Using Clinical Registries to Address Disparities in Covid-19

September 1, 2020 | 2:30 – 4:00 pm ET
About the Series:

- Made possible with funding from the Gordon and Betty Moore Foundation
- To foster collaboration between specialty societies and academia, we are grateful to collaborate with the Association of Academic Medical Colleges

Continue the Conversation:

- Use #COVIDRegistries when tweeting about the webinar series
- Follow @CMSSMed and visit CMSS.org for frequent updates
Today's Webinar:

Using Clinical Registries to Address Disparities in Covid-19

CMSS WEBINAR SERIES
Advancing Clinical Registries to Support Pandemic Treatment and Response

Moderator:
Helen Burstin, MD, MPH, MACP
Chief Executive Officer
Council of Medical Specialty Societies (CMSS)

Panelists:

Kirsten Bibbins-Domingo,
PhD, MD, MAS
Professor and Chair, Department of Epidemiology and Biostatistics; Lee Goldman, MD Endowed Chair in Medicine; Vice Dean of Population Health and Health Equity, School of Medicine UCSF

Eliseo Perez-Stable, MD
Director of the National Institute on Minority Health and Health Disparities (NIMHD), National Institutes of Health (NIH)

Clyde Yancy, MD, MSc, MACC, FAHA, MACP, FHFS
Vice Dean, Diversity & Inclusion, Magerstadt Professor of Medicine, Professor of Medical Social Sciences, Chief, Division of Cardiology Northwestern University, Feinberg School of Medicine

Bill Wood, MD, MPH
Chair, Data Hub Oversight Group, ASH Research Collaborative; Associate Professor of Medicine, Division of Hematology, University of North Carolina at Chapel Hill
CMSS Disparities and COVID19 Webinar, 09/01/2020

Health Disparities; now fully exposed by COVID19

Clyde W. Yancy, MD, MSc
Professor of Medicine,
Professor, Medical Social Science
Chief, Cardiology
Associate Director, Bluhm CV Institute
&
Vice-Dean, Diversity & Inclusion
Northwestern University, FSM
&
Deputy Editor, JAMA Cardiology
THE COLOR OF CORONAVIRUS:
COVID-19 DEATHS BY RACE AND ETHNICITY IN THE U.S.
• KEY FINDINGS:

• Through August 4, The coronavirus has claimed more than 155,000 American lives through Aug. 18, 2020

• Overall, American death rates from COVID-19 data (aggregated across all states with available data and the District of Columbia) have reached new highs for all race groups:
  
  • 1 in 1,125 Black Americans has died (or 88.4 deaths per 100,000)
  • 1 in 1,375 Indigenous Americans has died (or 73.2 deaths per 100,000)
  • 1 in 1,575 Pacific Islander Americans has died (or 63.9 deaths per 100,000)
  • 1 in 1,850 Latino Americans has died (or 54.4 deaths per 100,000)
  • 1 in 2,450 White Americans has died (or 40.4 deaths per 100,000)
  • 1 in 2,750 Asian Americans has died (or 36.4 deaths per 100,000)

Data now reported from 45 states; race/ethnicity data on 93% deaths; most recent update August 4, 2020
• The latest overall COVID-19 mortality rate for **Black Americans** is about 3.6 times as high as the rate for Whites; for Indigenous people 3.4 times as high; for Latinos, 3.2 times as high, Pacific Islanders, 3.0 times as high and Asians, 1.3 times as high.

• If they had died of COVID-19 at the same actual rate as White Americans, about 19,500 Black, 8,400 Latino, 600 Indigenous, and 70 Pacific Islander Americans would still be alive.
Adjusted for age, other racial groups are this many times more likely to have died of COVID-19 than White Americans

Reflects mortality rates calculated through Aug. 18.

<table>
<thead>
<tr>
<th>Race</th>
<th>Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>BLACK</td>
<td>3.6</td>
</tr>
<tr>
<td>INDIGENOUS</td>
<td>3.4</td>
</tr>
<tr>
<td>LATINO</td>
<td>3.2</td>
</tr>
<tr>
<td>PACIFIC ISLANDER</td>
<td>3</td>
</tr>
<tr>
<td>ASIAN</td>
<td>1.3</td>
</tr>
</tbody>
</table>

*Indirect age-adjustment has been used.*

Source: APM Research Lab • Get the data • Created with Datawrapper
The extent of the crisis:

JAMA. Published online April 15, 2020. doi:10.1001/jama.2020.6548

- **Chicago:**
  - 50% of COVID-19 cases & nearly 70% of COVID-19 deaths involve black individuals, although blacks make up only 30% of the population.
  - Moreover, these deaths are concentrated mostly in just 5 neighborhoods on the city’s South Side.⁶

- **New York City**
  - Blacks and Hispanics, have accounted for 28% and 34% of deaths, (population representation: 22% and 29%) respectively.⁸
The US has needed a trigger to fully address health care disparities; COVID-19 may be that bellwether event.
We propose that the overarching cause of these tragic statistics is decades of the effects of adverse social determinants of health.

People must make good choices, but they must have good choices to make.
Compared with white individuals, African American individuals have higher rates of uninsurance and underinsurance. Segregation of health care also contributes to racial disparities in health care with access to primary care and especially specialty care physicians more limited in communities of color.
Continued...

- “These data highlight that social inequities are patterned by place…”
- “The problem of segregation is not residing among persons of the same race, but the clustering of social disadvantage and systematic disinvestment in marginalized communities…”
- “The striking racial/ethnic disparities reported for COVID-19 infection, testing, and disease burden are a clear reminder that failure to protect the most vulnerable members of society not only harms them but also increases the risk of spread of the virus, with devastating health and economic consequences …”
- “The US must develop a new kind of “herd immunity,” whereby resistance to the spread of poor health in the population occurs when a sufficiently high proportion of individuals, across all racial, ethnic, and social class groups, are protected from and thus “immune” to negative social determinants.”
• “As the cases of coronavirus disease 2019 (COVID-19) continue to increase across the world, evidence is continuing to emerge that the pandemic could be disproportionately affecting people from black, Asian, and minority ethnic (BAME) communities...

... In the UK, this trend first came to public attention during media reports that showed the first 11 doctors who sadly lost their lives to COVID-19, were all from BAME communities...”
COVID19 deaths in UK healthcare workers

British Dental Journal volume 228, pages 919–922 (2020)

Likelihood of dying from COVID-19 compared to white ethnicity

<table>
<thead>
<tr>
<th>Male</th>
<th>Comparison group: White</th>
<th>Increased risk of dying from COVID-19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black</td>
<td>Just as likely</td>
<td>1.5x as likely</td>
</tr>
<tr>
<td>Bangladeshi/Pakistani</td>
<td>Just as likely</td>
<td>2x as likely</td>
</tr>
<tr>
<td>Indian</td>
<td>Just as likely</td>
<td>1.5x as likely</td>
</tr>
<tr>
<td>Other</td>
<td>Just as likely</td>
<td>2x as likely</td>
</tr>
<tr>
<td>Chinese</td>
<td>Just as likely</td>
<td>1.5x as likely</td>
</tr>
<tr>
<td>Mixed</td>
<td>Just as likely</td>
<td>2x as likely</td>
</tr>
</tbody>
</table>

Likelihood of dying from COVID-19 compared to white ethnicity

<table>
<thead>
<tr>
<th>Female</th>
<th>Comparison group: White</th>
<th>Increased risk of dying from COVID-19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black</td>
<td>Just as likely</td>
<td>1.5x as likely</td>
</tr>
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</tr>
<tr>
<td>Mixed</td>
<td>Just as likely</td>
<td>2x as likely</td>
</tr>
</tbody>
</table>

Northwestern Medicine
• Brazil has had more infections and more deaths than any country but the United States.

• Latin America became an epicenter of the coronavirus pandemic in May, driven by Brazil’s ballooning caseload, even as the number of known infections in Europe fell. Six months after its first known case, Brazil has had over 3.6 million cases — more than all of Europe — and about 115,000 deaths.
IOM Report: Differences, Disparities, and Discrimination

Disparities—racial or ethnic differences in healthcare that are not due to access related factors, clinical needs, patient preferences or the appropriateness of the intervention.

Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare. The Institute of Medicine, National Academies Press, Washington, DC. 2002
Exploring Equal/Equity/Reality
# Social Determinants of Health

<table>
<thead>
<tr>
<th>SEP</th>
<th>Race, ethnicity</th>
<th>Social support</th>
<th>Culture and language</th>
<th>Access to care</th>
<th>Residential environment</th>
</tr>
</thead>
</table>

SEP indicates socioeconomic position.
IMPACT OF SOCIAL DETERMINANTS OF HEALTH

Social determinants of health have tremendous affect on an individual’s health regardless of age, race, or ethnicity.

- **Socioeconomic Factors**
  - Education
  - Job Status
  - Family/Social Support
  - Income
  - Community Safety

- **Physical Environment**

- **Health Behaviors**
  - Tobacco Use
  - Diet & Exercise
  - Alcohol Use
  - Sexual Activity

- **Health Care**

**SDOH Impact**

- **20 percent** of a person’s health and well-being is related to **access to care** and **quality of services**

- The **physical environment**, **social determinants**, and **behavioral factors** drive **80 percent** of health outcomes

Source: Institute for Clinical Systems Improvement; Going Beyond Clinical Walls: Solving Complex Problems, 2014 Graphic designed by ProMedica.

©2018 American Hospital Association
Appropriate Public Health Initiatives; Ubiquitous Testing in High Risk Communities-

• Testing: targeting communities with higher infection rates
• Follow the SVI – Social Vulnerability Index
• https://svi.cdc.gov/
• “...resilience of communities when confronted by external stresses on human health, stresses such as natural or human-caused disasters, or disease outbreaks...”
• uses 15 U.S. census variables at tract level ...
• Possible scores range from 0 (lowest vulnerability) to 1 (highest vulnerability).
Chicago COVID and the Inequities

Risk scores by zip code
As of April 6, 2020

Locations of COVID-19 fatalities represented by green dots
“I have been impressed with the urgency of doing. Knowing is not enough; we must apply. Being willing is not enough; we must do.”
— Leonardo da Vinci

“This is my final recommendation: think about the metric by which your life will be judged, (not by your accolades but by the people you’ve helped), and make a resolution to live every day so that in the end, your life will be judged a success.”
- Clayton Christensen
The UCSF Population Health Data Initiative: Place and Health

Kirsten Bibbins-Domingo, PhD, MD, MAS
Professor and Chair, Epidemiology and Biostatistics
Vice Dean for Population Health and Health Equity
Background

Population Health Data Initiative (PHDI):

1. Increase population health data access
   a. Geocoding addresses within electronic health records (EHRs) at UCSF Health, San Francisco Health Network, and other UC medical centers
   b. Linking these data with existing population-level datasets at the neighborhood-level (i.e. US Census and California Health Interview Survey)

2. Partner with healthcare systems and the department of public health to align research, quality improvement, and programming using patient and population-level data
Initial focus on:
1) High-priority areas/conditions for healthcare leadership
2) Local patients within the SF Bay Area
Neighborhood Socioeconomic Status (nSES)

UCSF Population Health Data Initiative
Maps created by: UCSF DREAM Lab

Data Sources:
UCSF Health
Uncontrolled Diabetes Clusters Overlaying nSES

UCSF Population Health Data Initiative
Maps created by: UCSF DREAM Lab

Data Sources:


Harnessing EHR Data for Place-Based Research
A second clinical site for UCSF is the public delivery system, the San Francisco Health Network
- Includes Zuckerberg San Francisco General Hospital and community clinics throughout the city and county
- Creating matched geocoded cohorts of patients with diabetes, hypertension, and opioid use
  - Using same UCSF Health protocol for geocoding second system’s EHR data
Percent Controlled Blood Pressure Among Hypertension Patients in Two San Francisco Health Systems Overlaying Census Tracts According to Street Connectivity

UCSF Population Health Data Initiative
Map created by UCSF DREAM Lab

Data Sources:
California Neighborhoods Data System, Gomez et al. 2011
NavTeq. NAVSTREETS Street Data Reference Manual v3.7.12010.
But we know we’re not the entire population!
As part of the 54-city Partnership for Healthy Cities, San Francisco pursues citywide public health data project to tackle chronic disease

*San Francisco is committed to preventing chronic diseases as part of a global network of cities*

FOR IMMEDIATE RELEASE

Contact Rachael Kagan 415 554-2507, 415 420-5017 cell, rachael.kagan@sfdph.org

**San Francisco (October 31, 2018)**—On World Cities Day, Mayor London Breed affirmed her commitment to proven public health policies that prevent deaths and injuries as part of the Partnership for Healthy Cities. The San Francisco Department of Public Health is pursuing a city-wide initiative to leverage clinical data from San Francisco’s largest health systems to better address an array of chronic diseases that afflict city residents. This would allow for more timely and accurate information about chronic disease in San Francisco, which enables the Department of Public Health to more effectively tackle the greatest burdens of disease in the community.
COVID-19 in San Francisco

- San Francisco 165.3 cases per 100,000, but 10 fold difference in rates across highest and lowest zip codes
Screening in Mission Neighborhood Census Tract
Diane Havlir/Gabe Chamie
Demographics of Mission Census Tract

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Percentage</th>
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</thead>
<tbody>
<tr>
<td>Latinos</td>
<td>38.2%</td>
</tr>
<tr>
<td>COVID-19</td>
<td></td>
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<tr>
<td>Demographic</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td></td>
</tr>
<tr>
<td>Sex</td>
<td></td>
</tr>
<tr>
<td>Race/Ethnicity</td>
<td></td>
</tr>
<tr>
<td>Mexican</td>
<td>32.8%</td>
</tr>
<tr>
<td>Puerto Rican</td>
<td>0.6%</td>
</tr>
<tr>
<td>Central American</td>
<td>0.6%</td>
</tr>
<tr>
<td>Guatemalan</td>
<td>1.7%</td>
</tr>
<tr>
<td>Salvadoran</td>
<td>10.5%</td>
</tr>
<tr>
<td>South American</td>
<td>4.4%</td>
</tr>
<tr>
<td>White (Non-Hispanic)</td>
<td>28.1%</td>
</tr>
<tr>
<td>Black</td>
<td>2.4%</td>
</tr>
<tr>
<td>Native American</td>
<td>1.5%</td>
</tr>
<tr>
<td>Asian</td>
<td>10.1%</td>
</tr>
<tr>
<td>Native Hawaiian or Other Pacific Islander</td>
<td>0.2%</td>
</tr>
<tr>
<td>Multiracial</td>
<td>4.8%</td>
</tr>
<tr>
<td>Asian Indian</td>
<td>1.4%</td>
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<tr>
<td>Southeast Asian</td>
<td>0.9%</td>
</tr>
<tr>
<td>South Asian</td>
<td>1.6%</td>
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<tr>
<td>East Asian</td>
<td>2.8%</td>
</tr>
<tr>
<td>Chinese</td>
<td>1.6%</td>
</tr>
<tr>
<td>Filipino</td>
<td>3.7%</td>
</tr>
<tr>
<td>Japanese</td>
<td>0.1%</td>
</tr>
<tr>
<td>Korean</td>
<td>0.5%</td>
</tr>
<tr>
<td>Vietnamese</td>
<td>0.7%</td>
</tr>
</tbody>
</table>

Socioeconomic

Add a second characteristic
Overcrowding
>95% positive cases were LatinX (only 44% of sample)

>90% cannot work from home

>50% asymptomatic
Low-Barrier “test to care” approach

- Partnership: Unidos en Salud (UCSF and Latino Task Force), BART, SFMTA, DPH, Sup Ronen
- **Twice weekly testing** - morning or afternoon hours for 3 weeks in August
- Bilingual staff
- VIP cards for business, transport workers, contacts
- Test to community care response
"Like I said son, survival is all about location, location, location!"
The Data Hub

Creating the largest shared information resource to help conquer blood diseases worldwide

William Wood, MD, MPH
Associate Professor of Medicine
University of North Carolina School of Medicine
ASH Research Collaborative

• Non-profit
• Established by ASH in 2018
• Two programs:
  • Sickle Cell Disease Clinical Trials Network (SCD CTN)
  • Data Hub
• Improve lives of those affected by blood diseases

DATA → KNOWLEDGE → ACTION
Data Hub Programs

- Sickle Cell Disease
- Multiple Myeloma
- COVID-19 Registry for Hematology
Data Collection and Uses

- Quality Improvement
- Clinical Guideline Implementation
- Personalized Analytics and Decision Support
- Improving Care and Outcomes
- Cohort Selection
- Pre- and Post-Market Research
- Academic Research

Data Hub

- Health Systems / Consortia
- Genomic, molecular, other specialized data
- Direct EHR integration at Sites
- Closed Clinical Trial Datasets
- Patient Reported Outcomes
- Patient Generated Health Data

Evidence Generation

- Closed Clinical Trial Datasets
- Direct EHR integration at Sites
- Genomic, molecular, other specialized data
- Health Systems / Consortia

ASSEMBLE RESEARCH COLLABORATIVE
Accelerating Progress in Hematology
Addressing Disparities

- Ongoing engagement with the SCD and MM communities
  - SCD CTN Participation requirement includes implementing a community advisory board (CAB)
- Increasing awareness of clinical trials and reducing barriers to participation
- Creating learning networks
- Promoting shared decision making
- Generating real world evidence
Extending Our Reach

- ~110 sites expected in our SCD Data Hub (~50% US SCD pop.)
  - Academic institutions and community centers
- Data obtained from all patients
- Patient portal for longitudinal engagement
- Patient-reported outcomes
Goals and Opportunities

- COVID-19 and computable phenotypes
- Social determinants of health
- Consider interventions (e.g. testing, pragmatic studies)
- Additional hematologic conditions
- Continue community engagement
COVID-19 Registry for Hematology

Purpose

To provide hematologists on the front lines of the COVID-19 pandemic with near real-time information using data collected around from around the world.
Registry Overview

- Launched on April 1, 2020
- Inclusion criteria:
  - COVID-19 positive and
  - Past or present malignant or non-malignant hematologic condition or
  - COVID-19 related hematologic complication
- De-identified data
- Research exempt under 45 CFR § 46.104(d)(4) and approved for a waiver of authorization
- Publicly available real-time observational summaries
Data Summaries

• Real-time summaries
• Filters for hematologic conditions
• Publicly available
• New metrics added as case number increases
Questions?

info@ashrc.org
Using Clinical Registries to Address Disparities in Covid-19: NIMHD Perspectives

Council of Medical Specialty Societies Webinar

Eliseo J. Pérez-Stable, M.D.
Director, National Institute on Minority Health and Health Disparities
eliseo.perez-stable@nih.gov

September 1, 2020
NIH-Designated Populations with Health Disparities

• Racial/ethnic minorities defined by OMB/Census
• Less privileged socio-economic status
• Underserved rural residents
• Sexual gender minorities

• A health outcome that is worse in one of these populations in comparison to a reference group defines a health disparity

• Social disadvantage resulting in part from being subject to discrimination and being underserved in health care, contributes to health disparities in all
Race/Ethnicity and Socioeconomic Status Affect Health Outcomes

- Fundamental importance in human research
- Race/ethnicity predict life expectancy and mortality that are not fully explained
- African Americans have more strokes when compared to Whites for same SBP level
- Among persons with diabetes, all race/ethnic minorities have less heart disease and more ESRD when compared to Whites
- Race/ethnicity is a social construct with biological and other components
Relative Risk of All-Cause Mortality by US Annual Household Income Level in 2016

# National Institute on Minority Health and Health Disparities Research Framework

<table>
<thead>
<tr>
<th>Domains of Influence (Over the Lifecourse)</th>
<th>Levels of Influence*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Biological</td>
<td>Individual</td>
</tr>
<tr>
<td>Biological Vulnerability and Mechanisms</td>
<td>Caregiver-Child Interaction</td>
</tr>
<tr>
<td></td>
<td>Family Microbiome</td>
</tr>
<tr>
<td>Behavioral</td>
<td>Interpersonal</td>
</tr>
<tr>
<td>Health Behaviors</td>
<td>Family Functioning</td>
</tr>
<tr>
<td>Coping Strategies</td>
<td>School/Work Functioning</td>
</tr>
<tr>
<td>Physical/Built Environment</td>
<td>Community</td>
</tr>
<tr>
<td>Personal Environment</td>
<td>Functioning</td>
</tr>
<tr>
<td>Household Environment</td>
<td>Community Environment</td>
</tr>
<tr>
<td>School/Work Environment</td>
<td>Community Resources</td>
</tr>
<tr>
<td>Sociocultural Environment</td>
<td>Societal</td>
</tr>
<tr>
<td>Sociodemographics</td>
<td>Community Norms</td>
</tr>
<tr>
<td>Limited English</td>
<td>Local Structural</td>
</tr>
<tr>
<td>Cultural Identity</td>
<td>Discrimination</td>
</tr>
<tr>
<td>Response to Discrimination</td>
<td>Social Norms</td>
</tr>
<tr>
<td></td>
<td>Societal Structural</td>
</tr>
<tr>
<td></td>
<td>Discrimination</td>
</tr>
<tr>
<td>Health Care System</td>
<td>Health Outcomes</td>
</tr>
<tr>
<td>Insurance Coverage</td>
<td>Individual Health</td>
</tr>
<tr>
<td>Health Literacy</td>
<td>Family/Organizational Health</td>
</tr>
<tr>
<td>Treatment Preferences</td>
<td>Community Health</td>
</tr>
<tr>
<td></td>
<td>Population Health</td>
</tr>
</tbody>
</table>

*Health Disparity Populations: Race/Ethnicity, Low SES, Rural, Sexual/Gender Minority
Other Fundamental Characteristics: Sex/Gender, Disability, Geographic Region
Social Determinants of Health

- Demographics including family background
- Urban or rural residence or geographic region
- Cultural identity, religiosity, spirituality
- Language proficiency, Literacy, numeracy
- **Structural determinants**: housing, green space, broadband, economic opportunity, transportation, schools, healthy food access, public safety
- PhenX Toolkit on Social Determinants of Health: https://www.phenxtoolkit.org/collections/view/6
Perception of Unfair Treatment: 2015

In past 30 days were you treated unfairly because of racial or ethnic background in store, work, entertainment place, dealing with police, or getting healthcare?

<table>
<thead>
<tr>
<th></th>
<th>Percent Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All</td>
</tr>
<tr>
<td>Latinos</td>
<td>36%</td>
</tr>
<tr>
<td>African Americans</td>
<td>53%</td>
</tr>
<tr>
<td>Whites</td>
<td>15%</td>
</tr>
</tbody>
</table>

Trust in clinician/institution? Role of Unconscious Bias?

Kaiser Family Foundation Survey of Americans on Race, November 2015.
Racism as Research Construct

• *Interpersonal*: Most work done, excellent measures developed, associations established

• *Structural*: History, culture, institutions, and codified practices that perpetuate inequity; how do we incorporate into research?

• *Internalized*: How discrimination (as above) effects individuals who are not aware or sublimate; accept cultural or biological inferiority

• Perceived societal discrimination and second-hand effects of racism
Clinical Registries Research to Address Covid-19 Disparities: What is Needed?

• Standardized measurement of demographics and social determinants of health
• Address structural SDOH — incorporate into clinical management
• Track test results, symptoms, clinical cases
• Emphasis on participation in trials and promoting a science-based response
• Recognize and manage structural and interpersonal discrimination
NIH Programs to Address Covid-19 Disparities

• Social, behavioral, and economic consequences — funding 52 supplements to existing grants (NIMHD, NIMH, NIA, OBSSR, plus other ICs)

• Rapid Acceleration of Diagnostics for Underserved Populations (RADx-UP): supplements to promote testing (NIMHD, NIA, OD)

• Coordination and Data Collection Center RADx-UP

• Data harmonization and effort to “require” use of Common Data Elements

• Community Engagement Alliance against Covid-19 Disparities Initiative: 11 State Consortiums
Future Research Directions

• Linkage of clinical registries to population-based data through census imputation

• Unique personal identifiers maintained in a confidential manner

• Leverage the data in CMS (Medicare and State-Medicaid), Social Security death index with clinical data (SEER-Medicare linked data as example)

• Standard consent for future use of de-identified data and data sharing for science
Special Issue of AJPH: New Perspectives to Advance Minority Health and Health Disparities Research
Supplement 1, 2019, Vol 109, No S1

- Editor’s choice by Eliseo J. Pérez-Stable and Francis S. Collins
- Definitions for minority health, health disparities, and NIMHD Research Framework
- 30 research strategies in methods, measurement, etiology, and interventions
- Multi-year process with more than 100 authors, from NIH and academic scientists
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Follow us on Twitter @NIMHD

Join us on linkedin.com/company/nimhd-nih/

Questions & Answers

Please submit all questions through the question box.
Summary & Evaluation

- Thank you to all our panelists.
- A recording of the webinar will be available on the CMSS website in the coming weeks.
- Please compete a short evaluation following the webinar.
- For more information, contact info@cmss.org.
Summary & Evaluation

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Join Us

The Council of Medical Specialty Societies invites you to join us for the

CMSS Virtual Annual Meeting, October 28 - 30, 2020

Covid-19 and Beyond:
Digital Transformation of Healthcare, Research, and Education

Program Tracks:

Healthcare Transformation: focusing on telehealth and remote patient monitoring

Research Transformation: focusing on clinical registries, cloud-based computing, and digital research tools

Education Transformation: focusing on lessons learned and future opportunities for virtual meetings

Key Details:

- October 28: CMSS Members Only
- October 29-30: Open to All (Members and Non-Members)
- Registration Available mid-September
- Industry Partner and Exhibit Opportunities Available
- Visit www.cmss.org or follow @CMSSMed for frequent updates