

NYC Coalition to End Racism in Clinical Algorithms Meeting 7



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 *A Third Way: Race-Conscious Approaches to Health Inequities* –
Dr. Bram Wispelwey**

**03 *CERCA Evaluation Plan* -
Dr. Charlene Ngamwajasat**

04 Five-minute Break

05 Breakout Groups by Algorithm

06 Closing + Next Steps

Updates:

- New Senior Medical Advisor: Toni Eyssallenne, MD, PhD
- Status of CERCA deliverables:
 - 4 members have submitted both final deliverables!
- Awarded RWJF grant to conduct evaluation of CERCA



Bram Wispelwey, MD, MPH

Associate Physician, Division of Global Health Equity
Brigham and Women's Hospital
&

Instructor, Department of Global Health and Population Department of
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Harvard T.H. Chan School of Public Health

A Third Way: Race-Conscious Approaches to Health Inequities

CERCA Meeting

11/18/2022

Bram Wispelwey (he, him)

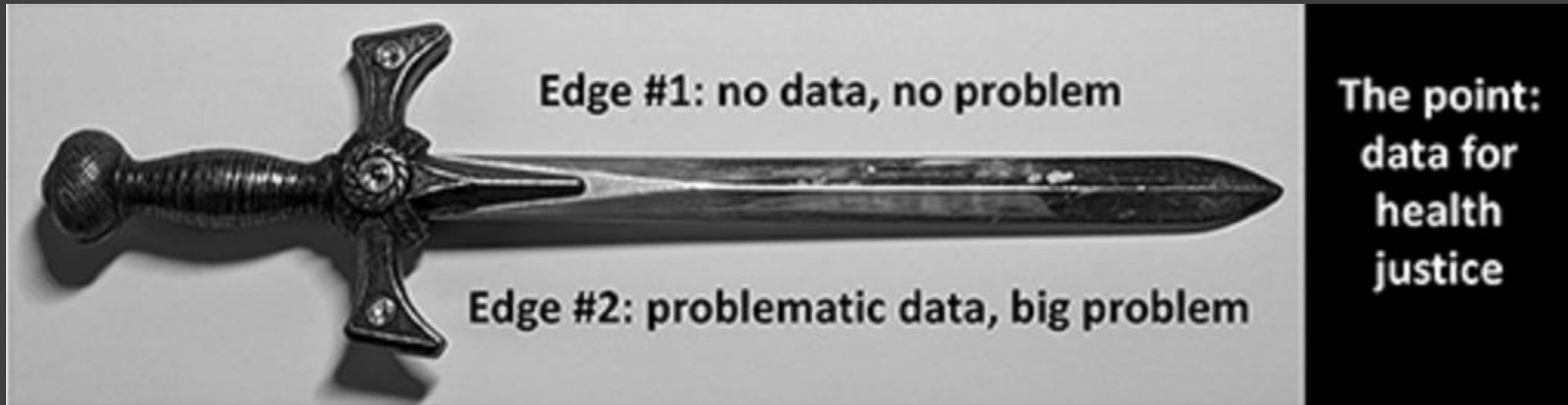
Co-Director | Palestine Program for Health and Human Rights | Harvard FXB Center

Instructor | Harvard Medical School & Harvard T.H. Chan School of Public Health

Associate Physician | Division of Global Health Equity | Brigham and Women's Hospital

Senior Technical Lead | Partners In Health United States

The Two-Edged Sword of Data



Nancy Krieger: Frontiers in Public Health:
<https://www.frontiersin.org/articles/10.3389/fpubh.2021.655447/full>

First edge: ignoring race

Ideas and Opinions | October 2021

Disparate Impact: How Colorblind Policies Exacerbate Black–White Health Inequities

Scott W. Delaney, ScD, JD, MPH  , Utibe R. Essien, MD, MPH , and Amol Navathe, MD, PhD 

[Author, Article, and Disclosure Information](#)

- The fatal fallacy of race-blind or “equal opportunity” over “equal outcome” approaches is that they fail to account for historical and structural racism and thus can often exacerbate existing inequities by benefitting primarily the most privileged

Second edge: misunderstanding
and/or misusing race

Racism

“Racism is the ordinary means through which dehumanization achieves ideological normality, while, at the same time, the practice of dehumanizing people produces racial categories.”

-Ruth Wilson Gilmore

What does ‘socially constructed’ mean?

Races can be understood as “traces of history,” since racialization acts to reflect, justify, and reproduce—into the present—the hierarchies engendered by historical processes of colonization and domination.

E.g. racism may be redundant since *race is already an ‘-ism’*

Medical racism in action

- Racial Essentialism: the belief that socially constructed racial categories reflect “inherent” biological differences
- Implicit & explicit in medical education, training
- Algorithms: kidney function, lung function, VBAC
- Temptation to consider/assume biological cause for inequities

Medical racism in action

- This is both a moral and an intellectual failing:

Racial essentialism attempts to utilize an oppressive sociopolitical fabrication (**race**) to understand genetic diversity and population distribution of alleles (**ancestry**)

Consequences of racial essentialism

- Racial essentialism “exacerbates learners’ racial prejudice and diminishes their empathy”
- “Essentialist medical approaches contribute to not only interpersonal racial biases but also *systemic* racial biases that create spurious standards of care for patients of color, delay diagnoses, and inhibit patients’ ability to access surgeries, treatments, and social resources.”

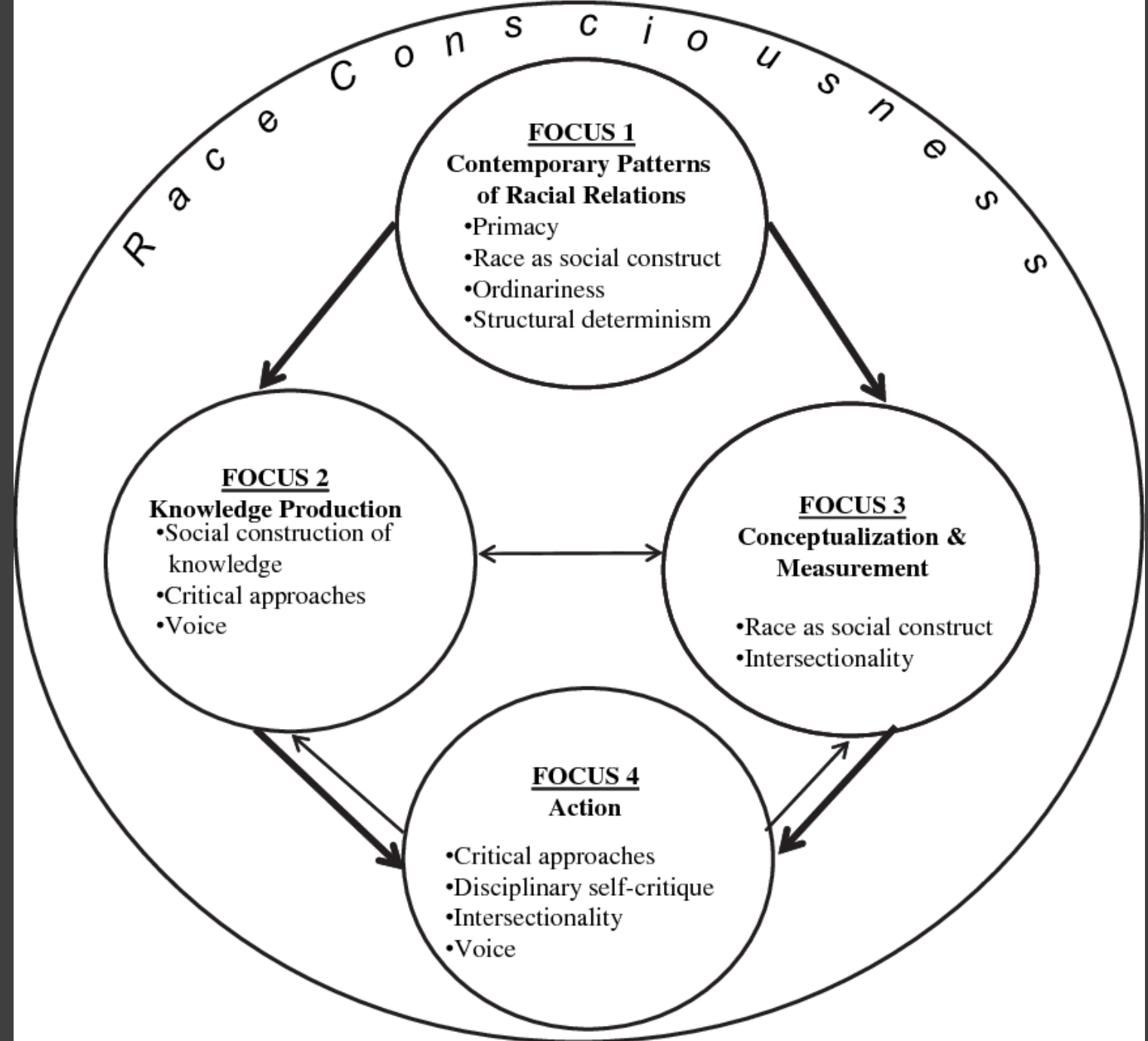
Third way (the point):
race for health justice

How to stay on point?

- Race-consciousness
- Targeted universalism
- Equity

Race-Blind/Equality-Driven Approach	Race-Conscious/Equity-Driven Approach
Quality interventions designed to improve care for all	Quality interventions targeting racism directly
Equality (same approach for all)	Equity (differential approaches based on historical injustice and racism experienced by some groups)
Avoid naming race/racism in the intervention	Center the naming of race/racism in the intervention
Assumes racism and bias is exceptional	Assumes racism and bias is pervasive
Using non-race proxies for inequities due to institutional racism (zip code, income, etc.)	Using race as a proxy for inequities due to institutional racism

Public Health Critical Race Praxis



Ford C and Airhihenbuwa C. Just What is Critical race theory and What's it doing in a Progressive Field like Public health? *Ethn Dis.* 2018; 28 (Suppl 1): 223-230.

Fig 1. Race consciousness, the four focuses and top-affiliated principles

Circulation: Heart Failure

ORIGINAL ARTICLE

Identification of Racial Inequities in Access to Specialized Inpatient Heart Failure Care at an Academic Medical Center

- Study was guided by Public Health Critical Race Praxis: an approach utilized by researchers to study and ameliorate instances of structural racism and resultant health inequities and developed out of the legal framework of Critical Race Theory
- Considered race to be a social construct that captures the impacts of racism rather than innate biological differences and, therefore, hypothesized that differences in HF outcomes were due to structural drivers rather than biological causes.

Heart Failure: Study Outcomes

Raw data:

- 67% of White vs 53% of Black and Latinx patients admitted to Cardiology

Primary Outcome, multivariate analysis:

- Black and Latinx patients admitted to Cardiology less frequently than White peers

Secondary Outcomes, Cardiology admission associated with:

- Significantly decreased likelihood of hospital readmission (hazard ratio = 0.84, 95%CI 0.72-0.97)
- Increased outpatient Cardiology follow up (46% vs 25% for GMS)

Characteristic	Multiply Imputed Analysis		
	Adjusted RR	95% CI	P Value
Race			
White	ref		
Black	0.91	0.84–0.98	0.015
Latinx	0.84	0.73–0.96	0.012

	Rate Ratio of Admission to Cardiology	95% CI	P Value
Black vs white	0.74	0.63–0.87	0.0001
Latinx vs white	0.75	0.60–0.95	0.014
Female vs male	0.86	0.77–0.96	0.0055

So what are steps we can take to improve investigation and address inequities?

- What's the fundamental action approach that adheres to Public Health Critical Race Praxis and avoids both edges of the sword?

Healing ARC: reparative approach to institutional racism

- 1) *Acknowledgement*: the institution voices ownership and responsibility for inequities to the communities impacted
- 2) *Redress*: a compensatory step in addressing patients and communities harmed by institutional racism
- 3) *Closure*: explores community oversight as a means of ensuring fair restitution for inequities

Healing ARC



A Reparative Approach

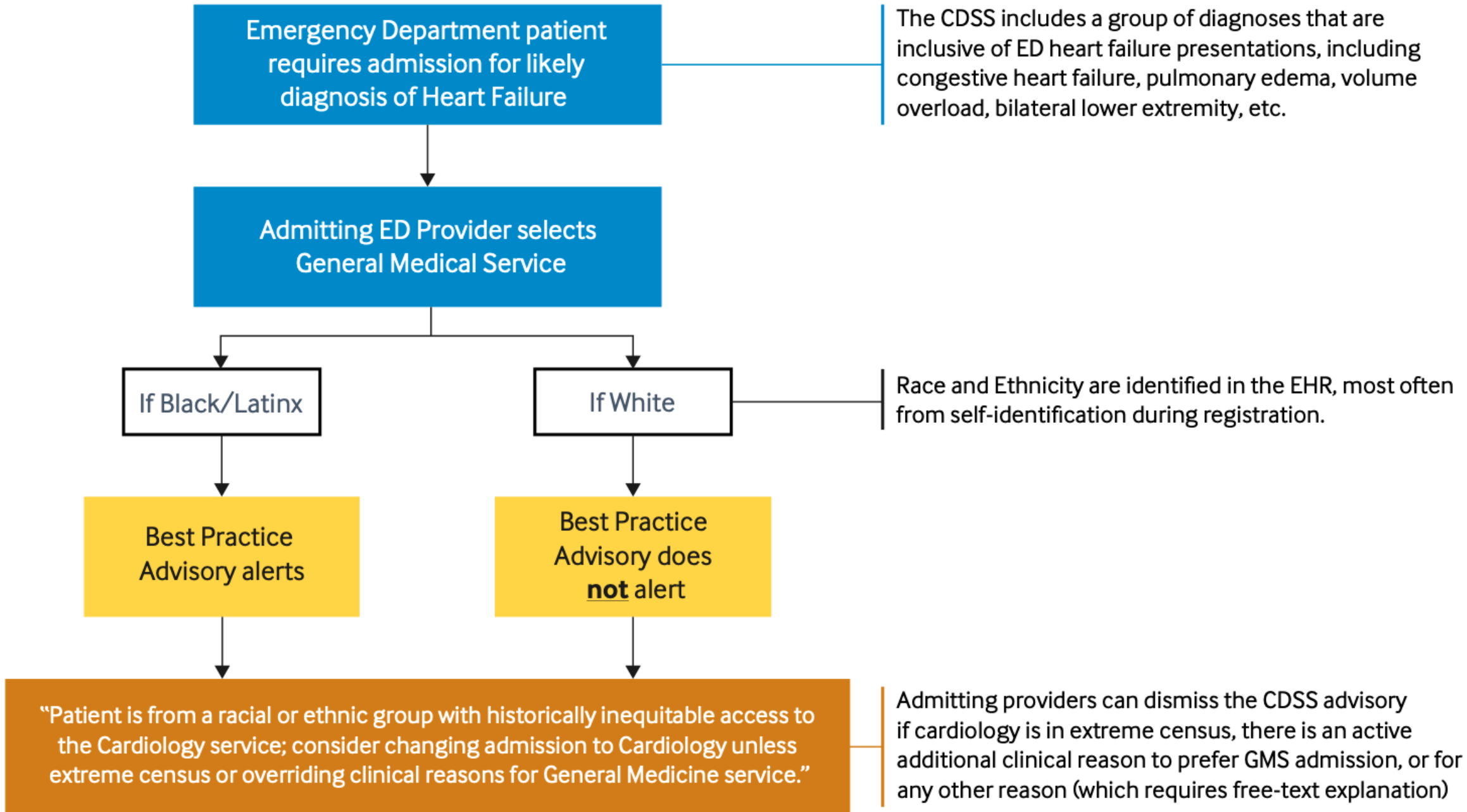
The outstanding debt from the harm caused by our institutions, and owed to our BIPOC patients, is long overdue: now is the time to start settling it.

COMMENTARY

Leveraging Clinical Decision Support for Racial Equity: A Sociotechnical Innovation

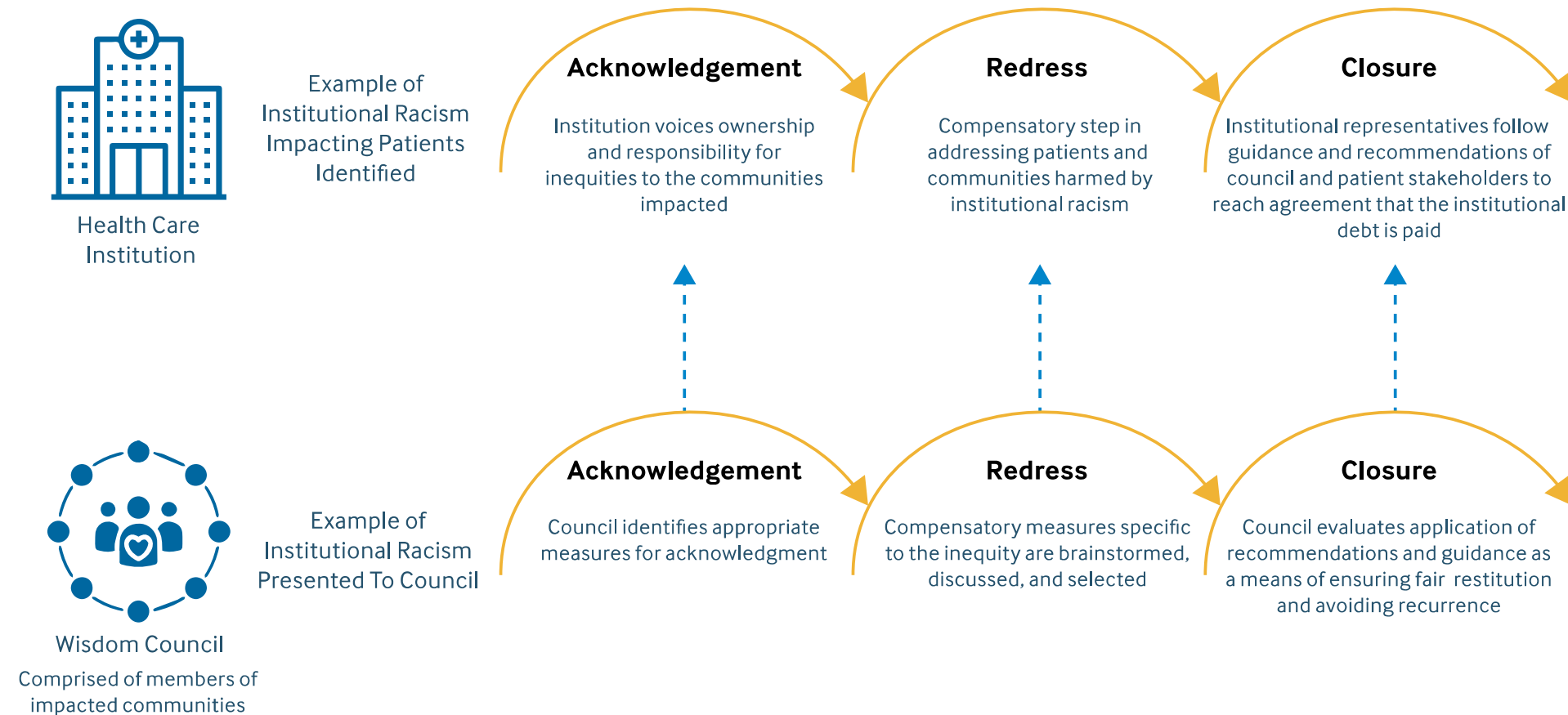
Bram P. Wispelwey, MD, MPH, MS, Regan H. Marsh, MD, MPH, Michael Wilson, MD, PhD, Sula Mazimba, MD, MPH, Scott K. Heysell, MD, MPH, Imoigele P. Aisiku, MD, MBA, Akshay S. Desai, MD, MPH, Cassandra Georges, , Michelle E. Morse, MD, MPH

DOI: [10.1056/CAT.22.0076](https://doi.org/10.1056/CAT.22.0076)



Wisdom Councils Guide Healing ARC Implementation for Institutional Accountability

This figure shows how the Wisdom Council facilitates the implementation of the Healing ARC model of addressing institutional racism.





November 7, 2022

Association Between Racial Wealth Inequities and Racial Disparities in Longevity Among US Adults and Role of Reparations Payments, 1992 to 2018

Kathryn E. W. Himmelstein, MD, MEd¹; Jourdyn A. Lawrence, PhD, MSPH^{2,3}; Jaquelyn L. Jahn, PhD⁴; Joniqua N. Ceasar, MD^{5,6}; Michelle Morse, MD, MPH^{7,8}; Mary T. Bassett, MD, MPH⁹; Bram P. Wispelwey, MD, MPH⁸; William A. Darity Jr, PhD¹⁰; Atheendar S. Venkataramani, MD, PhD¹¹

» [Author Affiliations](#) | [Article Information](#)

JAMA Netw Open. 2022;5(11):e2240519. doi:10.1001/jamanetworkopen.2022.40519

From: **Association Between Racial Wealth Inequities and Racial Disparities in Longevity Among US Adults and Role of Reparations Payments, 1992 to 2018**

JAMA Netw Open. 2022;5(11):e2240519. doi:10.1001/jamanetworkopen.2022.40519

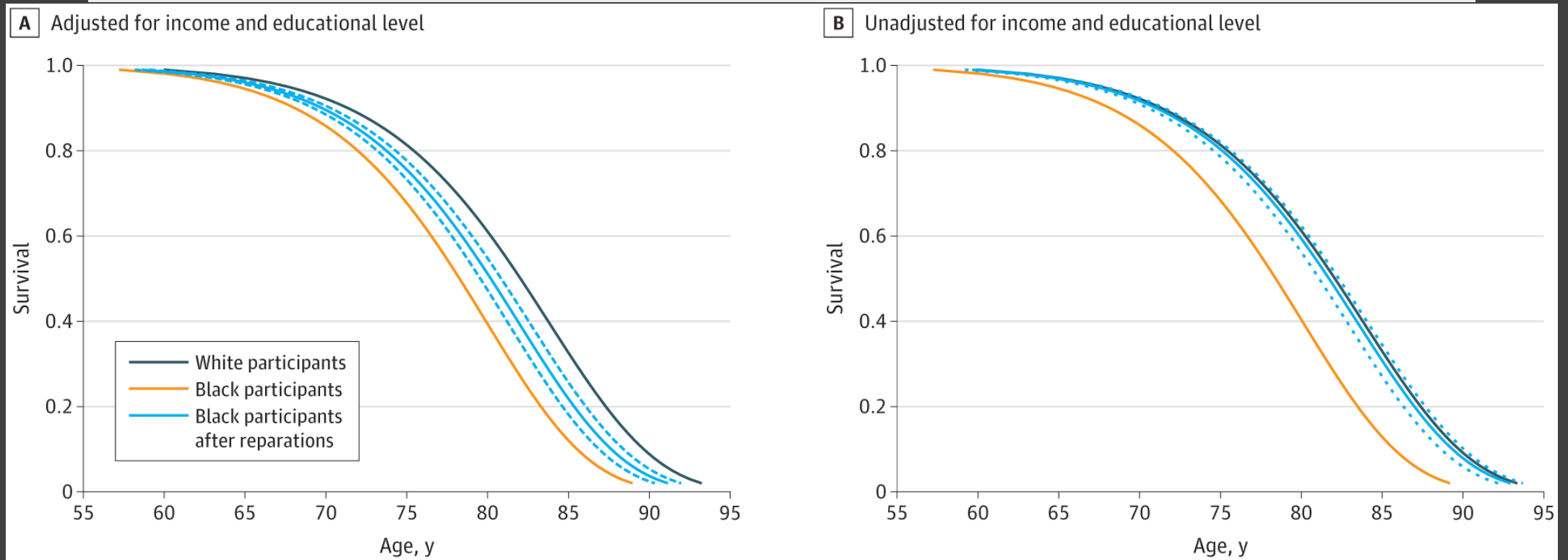


Figure Legend:

Survival of White and Black Participants and Projected Survival of Black Participants After Reparations Payments. Data are from the Health and Retirement Study. Survival curves are drawn for an individual with the mean value of all covariates and using the Weibull survival models from Table 2. Dashed lines represent 95% CIs.

What inequities are you uncovering in your work and how might you take a reparative approach to address them?

Acknowledgments

- Special thanks and acknowledgment to partners in this work: Cass Georges, Michelle Morse, Regan Marsh, Michael Wilson, Imo Aisiku, Claire Pierre, Akshay Desai, the BWH Community Wisdom Council

CERCA EVALUATION PLAN

Charlene Ngamwajasat MD
Senior Physician Informaticist/Population Health Clinical Advisor
Bureau of Equitable Health Systems
NYC Department of Health and Mental Hygiene
November 18, 2022

AGENDA

- Objectives
- Methodology
- Key Activities

CERCA EVALUATION

OBJECTIVES:

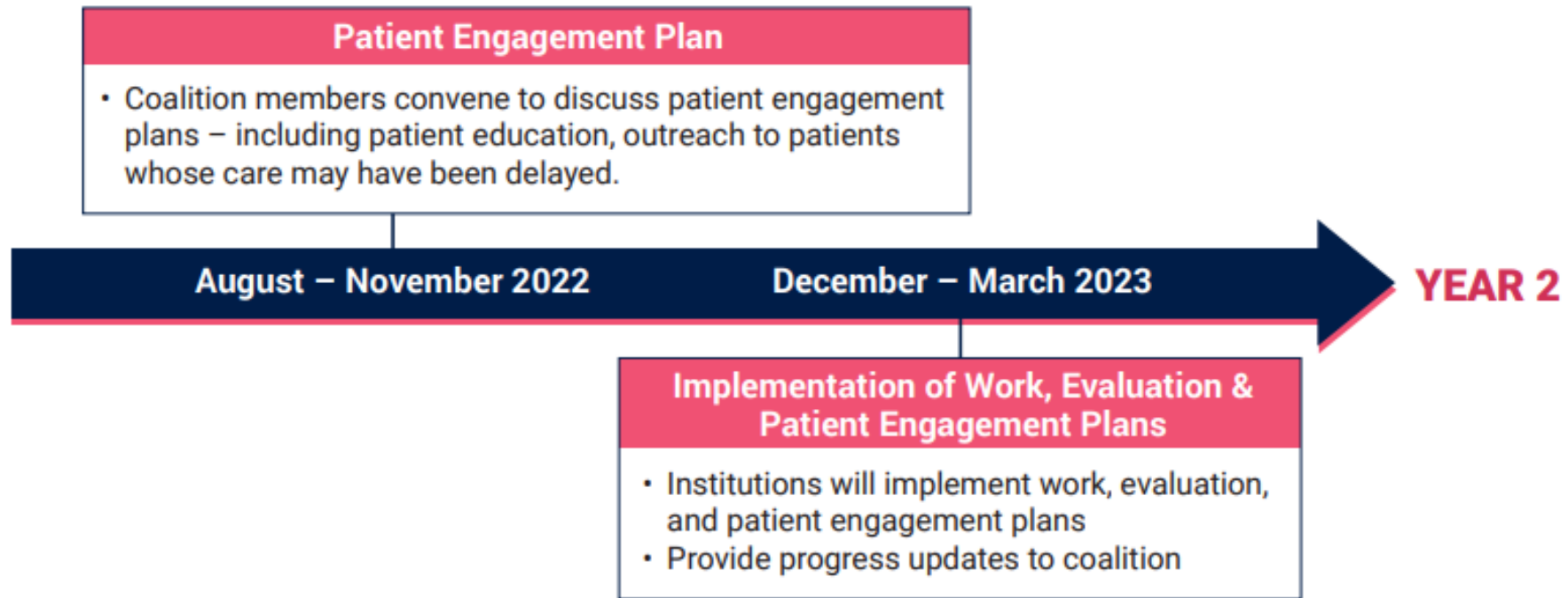
1. Assess the effectiveness of CERCA infrastructure and processes
2. Identify how healthcare systems eliminated race adjustment
3. Identify health systems' implementation facilitators and barriers
4. Assess development and implementation of patient engagement strategies

CERCA EVALUATION

METHODOLOGY:

- Timeline: November 2022-May 2024 (~18months)
- Summative process evaluation, including:
 - Document review (e.g., meeting agendas, notes, workplans)
 - Survey with CERCA members
 - Key informant interviews with CERCA members

Timeline



METHODOLOGY:

- Health systems are asked to evaluate change in racial inequities within their health systems and effectiveness of their patient engagement strategies
- Submit summary of their evaluation findings

CERCA EVALUATION

❑ For the remainder of 2022, we are conducting document review of CERCA member plan submissions and may reach out to individual health systems

Year	Timeframe	Key Activities
2023	January – March	<ul style="list-style-type: none">Continued document reviewIRB
	April – May	<ul style="list-style-type: none">Development of interview protocols and survey questionnaires
	June – December	<ul style="list-style-type: none">Administer surveys to CERCA membersConduct key informant interviews with CERCA members
2024	January – May	<ul style="list-style-type: none">CERCA health system members submit evaluation findingsData analysis and synthesisEvaluation report

Thank you!

For questions, please contact:

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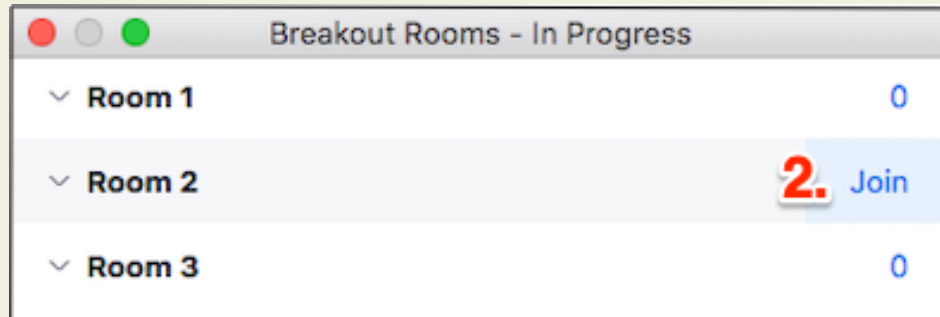
**We'll reconvene in
5 minutes.**



Breakout Groups by Clinical Algorithm

Facilitators:

- eGFR - Dr. Sophia Kostelanetz
- VBAC - Drs. Michelle Morse & Amita Murthy
- PFT- Dr. Toni Eyssallenne



To join breakout rooms:

1. Click the Breakout Rooms icon in toolbar at bottom of your Zoom screen
2. Hover your pointer over number to the right of desired breakout room, click **Join**, then click **Yes**

Next steps:

- Outstanding deliverables due to Adriana Joseph - will do individually follow-up
- CERCA meeting #8 will be **Friday, January 27th, 2023** from 1:00 to 2:30