Agenda

1. The Why

2. Shared Language

3. The Role of Data in Health Equity

4. Examples from Prior Literature

5. Group Engagement

Key Takeaways

➤ Health outcomes are heterogeneous

➤ Focusing on delivering high quality care for all patients means understanding which groups may be experiencing different outcomes

➤ Using race/ethnicity data is one way to understand how people experience care

➤ Best place to start is where you are now—build out from there

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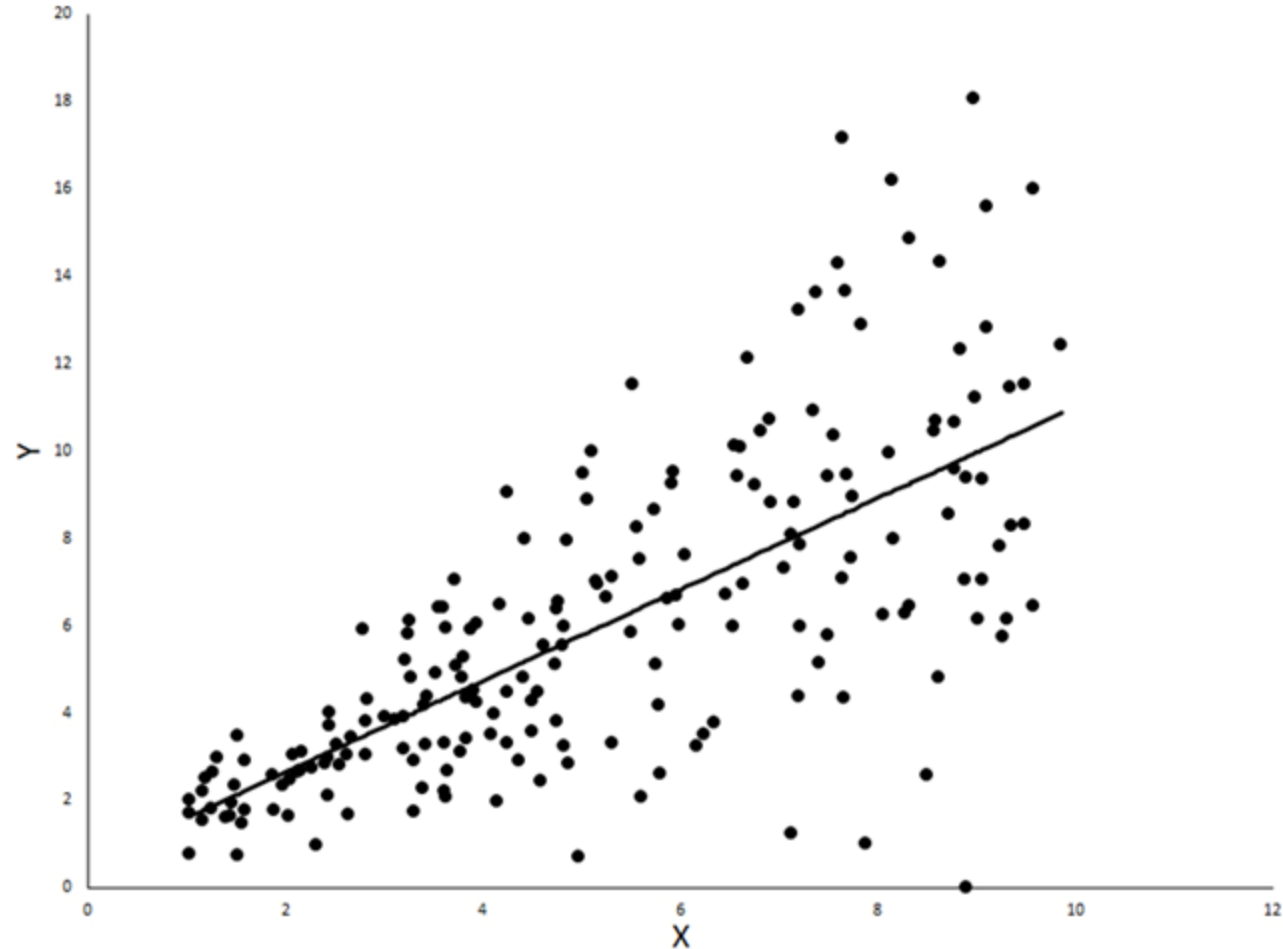# The Why

Legacy of CQIs in Quality Improvement

Easy Wins

2026?

Heterogeneity in Outcomes around Apparent Upward Trajectory

Shared Language

The world is changing rapidly…

…which means we must evolve

Health Equity / Health Care Equity / Equity: Definition / Synonyms

The fair distribution of health determinants, outcomes, and resources within and between segments of the populations, regardless of social standing

Synonyms to consider

- Ensuring access to high-quality care for all patients
- Ensuring the opportunity for all to achieve a better/high quality of life
- Achieving whole health* for all people
- Achieving the highest level of health for all people

- Providing the opportunity for all people to have/achieve optimal health
- Partnering together to ensure/help all people to have optimal health and health care outcomes
- Providing opportunities for better health and health care choices

*By whole health we mean physical, behavioral, spiritual, and socioeconomic well-being as defined by individuals, families, and communities
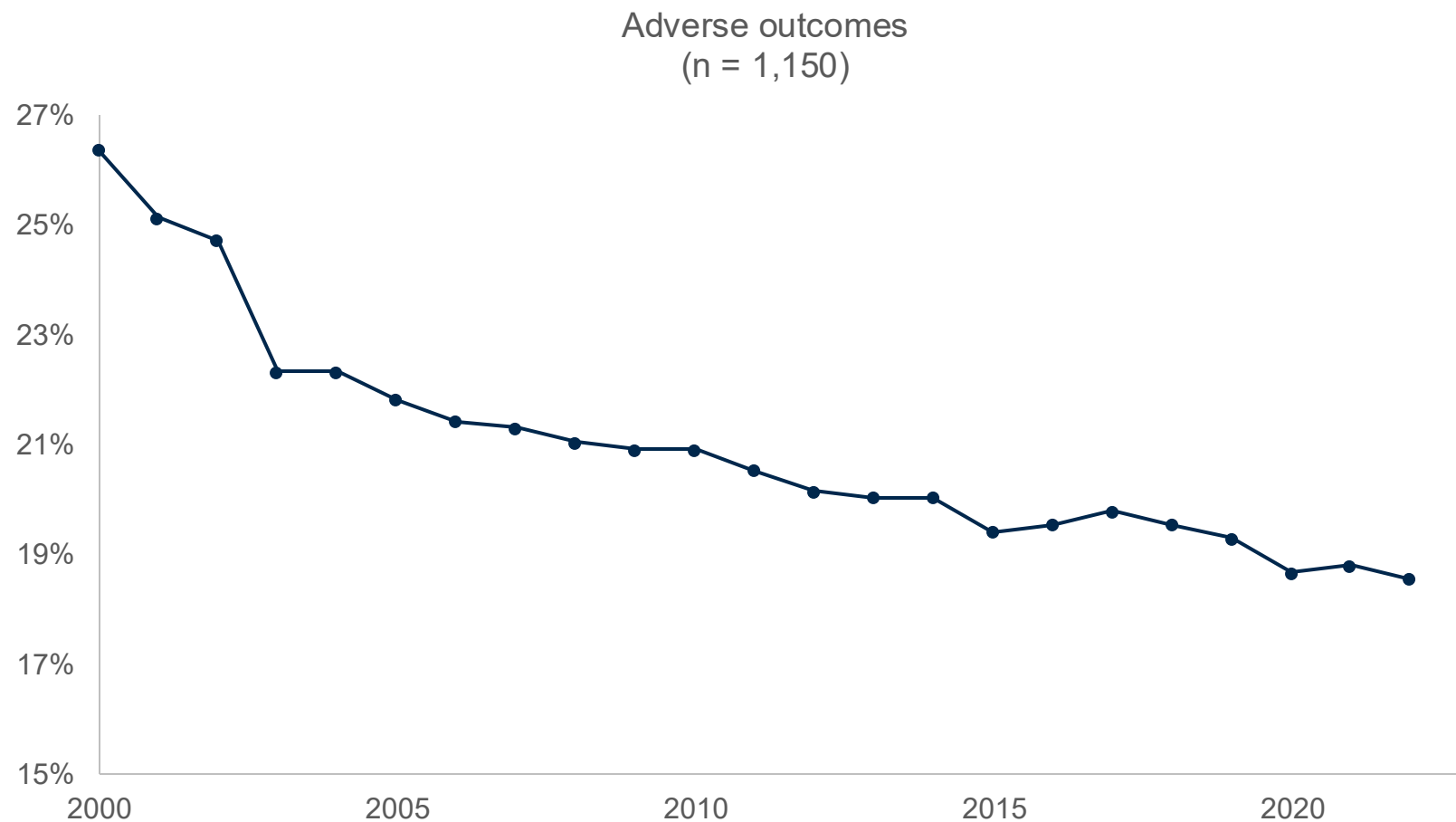
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The Role of Data in Health Equity

"Failure to disaggregate race or ethnicity data... can mask critical between- and within-group differences that policies and programs should address."

Braveman, P., Arkin, E., Proctor, D., Kauh, T., & Holm, N. (2021). Systemic and Structural Racism: Definitions, examples, health damages, and approaches to dismantling. Health Affairs 41, NO. 2 (171-178)

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Why do data aggregation choices matter?

Adverse outcomes
(n = 1,150)

Why do data aggregation choices matter?

Adverse outcomes by subgroup

Group A (n=1000)   Group B (n=150)
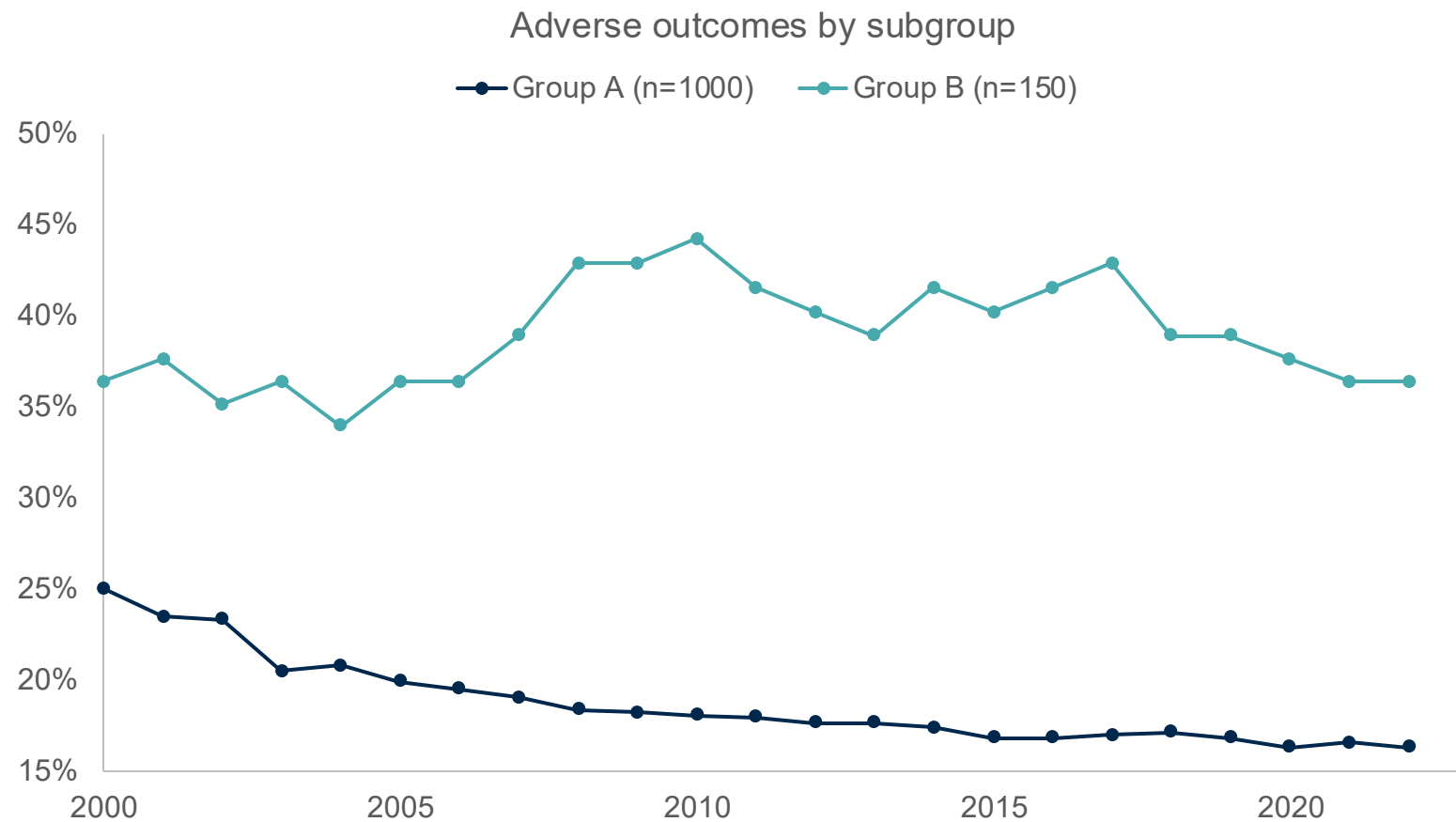
Race/Ethnicity as Sociopolitical Categories

The categories we collect and report on are often used as proxies for other more difficult-to-measure concepts
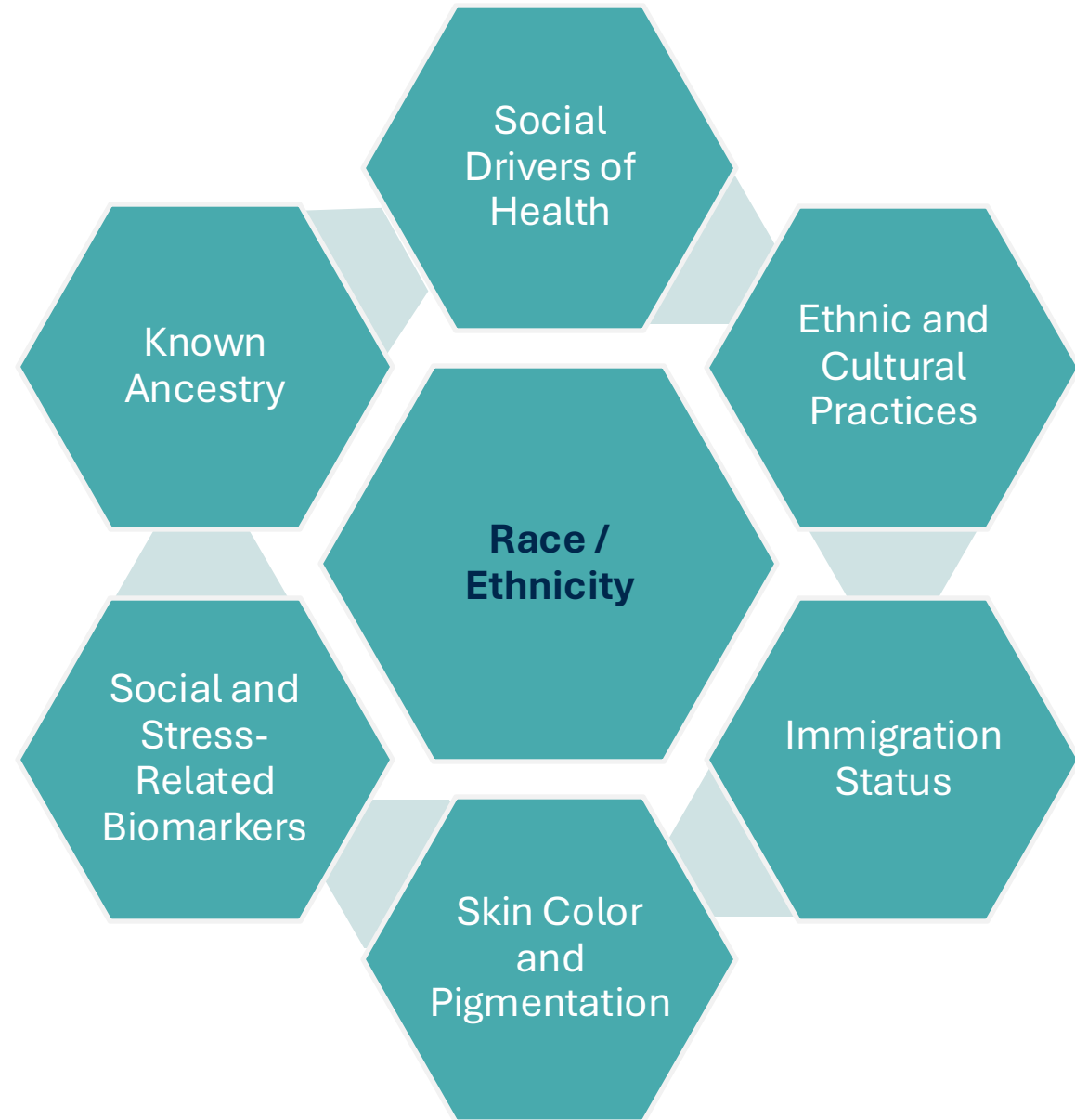
Data Collection and Cleaning

Gather the available race/ethnicity data.

Clean and prep data.

Information and Insights

Stratify performance and health outcomes by race/ethnicity to identify and measure disparities.

Analysis into Action

Use insights to develop QI strategies and interventions.
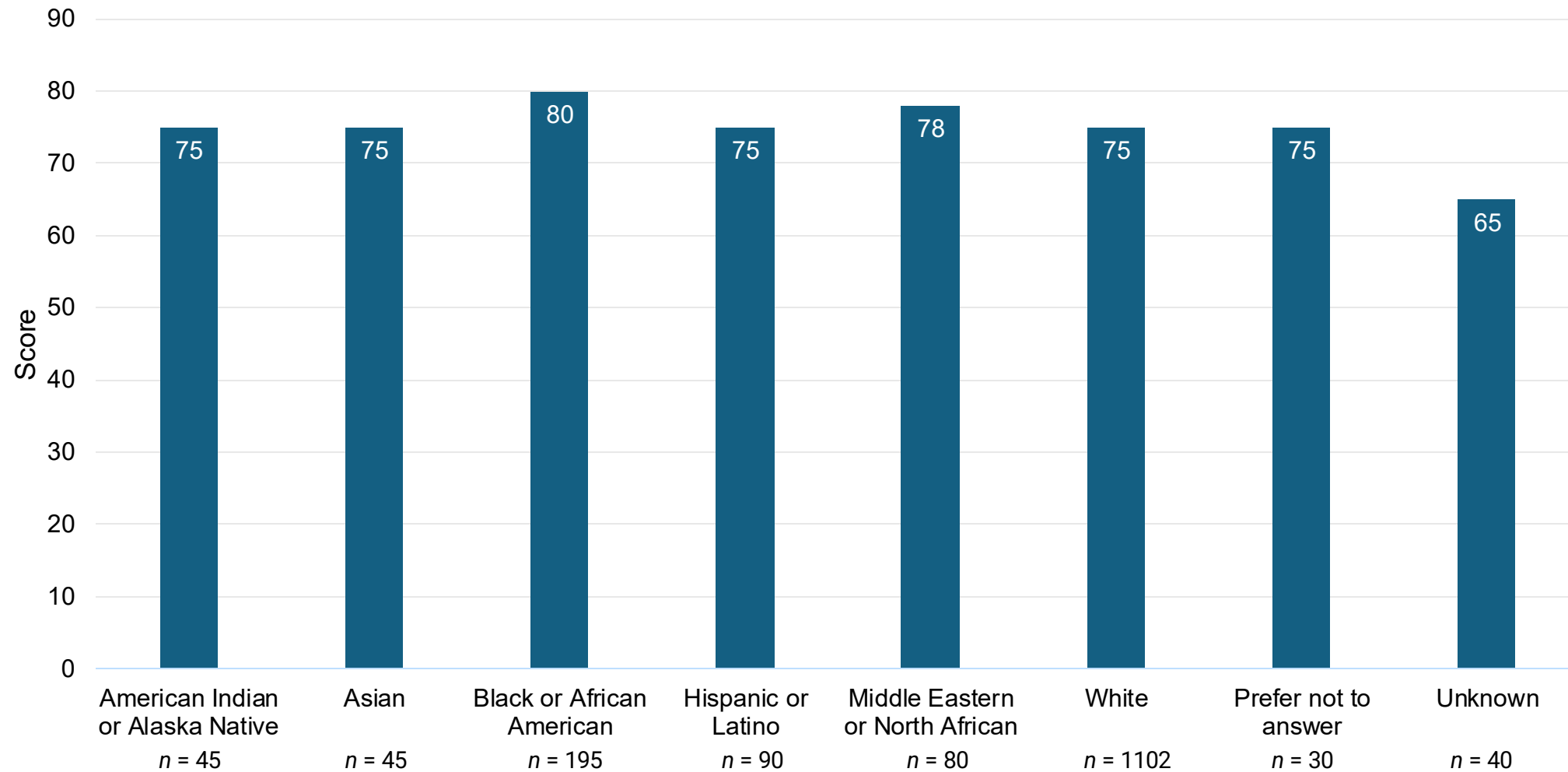
Intervention Evaluation and Adjustment

Share data and information to systematically review and evaluate progress.

Adjust intervention(s) as needed.

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Best Practices for Presenting Data in Visualizations

- Titles should correspond to the measure(s)
  - "Performance by race/ethnicity, per hospital admission records"
  - Alternatively, offer a definition of the measure as a footnote
- Include a footnote of the data source and the method used to collect the data
- Display the *n* under each bar label
- Display the x-axis categories/groups alphabetically
  - "Prefer not to answer" and "Unknown" can be last in the order
- If there is missing data, include a footnote of how much missing data there is (e.g., 30% missing)
- If groups are too small to report out, include this information as a footnote, but not in the figure itself

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Performance by Race/Ethnicity, as determined by Patient Attributes File

Score

Race/Ethnicity	Score
American Indian or Alaska Native (n = 45)	75
Asian (n = 45)	75
Black or African American (n = 195)	80
Hispanic or Latino (n = 90)	75
Middle Eastern or North African (n = 80)	78
White (n = 1102)	75
Prefer not to answer (n = 30)	75
Unknown (n = 40)	65

[1]Sample for Native Hawaiian or Pacific Islander was too small to report.
[2]Of all patients, 10% do not have performance data.
[3]Data was collected from 2015-2020.

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Avoiding Data Pitfalls

Data Best Practices

Avoid
Using White race as the default category
Collapsing small groups into "other" category
Using multiracial as an analytic category
Using race, ethnicity, and geographic origin as proxies for genetic ancestry

Do This
Compare to overall population or goal value
Disaggregate when possible; Address data limitations
Use non-mutually exclusive race/ethnicity categories
Provide a rationale for inclusion of race/ethnicity as a descriptor in any analysis

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Examples from Prior Literature

MPOG study finds Black vs. White patient race was associated with less antiemetic administration

ANESTHESIOLOGY

Antiemetic Administration and Its Association with Race: A Retrospective Cohort Study

Robert S. White, M.D., M.S.,
Michael H. Andreae, M.D., M.B.A. M.Sc., M.A.,
Briana Lui, B.S., Xiaoyue Ma, M.S.,
Virginia E. Tangel, M.A., M.Sc.,
Zachary A. Turnbull, M.D., M.B.A, M.S.,
Silis Y. Jiang, Ph.D., Anna S. Nachamie, M.B.A.,
Kane O. Pryor, M.D.; Multicenter Perioperative Outcomes Group Collaborators*

Table 2. Analysis of Ondansetron or Dexamethasone Administration

Characteristics	Adjusted Odds Ratio (95% CI)	P Value
Race/ethnicity		
White	1.00 (reference)	
Black	0.82 (0.81 to 0.82)	< 0.0001
Other	0.87 (0.86 to 0.88)	< 0.0001
Unknown	0.99 (0.98 to 1.00)	0.0043

- Previous studies found relationship between socioeconomic status and antiemetic administration

- Model also adjusted for patient sex, hospital-level factors, year, patient history (diabetes, motion sickness, smoking, etc.), and specifics about the care team and anesthesia technique

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Standardized pathways may help reduce disparities

- ERAS Protocols:
  - Standardized, multimodal perioperative pathways
  - Span the continuum of surgery (pre-, intra-, post-operative)
  - Include processes addressing patient education, multimodal analgesia, early mobility
  - Multidisciplinary input and implementation
  - Driven by best evidence, creates a culture of pathway adherence

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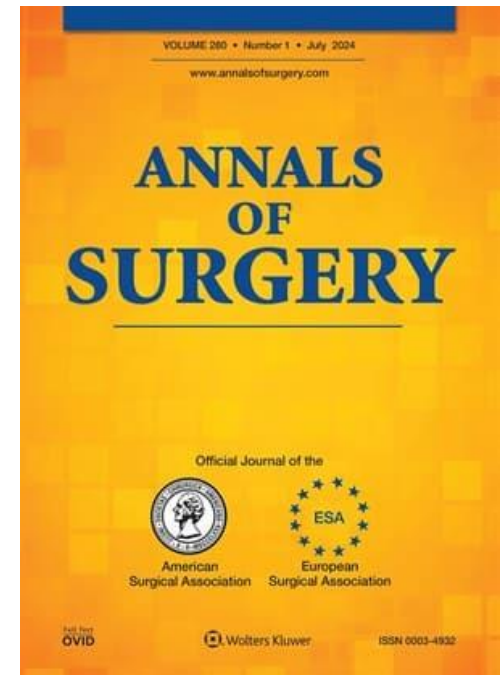
Group Engagement

Has your site been included in any departmental or hospital initiatives related to health equity?

- If yes, what opportunities have you come across? What challenges?

- If no, are there any you would like to be included in? Is there any support needed to make this happen?

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➤ Best place to start is where you are now—build out from there

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References

Braveman, et. Al. Systemic And Structural Racism: Definitions, Examples, Health Damages, And Approaches To Dismantling. Health Aff (Millwood). 2022. doi:10.1377/hlthaff.2021.01394.

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Feero, et al. Guidance on Use of Race, Ethnicity, and Geographic Origin as Proxies for Genetic Ancestry Groups in Biomedical Publications. *JAMA*. 2024. doi:10.1001/jama.2024.3737

Quint JJ, Keaweʻaimoku Kaholokula J. Now That We Are Disaggregating Race and Ethnicity Data, We Need to Start Understanding What They Mean. *JAMA Netw Open*. 2024. doi:10.1001/jamanetworkopen.2024.3674

Frey T. Updated Guidance on the Reporting of Race and Ethnicity in Medical and Science Journals. *AMWA*. 2023. doi:10.55752/amwa.2023.195

White, et. Al. Antiemetic Administration and Its Association with Race: A Retrospective Cohort Study. Anesthesiology. 2023. doi: 10.1097/ALN.0000000000004549.

Thank you!

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to ELIMINATE DISPARITIES

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of Michigan

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the Blue Cross and Blue Shield Association

Evaluation

https://umichumhs.qualtrics.com/jfe/form/SV_0NFY7g9CRoYSGai