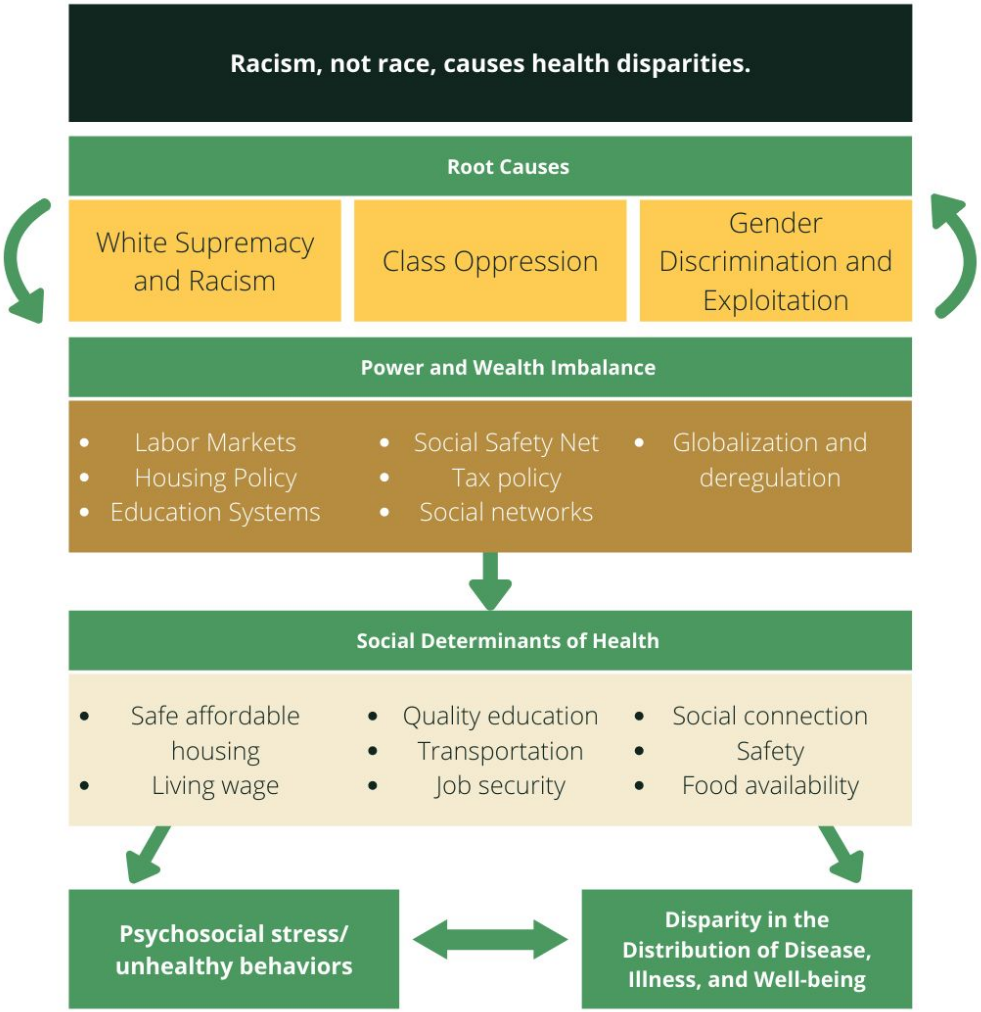
RACISM HAS BEEN HISTORICALLY CODIFIED IN SCIENCE AND MEDICINE



People	Cranial capacity (in^3)
Modern Caucasians	87
Native Americans	86
Mongolians	85
Malays	85
Ancient Caucasians	84
Africans	83



THE CONCEPTUALIZATION OF RACE AS BIOLOGY IS ROOTED IN COLONIZATION



Graphic adapted from Dr. Joia Crear-Perry, who adapted from R. Hofrichter

Race-Based Medicine: Examples

	How race is used	Rationale for race-based management	Potential harm	Race-conscious approach
eGFR[6]	eGFR for Black patients is multiplied by 1·16–1·21 the eGFR for White patients, depending on the equation used	Black patients are presumed to have higher muscle mass and creatinine generation rate than patients of other races	Black patients might experience delayed dialysis and transplant referral[8,9]	Use eGFR equations that do not adjust for race (eg, CKD-EPI Cystatin C)[10]
BMI risk for diabetes[7]	Asian patients considered at risk for diabetes at BMI ≥23 *vs* 25 for patients of other races	Asian patients are presumed to develop more visceral than peripheral adiposity than patients of other races at similar BMI levels, increasing risk for insulin resistance[7]	Asian patients screened for diabetes despite absence of other risk factors might experience increased stigma and distrust of medical providers[11]	Screen patients with lower BMIs on the basis of indications of increased body fat (eg, body roundness,[12] body not based on race
FRAX[13]	Probability of fracture is adjusted according to geography or minority status, or both	Different geographical and ethnic minority populations are presumed to have varied relative risks for fracture on the basis of epidemiological data	Some populations, including Black women, might be less likely to be screened for osteoporosis than other populations[14]	Screen patients fo on the basis of clin rather than race; c existing biases tha patients at risk bec essentialist beliefs in bone density[15]
PFT[16]	Reference values for pulmonary function are adjusted for race and ethnicity	Racial and ethnic minority groups are presumed to have varied lung function on the basis of epidemiological data	Black patients might experience increased difficulty obtaining disability support for pulmonary disease[17]	Use unadjusted m function for all pat counteract existin harm Black patient racial essentialist b variation in lung c
JNC 8 Hypertension Guidelines[19]	Treatment algorithm provides alternate pathways for Black and non-Black patients	ACE-inhibitor use associated with higher risk of stroke and poorer control of blood pressure in Black patients than in patients of other races	Black patients might be less likely to achieve hypertension control and require multiple antihypertensive agents[20]	Consider all antihy options for blood in Black patients; a to achieve goals an adverse effects

MEDICINE AND SOCIETY

Debra Malina, Ph.D., *Editor*

Hidden in Plain Sight — Reconsidering the Use of Race Correction in Clinical Algorithms

Darshali A. Vyas, M.D., Leo G. Eisenstein, M.D., and David S. Jones, M.D., Ph.D.

Physicians still lack consensus on the meaning of race. When the *Journal* took up the topic in

diagnostic algorithms and practice guidelines that adjust or "correct" their outputs on the basis

thnicity. Physicians use these
lualize risk assessment and
ns. By embedding race into
cisions of health care, these
race-based medicine. Many
l algorithms guide decisions
irect more attention or re-
ents than to members of ra-
rities.
potential dangers of such
mpiled a partial list of race-
(Table 1). We explore several

POLICY BRIEF

LUNGANDJUSTICE.ORG

Othering & Belonging Institute

Center for Race & Gender

Institute for Healing and Justice in Medicine

Toward the Abolition of Biological Race in Medicine

Transforming Clinical Education, Research, and Practice

Noor Chadha, Bernadette Lim, Madeleine Kane, and Brenly Rowland

KFF Filling the need for trusted information on national health issues

Use of Race in Clinical Diagnosis and Decision Making: Overview and Implications

Michelle Tong and Samantha Artiga

Published: Dec 09, 2021

ISSUE BRIEF | APPENDIX

Introduction

Despite race being a socio-political system of categorization without a biologic basis, race
and continues to play a role in medical teaching and clinical decision making within health
permeates clinical decision making and treatment in multiple ways, including: (1) through
attitudes and implicit biases, (2) disease stereotyping and clinical nomenclature, and (3) cl
algorithms, tools, and treatment guidelines. While some diseases have higher prevalence
individuals with certain genetic ancestry, genetic ancestry is poorly correlated with comm

From Race-Based to Race-Conscious Medicine

Race-Based Medicine:

Attribution of differences in the natural history and epidemiology of disease to biological differences between races; and the ideology surrounding such a practice.

Treats race as a discrete, constant, and categorical variable

Views race as a risk factor and ignores disparities engendered by racism

Provides false sense of attention to health equity

Race Conscious Medicine:

Attribution of differences in the natural history and epidemiology of disease to differences in access, treatment, opportunities, exposures, and experiences of racial and ethnic minorities due to racism

Acknowledges race as contrived, continuous, fluid, and unscientific

Views racism as a root cause operating through structural mechanisms

Emphasizes health equity, centering

Race Conscious Medicine

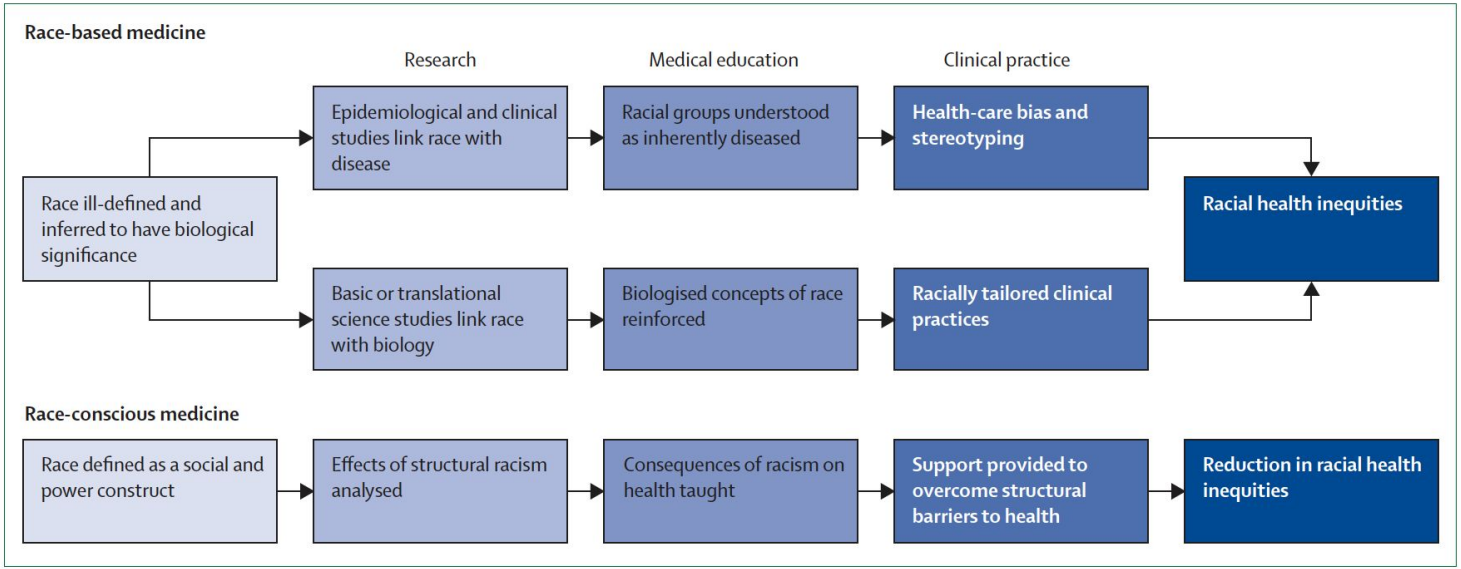


Figure: **How race-based medicine leads to racial health inequities**
An alternative approach to race-conscious medicine; defined as medical practice and pedagogy that accounts for how structural racism determines illness and health.

Cerdeña JP, Plaisime MV, Tsai J. From race-based to race-conscious medicine: how anti-racist uprisings call us to act. *Lancet*. 2020;396(10257):1125-1128. doi:10.1016/S0140-6736(20)32076-6

INSTITUTE FOR HEALING AND JUSTICE IN MEDICINE

THE HUB

Interdisciplinary Working Groups

INSTITUTE FOR HEALING AND JUSTICE IN MEDICINE
THE HUB

Highlights

Policy Advocacy:
- Informal advocacy for AMA position statements
- Commentary and responses submitted for Ways & Means Committee, AHRQ, etc.
- Organizing testimony at NKF forum on eGFR
- National petitions & institutional-level petitions

Tools created:
- Teach-ins
- eGFR implementation & advocacy toolkit
- eGFR patient- and clinician-aimed infographics

Networks & Connections:
- Many (many!) media-based pieces across local & national news outlets (NPR, Consumer Reports, op eds, etc.)
- Interdisciplinary efforts:
  - lawsuit, Epic engagement, lab medicine, pharmacy
- Many more informal connections for research, mentorship & advocacy

INSTITUTE FOR HEALING AND JUSTICE
FALL TEACH-OUT SERIES

centering student activism & interdisciplinary collaboration

REMOVING RACE FROM eGFR

RSVP AT
INSTITUTEFORHEALINGANDJUSTICE.ORG/EG

TUESDAY, AUGUST 18
4:30-6:30 PM PST | 7:30-9:30 PM EST

learn about institution-specific activism from trainees and facul
uc san francisco, university of washington, brown, vanderbilt, &

resource-share and organize for local action in facilitated small g

zoom link sent upon rsvp

INSTITUTE FOR HEALING AND JUSTICE IN MEDICINE
THE HUB

ADVOCACY TO ABOLISH RACE-BASED MEDICINE

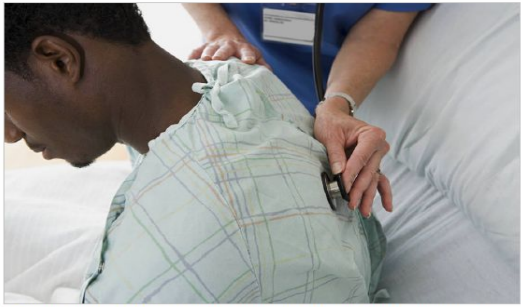
Trainee Perspectives on Race, Antiracism, and the Path toward Justice in Kidney Care

Anna S. Heffron,[1] Rohan Khazanchi,[2,3] Naomi Nkinsi,[4,5] Joel A. Bervell,[6] Jessica P. Cerdeña,[7] James A. Diao,[8] Leo Gordon Eisenstein,[9] Nali Julia Gillespie,[10] Natasha Hongsermeier-Graves,[2,11] Maddy Kane,[12] Karampreet Kaur,[13] Luis E. Seija,[14] Jennifer Tsai,[15] Darshali A. Vyas,[16] and Angela Y. Zhang[17]

CJASN 17: 1251–1254, 2022. doi: https://doi.org/10.2215/CJN.02500222

Introduction

In 1999, researchers introduced a Black race coefficient of 1.21 to the estimated glomerular filtration rate (eGFR) on the basis of the observation that participants who self-identified as Black had a 21% higher measured GFR after controlling for age, sex, and serum creatinine than those who did not self-identify as Black. Use of this coefficient mitigated underestimation bias among Black individuals and overestimation bias among non-Black individuals in the study population, but did not consider confounding from socioeconomic examples of trainee contributions in Figure 1. We came to this work from a variety of perspectives, often experiencing the health consequences of race-based medicine ourselves or through our family members, friends, communities, and patients. As newcomers to medicine, we perceived a troubling discordance between stated priorities—of equity and rigorous scientific evidence as the basis of clinical decisions—and actual clinical practice. Inadequate explanations, perceptive mentors, and existing antiracist literature propelled us toward advocacy.



Doctors should educate themselves toward ending manifestations of race-based medicine.(Courtesy photo)

Toward the elimination of race-based medicine: replace race with racism as preeclampsia risk factor

Erinma P. Ukoha, MD, MPH; Michael E. Snavely, MD; Monica U. Hahn, MD, MPH, MS; Jody E. Steinauer, MD, PhD; Allison S. Bryant, MD, MPH

Introduction

Racial health inequities in pregnancy-related morbidity and mortality are drastic and particularly affect birthing people who identify as Black.[1–3] Black birthing people in the United States are 3 to 4 times more likely to die from complications related to pregnancy than their White counterparts.[4] Based on this increased morbidity and mortality, obstetrical preventive clinical guidelines identify Black race as a risk factor for death and disease, despite the current scientific consensus that race is a sociopolitical construct that has no biological or genetic basis.[5–8] For example, systematic reviews of the literature have found that pregnant

Pregnancy-related morbidity and mortality continue to disproportionately affect birthing people who identify as Black. The use of race-based risk factors in medicine exacerbates racial health inequities by insinuating a false conflation that fails to consider the underlying impact of racism. As we work toward health equity, we must remove race as a risk factor in our guidelines to address disparities due to racism. This includes the most recent US Preventive Services Taskforce, American College of Obstetricians and Gynecologists, and Society for Maternal-Fetal Medicine guidelines for aspirin prophylaxis in preeclampsia, where the risk factor for "Black race" should be replaced with "anti-Black racism." In this commentary, we reviewed the evidence that supports race as a sociopolitical construct and the health impacts of racism. We presented a call to action to remove racial determination in the guidelines for aspirin prophylaxis in preeclampsia and more broadly in our practice of medicine.

Key words: aspirin prophylaxis, health inequities, maternal morbidity and mortality, obstetrical outcomes, preeclampsia, race-based medicine, racism

Abolish race-based medicine in kidney disease and beyond

COMMUNITY CONTRIBUTOR / Nov. 27, 2019 1:30 a.m. / OPINION

Racism in health care made headlines last month when it was revealed that a prominent algorithm, used widely in hospitals across the U.S. to manage and allocate health care, has been systematically relegating black patients to decreased access and poorer quality of care. While some scientists are shocked that an algorithm that set out to be "color blind" has led to racial inequity, blatant examples of race-based medicine leading to unequal treatment are commonplace.

Clinical Updates on eGFR

Removal of "Correction" for Race

INSTITUTE FOR HEALING AND JUSTICE IN MEDICINE

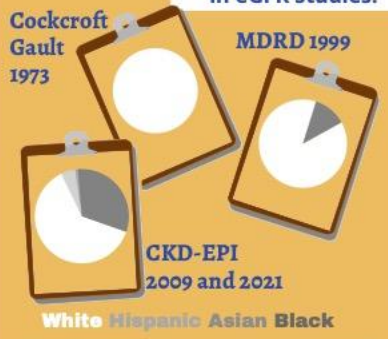
Why was a race coefficient included in GFR estimation equations in the past?

Analysis of the MDRD study in 1999 showed a discrepancy in kidney function between self-identified Black and non-Black participants.

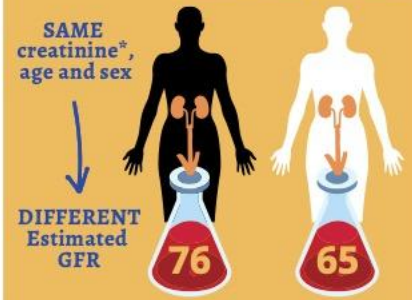
The discrepancy was attributed to a biological difference, and the race coefficient was added, setting the standard for future studies.

For decades, inclusion of the race coefficient was questioned, but its use continued.

Participant diversity in eGFR studies.



Outcome of estimates that include race.



In 2021, the race coefficient was re-evaluated and removed. Race is a social construct, not a marker for biological function.

Who recommended removing race correction? Who advocated for this recommendation?

NATIONAL KIDNEY FOUNDATION / ASN

Patients and advocacy groups, nurses, medical students, trainees, clinical, biomedical and social scientists, lawyers, health informatics personnel and physicians advocated for many years to bring about the removal of race from eGFR.

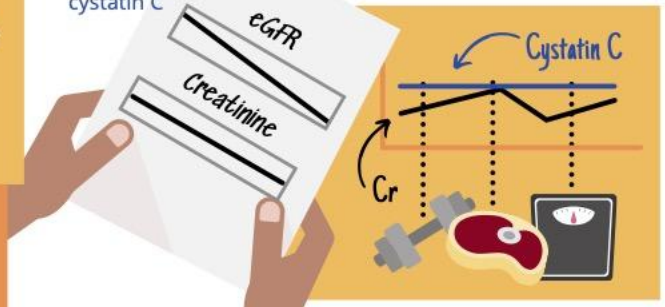
How did the inclusion of race impact patients?

Kidney function was often over-estimated for Black patients, leading to:

- Delays in diagnosis, nephrology referral and transplant
- Inappropriate dosing of medications

How will this affect my practice and my patients?

- A patient's eGFR may go up or down
- Check for a concurrent change in creatinine
- Consider a one-time cystatin C
- These changes will not disrupt patient care
- We recommend discussing the change with patients



2021 CKD-EPI Equation without Race

$$\frac{eGFR}{1.73\ m^2} = 142 * min(\frac{Scr}{k}, 1)^{a} * max(\frac{Scr}{k}, 1)^{-1.200} * 0.9938^{Age} * 1.012\ [if\ female]$$

The updated equation will allow for:**

- About 430,000 Black adults newly diagnosed with CKD
- About 29,000 more Black patients referred to a nephrologist for the first time
- About 3,200 more Black patients with timely access to transplant evaluation

SCAN TO LEARN MORE

*measured by potentially biased Jaffe method (DOI: 10.1515/cclm-2017-1170). **analyzed by methods in DOI: 10.1001/jama.2020.22124

Updates on eGFR

Removal of "Correction" Factor for Race

INSTITUTE FOR HEALING AND JUSTICE IN MEDICINE

Why was a race correction included in estimated GFR (eGFR) equations in the past?

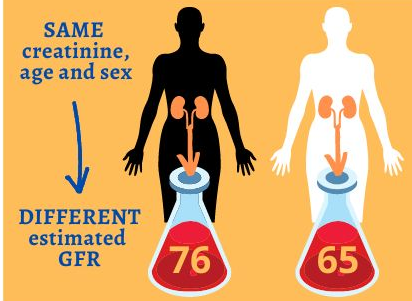
Analysis of the MDRD study in 1999 showed a difference in kidney function between self-identified Black and non-Black participants.

The difference was assumed to be biological, and the race correction factor was added to the eGFR equation. This set the standard for future studies.

For decades, inclusion of the race factor was questioned, but its use continued.

Participant diversity in eGFR studies.

Outcome of estimates that include race.



In 2021, the race factor was re-evaluated and removed. Race is a social construct, not a marker for biological function.

Who recommended removing race correction? Who advocated for this recommendation?

NATIONAL KIDNEY FOUNDATION / ASN American Society of Nephrology

Patients and advocacy groups, nurses, medical students, trainees, clinical, biomedical and social scientists, lawyers, health informatics personnel and physicians advocated for many years to bring about the removal of race from eGFR.

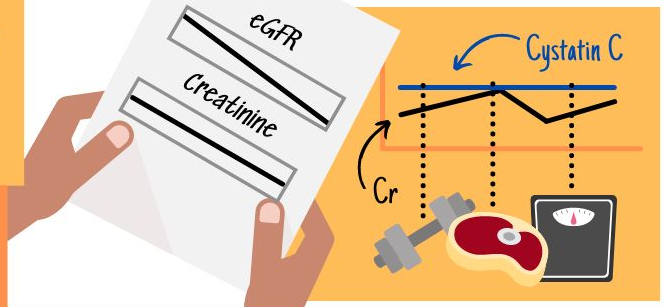
How did the inclusion of race impact patients?

Kidney function was often over-estimated for Black patients, leading to:

- Delays in diagnosis, referral to kidney doctor and transplant
- Inappropriate dosing of medications

How does this change affect me as a patient?

- Your eGFR may go up or down
- Doctors may check for a change in creatinine or test for cystatin C
- These changes will not disrupt your patient care
- We recommend discussing the change with your doctor



2021 CKD-EPI Equation without Race

$$eGFR = 142 * \min\left(\frac{Scr}{k}, 1\right)^{a} * \max\left(\frac{Scr}{k}, 1\right)^{-1.200} * 0.9938^{Age} * 1.012 \text{ [if female]}$$

The updated equation will allow for*:

- About 430,000 Black adults newly diagnosed with chronic kidney disease
- About 29,000 more Black patients referred to a kidney doctor for the first time
- About 3,200 more Black patients with timely access to transplant evaluation

SCAN TO LEARN MORE

*analyzed by methods in DOI: 10.1001/jama.2020.22124

ADVOCACY WORKS! ABOLITION OF RACE-BASED eGFR NATIONALLY, SEPTEMBER 2021

NKF and ASN Release New Way to Diagnose Kidney Diseases

Both Organizations Recommend Race-Free Approach to Estimate GFR

Sept. 23, 2021, New York, NY – Today, the National Kidney Foundation (NKF) and the American Society of Nephrology (ASN) Task Force on Reassessing the Inclusion of Race in Diagnosing Kidney Diseases has released its final report, which outlines a new race-free approach to diagnose kidney disease. In the report, the NKF-ASN Task Force recommends the adoption of the new **eGFR 2021 CKD EPI creatinine equation that estimates kidney function without a race variable. The task force also recommended increased use of cystatin C combined with serum (blood) creatinine, as a confirmatory assessment of GFR or kidney function.** The final report, published today online in the *American Journal of Kidney Diseases (AJKD)* and the *Journal of the American Society of Nephrology (JASN)*, was drafted with considerable input from hundreds of patients and family members, medical students and other trainees, clinicians, scientists, health professionals, and other stakeholders to achieve consensus for an unbiased and most reasonably accurate estimation of GFR so that laboratories, clinicians, patients and public health officials can make informed decisions to ensure equity and personalized care for patients with kidney diseases.

INSTITUTE FOR HEALING AND JUSTICE IN MEDICINE
THE HUB

What's new

Patient integration in eGFR

- Building connections with Advisory Councils, considering restructuring

PFT campaign

- Launching Sept 29 in conjunction w/ CERCA advocacy

New working groups & initiatives

- Weight Inclusive Healthcare
- THRIVE Magazine (Transforming Health and Reimagining Values in Equity)

Upcoming IHJM webinar Sept 29th

INSTITUTE
FOR HEALING
AND JUSTICE
IN MEDICINE

THE HUB

Weight Inclusive Healthcare Initiative

Are you passionate about combating weight bias & discrimination in the medical field?

Join our team as an organizer!

EXPLORE:

- Racism & eugenics of BMI
- Pathologization of size
- Food justice & disordered eating
- And more!

INTERESTED?

RSVP at:
tinyurl.com/IHJMWorking Groups

INSTITUTE FOR HEALING AND JUSTICE IN MEDICINE

THE HUB

INSTITUTE
FOR HEALING
AND JUSTICE
IN MEDICINE

THE HUB

INSTITUTE
FOR HEALING
AND JUSTICE
IN MEDICINE

THE HUB

STATE OF HEALING & JUSTICE IN MEDICINE

PAST, PRESENT, FUTURE

In May 2020, the Institute for Healing and Justice in Medicine was founded to bring together the thousands of people who engaged with our inaugural report, "Towards the Abolition of Biological Race in Medicine."

Two years later, we invite you to join our founding members and working group leaders in discussing:

- where we began
- what we have all accomplished as a community
- our visions for the future of medicine that is centered around healing and justice

thursday, september 29, 2022

5:30 - 7:30 pm pst / 8:30-10:30 pm est

RSVP at instituteforhealingandjustice.org

People of all backgrounds and levels of knowledge about our work are welcome to join, whether you have long been part of our community or are hearing about us for the first time! Zoom link will be sent the week of the event.

INSTITUTE FOR HEALING AND JUSTICE IN MEDICINE

THE HUB

Thank you for being with us today!

instituteforhealingandjustice.org

National Kidney Foundation

Advancing Health Equity Through Patient Education & Engagement

A COLLABORATION

NATIONAL KIDNEY FOUNDATION®

ALIGNED OBJECTIVES

National Kidney Foundation's Commitment to Health Equity in a Clinical Setting

Since its founding in 1964, National Kidney Foundation (NKF) has served as a lifeline for all patients affected by kidney disease. While our mission has remained steadfast, our approach to delivering on that mission has kept pace with – and often driven – changes in the health care community to best meet the needs of the people we serve.

In 2021, NKF and the American Society of Nephrology (ASN) developed a joint task force to Reassess the Inclusion of Race in Diagnosing Kidney Diseases. **The final report recommended the adoption of the new eGFR 2021 CKD EPI creatinine equation that estimates kidney function without a race variable. The task force also recommended increased use of cystatin C combined with serum (blood) creatinine, as a confirmatory assessment of GFR or kidney function.** The final report, published online in the *American Journal of Kidney Diseases (AJKD)* and the *Journal of the American Society of Nephrology (JASN)*, promotes a consistent method of diagnosing kidney diseases that is independent of race – as race, is a social, not a biological, construct.

ALIGNED OBJECTIVES

Collaboration to advance CERCA Objectives in Patient Education and Engagement

Supported by a national framework of resources and expertise, NKF-GNY provides education and support at the local level, serving the New York Metropolitan area with patient education programs, support, and information. As the largest field office of our organization, NKF-GNY has the infrastructure, expertise, and resources to support kidney patients in New York City and help advance the NYC Department of Health's commitment as part of CERCA.

NKF-GNY is poised and prepared to support the New York City Department of Health engage with patients to:

1. Address how the new race free eGFR equation may change existing diagnoses for Black patients

2. Empower patients to advocate for their health from a position of knowledge (e.g. what to ask your doctor; know what your numbers mean; understand your new diagnosis, etc.).

3. Empower patients to take specific follow up steps to understand their (new) disease state and slow the progression of chronic kidney disease.

RISK FACTORS

Two Leading Causes

1 DIABETES

More than 100 million Americans have diabetes, the leading cause of kidney disease. 1 in 3 adults with diabetes may have kidney disease.

2 HIGH BLOOD PRESSURE

1 in 5 adults with high blood pressure may have kidney disease. It is the 2nd leading cause of kidney failure.

PATIENT EDUCATION GUIDING PRINCIPLES

National Kidney Foundation Serving Greater New York believes that optimal kidney care results when patients are empowered to:

01 | **UNDERSTAND RISKS**

Understand their risk factors for and/or diagnosis of Chronic Kidney Disease (CKD)

02 | **SELF ADVOCATE**

Ask questions and understand what their tests results mean

03 | **MODIFY BEHAVIORS**

Adopt healthier lifestyles and habits

04 | **NAVIGATE**

Effectively follow up with providers and take clear actions for better outcomes

05 | **FEEL SUPPORTED**

Feel supported by a community of peers and providers

PATIENT EDUCATION MODEL

An Integrated Approach to Patient Engagement, Education & Empowerment

We provide 7-10 interactive patient webinars each year using patient-friendly platforms

Our Patient Community consists of nearly 15,000 emails through which to promote upcoming programs. We also use fliers with QR codes for use in provider waiting rooms.

NKF GNY provides patients with helpful and understandable content that empowers them to take action

Social media, patient sessions, awareness walks and other events build a community of support (40,000 followers)

Our NKF Cares line, Peer Support Groups, and our Kidney Awareness Walks helps patients feel that they are part of a community.

NKF GNY follows up with patients through surveys, ongoing education opportunities and other touchpoints

Patient Education Campaign Architecture

NOV - DEC	JAN				FEB			
	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Week 8

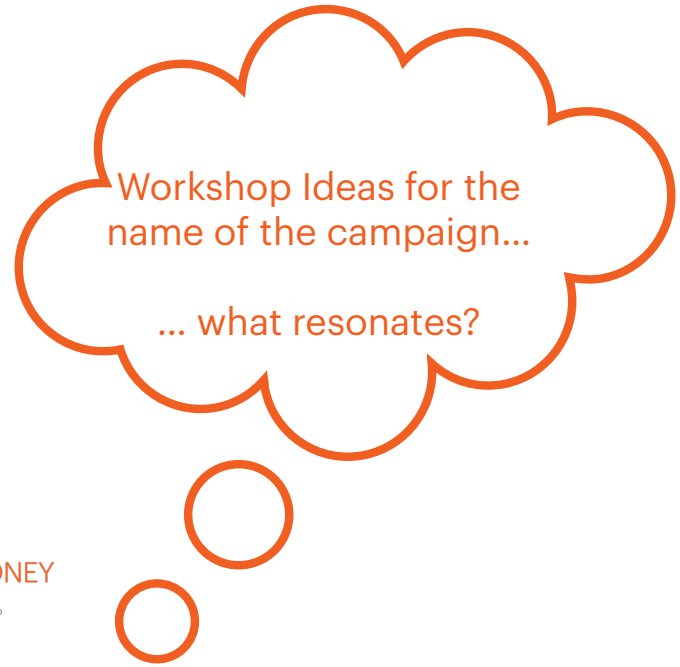
Plan Content, Key Points, Messaging and Program Format

Create a sense of Relevance & Urgency
Essential Facts/ Targets Self Identify

Promote Specific Program
Social Media, Email, & Fliers

Patient Program

Follow Up, Evaluation & Action Items
Patient surveys, follow up materials and outreach



NATIONAL KIDNEY FOUNDATION®

NOV - DEC

Plan Content, Key Points, Messaging and Program Format

- Build consensus and collaboration among CERCA partners
- Agree on timeline and cadence
- Build existing outreach to address Black communities
- Identify target audiences
  - Primary audience: Black individuals with Diabetes, Hypertension and CKD… and their families
  - Secondary audience: providers
- Identify Key Messages for patients and providers regarding new race-free approach to diagnosis.
- Identify existing channels for patient and provider outreach among NKF, DOH and other CERCA members.
- Establish Program format, platform, speakers and participants.
- Develop key messaging points to draw interest and curiosity.
- Identify key resources for patients from NKF and other existing content libraries
- Identify take aways and action items – including support materials; post event surveys; and ongoing touchpoint strategies

JAN

Week 1 | Week 2 | Week 3 | Week 4

Create a sense of Relevance & Urgency

Essential Facts/ Targets Self Identify

Promote Specific Program

Social Media, Email, & Fliers

Concentrate on awareness-building messaging within the first two weeks to create a sense of urgency and help patients self-identify that content is relevant to them. Use across multiple platforms in coordination with all partners.

Same “teaser” language… to be refined with stakeholder feedback.

- *Being Black with Kidney Disease- Your diagnosis may have changed*
- *Medical Bias and Your Kidneys – what you need to know*
- *Black Americans suffer more from Kidney Disease…what you need to know*
- *Kidney Disease and the New Math that affects the Black population.*
- *Systemic racism in healthcare: your kidneys*
- *Medical Bias and Your Health – what you need to know*
- *It’s more than just high blood pressure/ diabetes/ CKD*

Program promotion to begin on Week 2 and extend through Week 4 with registration information and “what to expect.”

- Use all available channels: social media; email; EHR systems; waiting room fliers
- Encourage CERCA member engagement

FEB

Week 5 | Week 6 | Week 7 | Week 8

Patient Program

- **We envision a presentation developed for laypeople and delivered by a Black Nephrologist and a Black patient.** NKF can help secure the speakers.
- We believe a **talk show format** will work well to demonstrate an effective interaction between a **patient and provider** – with real-life perspectives. Participants can ask questions either in the chat or on video/audio.
- NKF-GNY has the infrastructure and technology in place to handle registrations and to deliver robust programming in a virtual setting, both video and call-in. We also can record the session and make the video available for download to all registrants after program.
- Using the channels described earlier, invite both patients and providers – so that they can observe the interaction from both perspectives
- Provide tangible tools and action items so that patients are empowered to follow up and ask questions.
- Registrant information can be shared with DOH for follow up and to hand over to CERCA members for patient follow up.

FEB

Week 5 | Week 6 | Week 7 | Week 8

Follow Up, Evaluation & Action Items

Patient surveys, follow up materials and outreach

Patient/Provider Feedback:
Immediately following the session, participants will leave the session with concrete takeaways/action items.

NKF will follow up with all registrations via email and text. This follow-up will include:

- a video recording
- a printable check list of items, along the lines of: What to ask your provider to advocate for your health. We can also provide a “cheat sheet” about “what your numbers mean” for eGRF, A1C, etc.
- Follow up focus/feedback group to develop additional follow up actions.

NKF can also follow up via text message – with a link to follow up items on a website and a reminder to make an appointment.

NKF will send a second follow-up/check-in email 2 months after the program. In addition, anyone who registered for the patient education session will be invited to NKF-GNY’s regular patient education and support programs (all offered virtually).

NATIONAL KIDNEY FOUNDATION®

FEB			
Week 5	Week 6	Week 7	Week 8

Follow Up, Evaluation & Action Items

Patient surveys, follow up materials and outreach

Metrics

Beyond raising awareness, one of the main objectives of this campaign is to drive Black individuals to make appointments with their providers and discuss their risks for or diagnoses of CKD.

Metrics around the following can serve as indicators:

- Social media engagement and email opens
- Webinar registration
- Webinar participation
- Data from follow up surveys
- Downloads of tools
- Patients who make appointments over the next 3 months*

*requires intake, architecture and coordination on the part of the health system. A Topic for future discussion.

How we can collaborate…

	OVERALL PLANNING	SOCIAL MEDIA	EMAIL	KEY MESSAGES	WAITING ROOM FLIERS	EHR COMMS	ID KEY RESOURCES	PROGRAM LOGISTICS (PLATFORM/ REGISTRATION)	IDENTIFY SPEAKER/ PATIENT	FOLLOW UP ACTIVITIES	PATIENT INTAKE
NKF	☑	☑	☑	☑	-	-	☑	☑	☑	☑	-
CERCA MEMBERS	-	☑	☑	-	☑	☑	☑	-	?	☑	☑

3 Ways to Get Started

1) Declare your interest in collaborating on this initiative patient & provider education and engagement campaign with an email to Saskia.Thomson@kidney.org and to ChiefMedicalOfficer@health.nyc.gov

2) Identify & E-Introduce key personnel in charge of:
   - Patient communication
   - Social media
   - Internal provider communication

3) Walk alongside the National Kidney Foundation at our New York City Kidney Awareness Walk on November 13!
   https://www.kidneywalk.org/NYC

***Next steps*:**

- *Health Equity* special issue on algorithmic bias in medicine and health care
- Outstanding deliverables due to Adriana Joseph - will do individually follow-up regarding deadlines
- CERCA meeting #7 will be **Friday, November 18th** from 1:00 to 2:30