October 16, 2020

Richard E. Neal
Chairman, Committee on Ways and Means
U.S. House of Representatives
Washington, DC 20515

Re: Call for Comments on Use of Race in Clinical Algorithms

Dear Chairman Neal,

Thank you for the invitation to submit comments on the important issue of using race in clinical algorithms. The Society of General Internal Medicine represents about 3000 general internists who provide clinical services and conduct research and teaching intended to help achieve our vision for a just system of care in which all people can achieve optimal health. We offer the following answers to the questions in your letter from September 17, 2020.

Question 1: To what extent is it necessary that health and health related organizations address the misuse of race and ethnicity in clinical algorithms and research? What role should patients and communities play?

Many of our members have been leaders in conducting research to improve understanding of racial disparities in health and health care., and we believe much more research is needed to develop solutions for addressing the disparities that have been identified in previous research. We also affirm the importance of doing more research focusing specifically on the use of race and ethnicity in clinical algorithms. We believe that such research is needed to improve understanding of the potential benefits and harms associated with use of race and ethnicity in clinical algorithms, while taking into consideration the possible benefits and harms that could result from avoiding all use of race and ethnicity in clinical algorithms. Evidence from such research could help to ensure that policies on the use of race and ethnicity in clinical algorithms do not have unintended adverse effects on minority populations. Ideally, research on this topic should engage representatives of minority communities, following the principles of patient and community engagement that have been developed by the Patient Centered Outcomes Research Institute (PCORI).

Question 2: What have been the most effective strategies that you or your organization have used to correct the misuse of race and ethnicity in clinical algorithms and research, if any? What have been the challenges and barriers to advancing those strategies?

Many of our members have conducted research that has helped to demonstrate that racial disparities in health are associated with differences in social determinants of health (SDOH). SGIM has addressed the overarching issue by publishing a position statement calling on general internists and community practitioners to address SDOH in their spheres of influence as practicing physicians, educators, researchers, health system leaders, and public health advocates

1500 King Street • Suite 303 • Alexandria • VA 22314
Tel: 202.887.5150 • 800.822.3060 • Fax: 202.887.5405
Web: http://www.sgim.org

(https://link.springer.com/article/10.1007/s11606-020-05934-8). The position statement presents a comprehensive look at how the entire range of SDOH affects the ability to care for individual patients, form partnerships with local community organizations, and impact population health and equity. General internists must teach future physicians about SDOH and their upstream causes of health inequities and must collaborate with other professionals in health and non-health sectors to achieve parity in healthcare settings. The paper issues the following actionable recommendations:

As Clinicians – embrace relationship-centered communication and interprofessional care teams.
As Health Systems Leaders - encourage our organizations to partner with community members and community-based organizations.
As Educators - ensure social and relational competency for future physicians by developing curricula that incorporate SDOH at every stage of education and evaluation.
As Researchers - use science as a tool of inclusion by encouraging authentic partnerships with community members at all levels while partnering with other fields of research to solve complex social problems that result in poor health.
As Advocates - advocate for the assessment of health impacts of key federal policies and advocate to federal and state governments to create financial structures that share dollars from all-payer, incentive-driven savings programs from healthcare with other public sectors such as housing.

Although our organization has not established a consensus on how to address the use or misuse of race and ethnicity in clinical algorithms, our members are involved in conducting the types of research needed to develop evidence-based strategies for addressing the issue. For example, Dr. Essien is the lead author of an article on race effects in cardiovascular disease prediction models - https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6445914/. He emphasizes that attention needs to be given to why racial minorities have been regularly excluded from the studies that have been used to derive clinical prediction models. In an article just published in our Journal of General Internal Medicine, investigators examined the potential impact of race multiplier utilization in estimated glomerular filtration rate (eGFR) calculation in African-American care outcomes - https://link.springer.com/article/10.1007/s11606-020-06280-5. Their study found a meaningful impact of race-adjusted eGFR on care provided to African Americans with chronic kidney disease. In an article published in JAMA, Dr. Powe discusses challenges in approaches to mitigating the use of race in clinical algorithms, and points out that variable approaches by institutions may lead to uninterpretable eGFR trends for patients and confusion for health care professionals - https://jamanetwork.com/journals/jama/fullarticle/2769035.

One of the most important challenges is that we need medical professional societies to collaborate in acting upon these recommendations. We believe the time is ripe to foster such collaboration now that most professional societies recognize the extent of the disparities in health that exist in our country. Such collaboration will be particularly important in addressing the use of race and ethnicity in clinical algorithms. Clinicians in all specialties need to have a standardized approach to clinical algorithms in order to avoid problems with coordination of

care between generalists and specialists. We are interested in working with other professional societies to foster a consistent approach to clinical care.

Question 3: What strategies would you propose to build consensus and widely used guidelines that could be adopted broadly across the clinical and research community to end the misuse of race and ethnicity in clinical algorithms and research?

We recommend giving priority to the development of evidence-based clinical practice guidelines that adhere to the guidance from the Institute of Medicine on developing trustworthy guidelines (https://www.nap.edu/resource/13058/Clinical-Practice-Guidelines-2011-Report-Brief.pdf) and that are based on a consensus of relevant stakeholders, including medical professional societies representing generalists and specialists, as well as community representatives.

Best regards,

Eric B. Bass, MD, MPH

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Web: http://www.sgim.org