

APPLYING A HEALTH EQUITY LENS TO QUALITY IMPROVEMENT

Eric Wei, MD, MBA

Nichola Davis, MD, MS



GREATER NEW YORK HOSPITAL ASSOCIATION & UNITED HOSPITAL FUND

CLINICAL QUALITY FELLOWSHIP PROGRAM

Disclosures

No relevant financial or nonfinancial relationships to disclose.

Session Objectives

After attending this session, fellows will be able to:

- Apply an equity lens to quality improvement work
- Utilize a framework to discuss bias or structural inequities that contribute to adverse events
- Identify three key action items to apply within an institution to promote health equity goals

What is Health Equity?



What is it?

**Health
Equity**

*Why Does
it Matter?*

What is Health Equity?

“Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care”.

Robert Wood Johnson Foundation

Definitions

Equality



The assumption is that **everyone benefits from the same supports**. This is equal treatment.

Equity



Everyone gets the supports they need (this is the concept of "affirmative action"), thus producing equity.

Justice



All 3 can see the game without supports or accommodations because **the cause(s) of the inequity was addressed**. The systemic barrier has been removed.

The Cliff Analogy



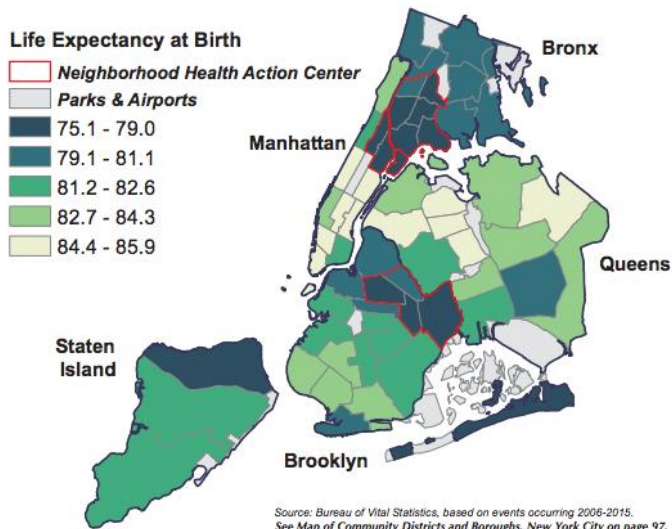
[Cliff Analogy Video](https://www.youtube.com/watch?v=to7Yrl50iHI)

<https://www.youtube.com/watch?v=to7Yrl50iHI>

Why Health Equity?

LIFE EXPECTANCY

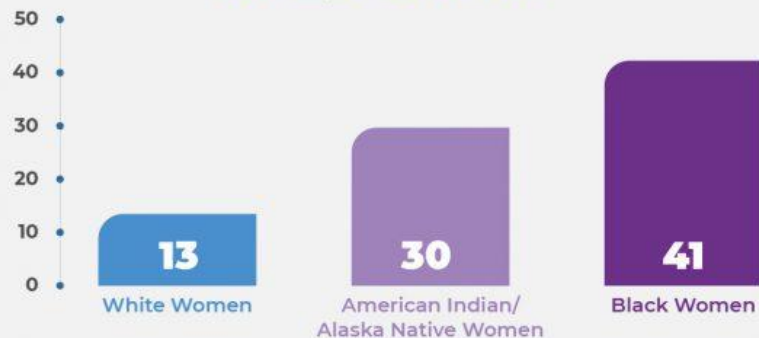
Figure 4. Life Expectancy at Birth by Community District, New York City, 2006-2015



- In 2015, New York City's life expectancy at birth was highest in Murray Hill (85.9), the Upper East Side (85.9), Battery Park/Tribeca (85.8), Greenwich Village/SOHO (85.8), and Elmhurst/Corona (85.6).
- In 2015, life expectancy at birth was lowest in Brownsville (75.1), Morrisania (76.2), Central Harlem (76.2), The Rockaways (76.5), and Bedford Stuyvesant (76.8).

PREGNANCY-RELATED DEATHS

PER 100,000 LIVE BIRTHS



MMWR

Full report: bit.ly/maternaldeath_

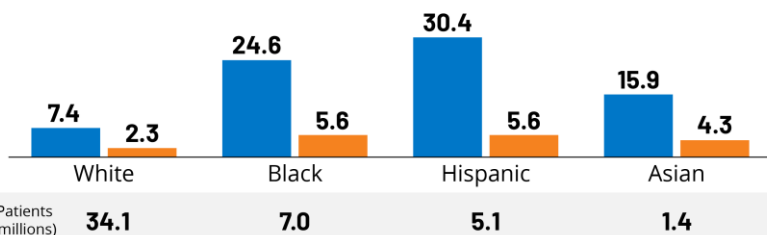
Petersen EE, Davis NL, Goodman D, et al. Racial/Ethnic Disparities in Pregnancy-Related Deaths — United States, 2007–2016. MMWR Morb Mortal Wkly Rep 2019;68:762–765. DOI: http://dx.doi.org/10.15585/mmwr.mm6835a3external_icon

Why Health Equity?

COVID-19 Hospitalization and Death Rates among Active Epic Patients by Race/Ethnicity

Rate per 10,000, as of July 2020

● Hospitalization Rate ● Death Rate



NOTE: Rates for Black, Hispanic, and Asian patients are statistically significantly different from White patients at the $p < 0.05$ level. Persons of Hispanic origin may be of any race but are categorized as Hispanic; other groups are non-Hispanic. Data for other racial groups not shown due to insufficient data.

SOURCE: Epic and KFF analysis of Epic Health Record System COVID-19 related data as of July 2020.



Why Quality & Safety?

Institute of Medicine 6 Dimensions of Healthcare Quality (STEEP)

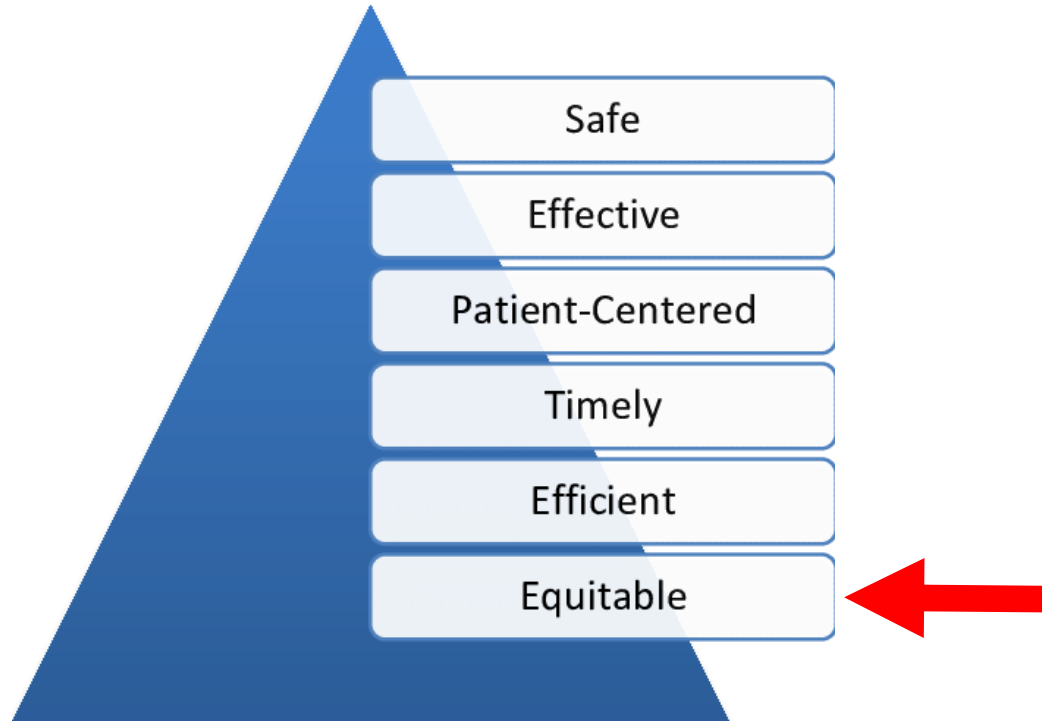
- Safe
- Timely
- Effective
- Efficient
- Equitable
- Patient Centered



*IOM STEEEP dimensions of quality: Safe, Timely, Effective, Efficient, Equitable, and Patient centered

*IHI Framework for Effective Board Governance of Health System Quality white paper

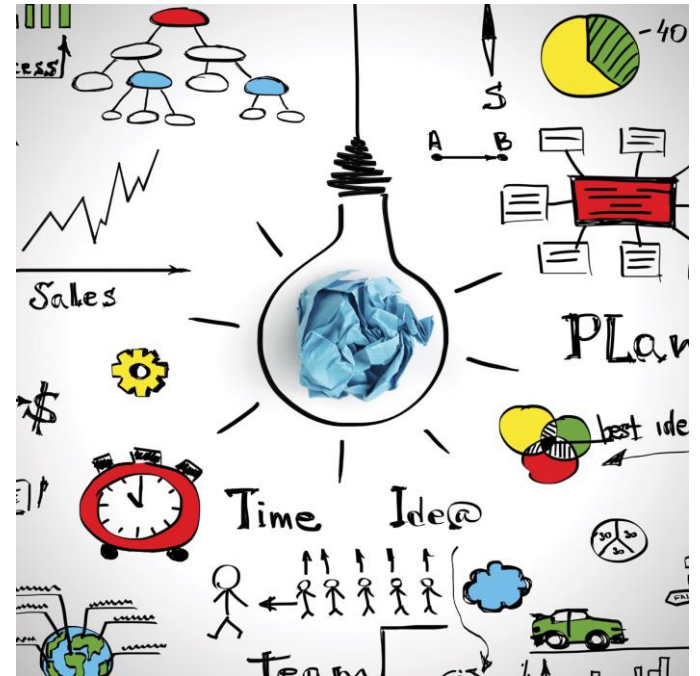
Why Quality & Safety?



Board and Leadership Buy-In

Board chair, Dr. Jose Pagan, and board members putting emphasis on Social and Racial Equity:

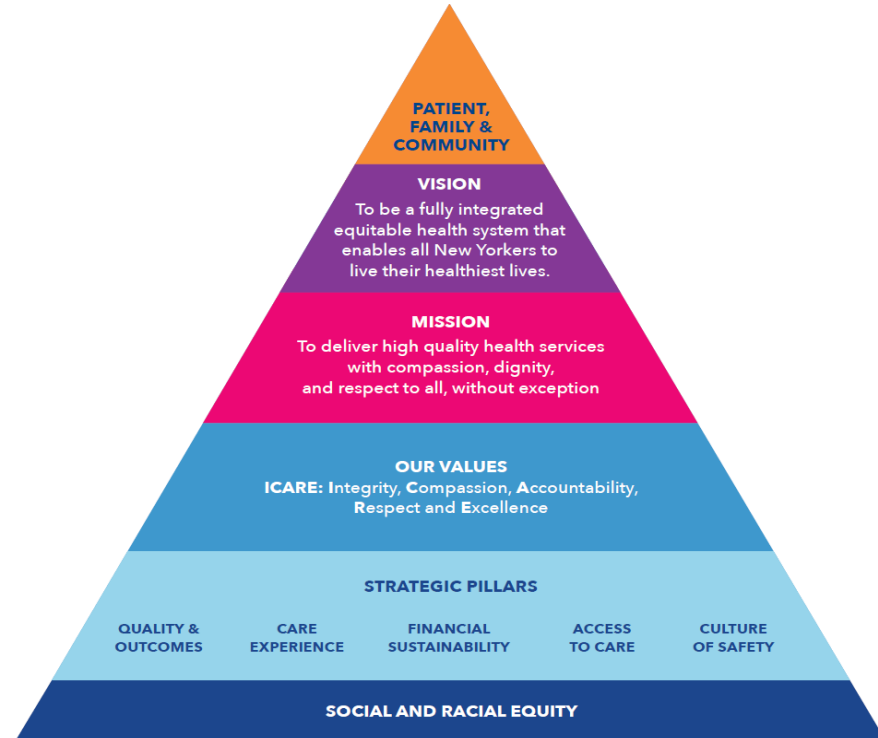
- Strategic Pyramid – explicitly calling out equity
- System Dashboard – equity metrics section
- MWBE for procurement – 30% goal
- Board Equity, Diversity & Inclusion (EDI) Committee
- Formation of the Equity & Access Council



Alignment with Mission & Vision

NYC Health + Hospitals Strategic Pyramid

- Added **equitable** to the Vision Statement
- Added **Social and Racial Equity** as the Foundation
- Included Social and Racial Equity metrics in System Dashboard



Engraining Equity into Quality & Safety

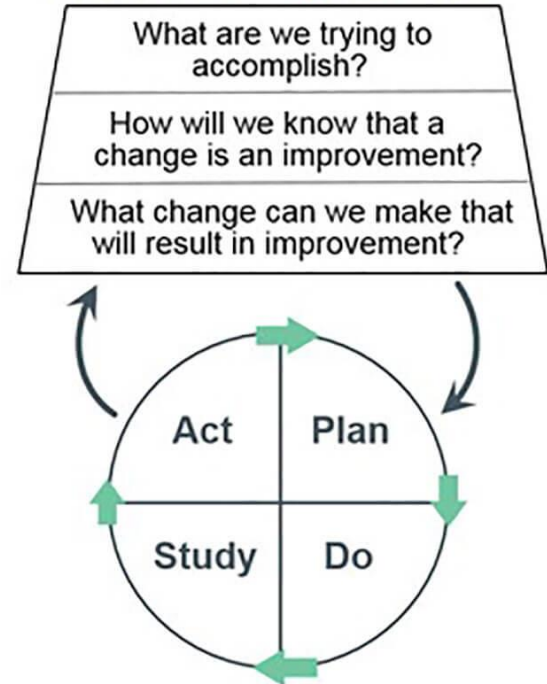
- Started with allowing staff to speak their truth, share, support, and heal through series of Helping Healers Heal (H3) debriefs
- Book club starting with How to Be An Antiracist by Ibram X. Kendi
- Hired a Director of Equity, Quality, and Safety
- Challenged everyone in Quality & Safety to engrain equity into everything we do



Where Do You Start?

- What small change can you test tomorrow?
- Existing patient safety and risk management structure for adverse event reporting, investigation, RCA, corrective actions, report to Governing Body
- Lessons learned with Helping Healers Heal (H3) implementation

Model for Improvement



Setting an Expectation



Added standing prompt to all QAPI board case discussions:

Discuss any bias or structural inequities that contributed to this case.

How Do You Define Bias?



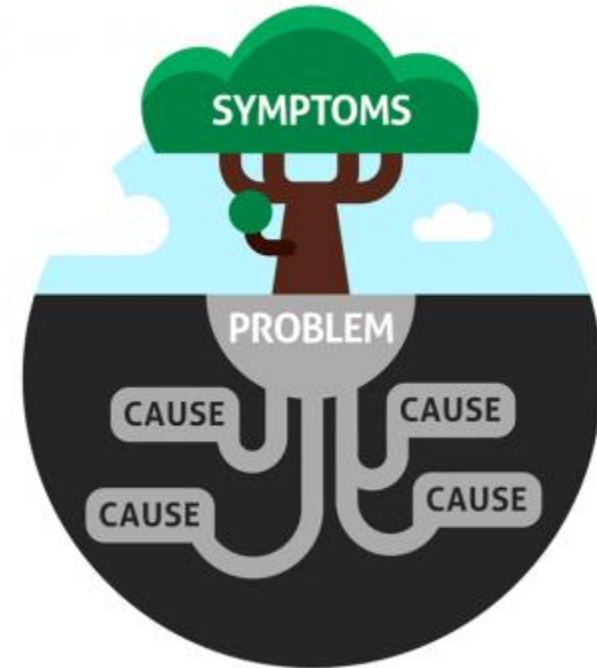
BIAS

A close-up photograph of a hand holding a black marker, writing the word "BIAS" in large, bold, black letters on a piece of blue grid paper. The paper is slightly crumpled and has some other crumpled paper nearby. The background is a dark wooden surface.

Bias Training – Speaking the Same Language

Must take a proactive approach to continuously investigate, catalogue and monitor for bias as a contributing factor at:

- the interpersonal level (i.e. explicit bias)
- the human behavioral level (i.e. implicit bias)
- the institutional level (i.e. policies and practices)
- the structural level (i.e. social and political determinants of health)



Leverage Incident Reporting System



Allow frontline staff to identify need for investigation of potential bias and structural inequities that contribute to adverse events, near misses/good catches, patient safety risks

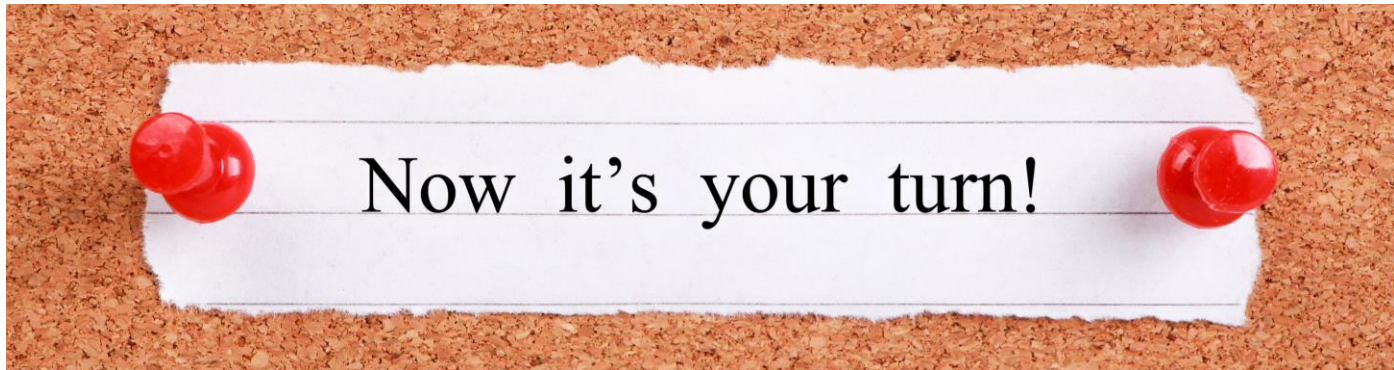
Care Experience

- Leverage same equity prompt in investigations and discussions on patient complaints and grievances
- Unearth and address bias and structural inequities leading to poor care experience



Exercise 1

- Discuss bias and structural inequities that contributed to example RCA case (groups of 6)
- Each group report out



Quality Assurance

- Ability to apply equity filters to all existing and new dashboards and reports with quality metrics
- Opportunity to review QAPI and other key dashboards and reports to ensure there are equity metrics



Data and Analytics

- High fidelity self-reported REAL SOGI data
- REAL data now required (hard stop) in MyChart for the patients to complete in “Prepare for your Visit”
- E&A Council collaborating with Epic, EITS, informatics to expand ethnicities from 20 to 200 categories
- New performance improvement projects with AIM statements to improve REAL SOGI data collection at facility level



Population Health Dashboards

Diabetes Measures by Sociodemographics

A1c Control: 66.3%

Time period: **Year ending November 2021** Facility: **All** Department: **All** General PCP: **All**



1. Select a measure

- Composite
- A1c
- BP
- Mod/High Statin
- Aspirin/IVD

Grey color indicates unreliable da..

2. Select filters

Most Recent Facility [ⓘ]
All

Most Recent Department
All

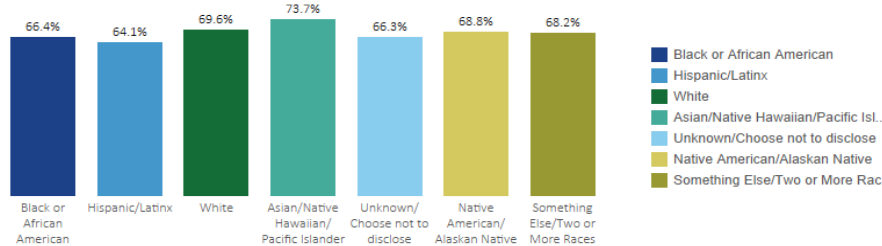
General PCP

Explore measures by Race/Ethnicity, Language, Payer, Age or Sex

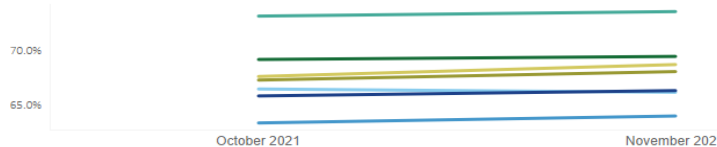
Use buttons at right to choose how to stratify the measure on the bar chart and trendline:

- Choose Stratification [ⓘ]
- Race/Ethnicity
 - Language
 - Payer
 - Age
 - Sex

A1c Control Rate by Race/Ethnicity



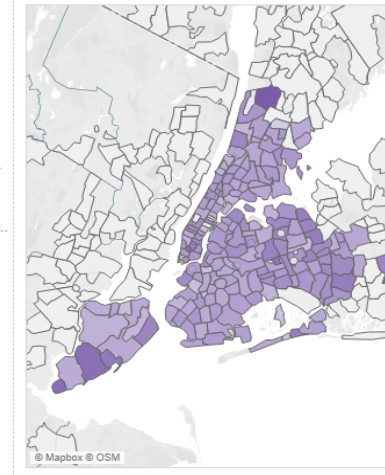
Trend in A1c Control Rate by Race/Ethnicity, Rolling 12-month period



Explore measures by neighborhood

See measure rate stratified by ZIP Code [ⓘ]

A1c Control Rate Map



Population Health Dashboards

Diabetes Measures by Sociodemographics

A1c Control: 66.3%

Time period: **Year ending November 2021** Facility: **All** Department: **All** General PCP: **All**



Click to send
feedback

1. Select a measure

- Composite
 A1c
 BP
 Mod/High Statin
 Aspirin/IVD

Grey color indicates unreliable da...

2. Select filters

Most Recent Facility [ⓘ]
All

Most Recent Department
All

General PCP

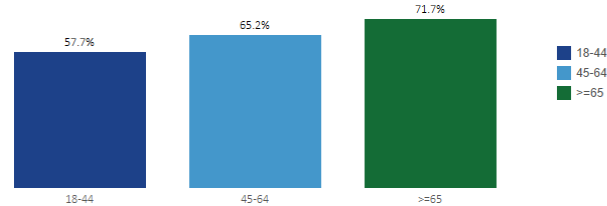
Explore measures by Race/Ethnicity, Language, Payer, Age or Sex

Use buttons at right to choose how to stratify the measure on the bar chart and trendline:

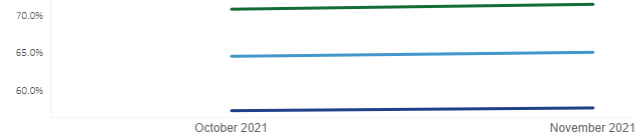
Choose Stratification [ⓘ]

- Race/Ethnicity
 Language
 Payer
 Age
 Sex

A1c Control Rate by Age



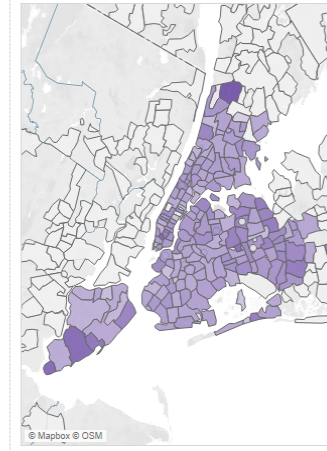
Trend in A1c Control Rate by Age, Rolling 12-month period



Explore measures by neighborhood

See measure rate stratified by ZIP Code [ⓘ]

A1c Control Rate Map



Population Health Dashboards

Start Here:

1. Select a measure ⓘ

PHQ Screening

New measures available

Grey color indicates unreliable data (n<30)

2. Select filters

Most Recent Facility All

Facility Type All

Ped/Adol Practices ⓘ All

Most Recent Department All

General PCP

PHQ Screening across NYC H+H

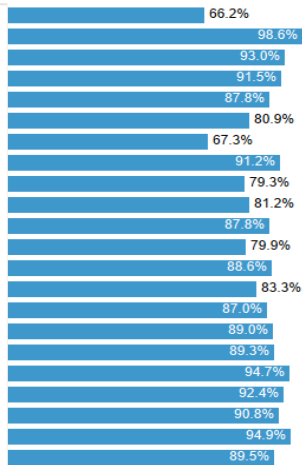
(Year ending December 2021)

83.7%

Note: This is an adult measure and does not look at screening completed in Pediatric and Adolescent Medicine departments.

PHQ Screening by Facility

View chart by Facility, Department or Provider: Facility ⓘ



Measure Explorer

Depression Screening (PHQ): 83.7%

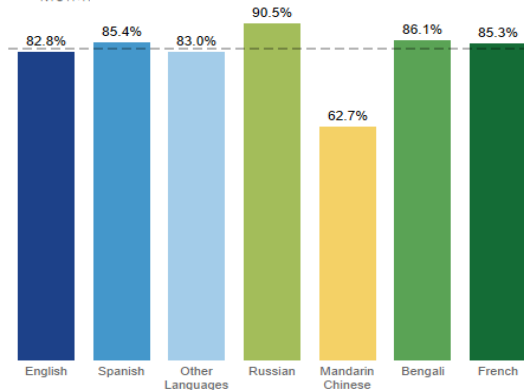
Time period: Year ending December 2021 Facility: All Facility Type: All Ped/Adol Practice: All Department: All General PCP: All



PHQ Screening by Language

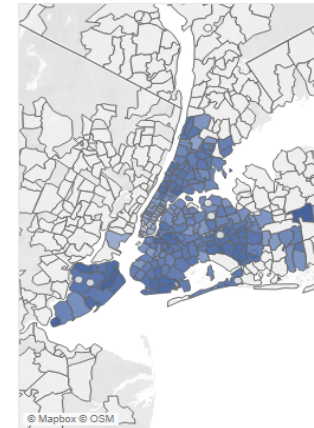
View chart by Race/Ethnicity, Age, Sex, Language or Payer: Language ⓘ

-- NYC H+H



PHQ Screening Map

View data by ZIP Code ⓘ



☰ Click to show/hide measure by Language as text table

PHQ Screening Trend among Patients Seen in the Month



Engraining Equity in Performance Improvement

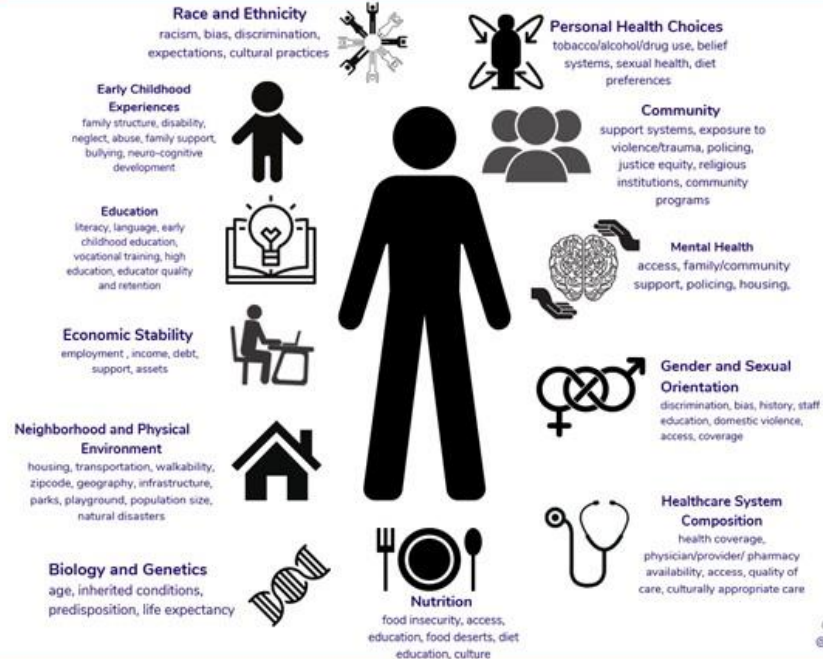
Purpose: This tool should be used by senior leadership, including the CEO, CMO, CQO, and CNO, to plan a comprehensive strategy for department-level performance improvement (PI). Please include information about each anticipated PI initiative, aligning with the NYC Health + Hospitals 5 strategic pillars.

STRATEGIC PILLARS

	Quality & Outcomes	Financial Sustainability	Care Experience	Culture of Safety	Access to Care
PI Initiative Name:					
PI Initiative Aim (baseline data included in aim):					
Primary Metric Description:					
Primary Metric Numerator:					
Primary Metric Denominator:					
Equity Lens of PI Initiative:					
PI Initiative Lead(s)					

Types of Equity Lens

SYSTEMIC EQUITY: HEALTH & CARE FOR THE WHOLE BEING



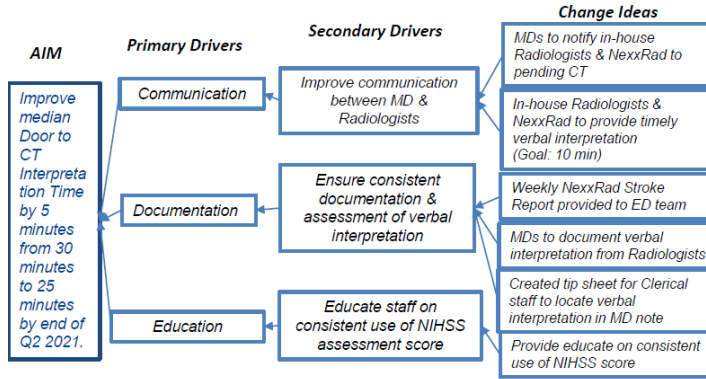
Performance Improvement

Project Title: *Reducing Median Door to CT Interpretation Time*
 Project Leader: *Dr. Mark Kindschuh*
 Executive Sponsors: *Dr. Theresa Madaline*
 Team Members: *Dr. Mark Kindschuh, Yashwant Patel, Gaetano (Tom) Cumella, Jasmin Ryan, Wilfredo Yap, Mervat Hanna, Alexander Ostrovsky, Nirav Patel, Jaisa Perez, Dominick Calandro, Michael Gordon*



AIM STATEMENT

Improve median Door to CT Interpretation Time by 5 minutes from 30 minutes (Q3 2020) to 25 minutes by end of Q2 2021.

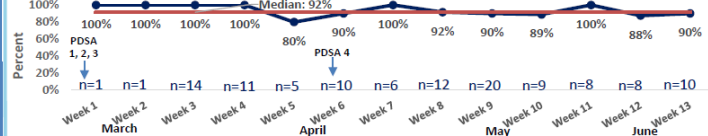


	PDSA / ACTION PLANS	PERSON
1	Provide real time NexxRad Stroke Report of all cases read & interpreted by NexxRad team (Feb.2021)	M. Gordon
2	Education provided to ED MD Staff to notify Radiologists (both in-house & NexxRad) by phone of CT for priority interpretation (Feb/Mar. 2021)	M. Kindschuh
3	Education provided to Radiology staff of process of receiving calls from ED MD & to provide verbal interpretation (Goal: 10 mins) (Feb/Mar 2021)	Y. Patel, G. Cumella
4	Created tip sheet for clerical staff to locate verbal interpretation & time received in MD Note (April)	J. Ryan

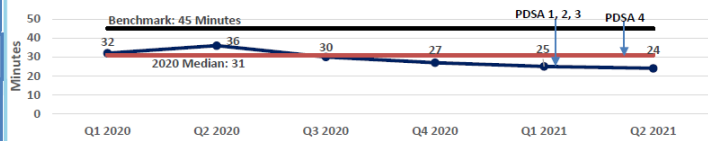
Long-Term Sustainability Plan

- Continue to monitor notification calls made to Radiologists
- Provide education to staff to better identify potential stroke patients with atypical presentation
- Utilize new streamlined process to focus on improving Door to Needle time for eligible patients
- Conduct community education on stroke prevention & timely arrival to ED

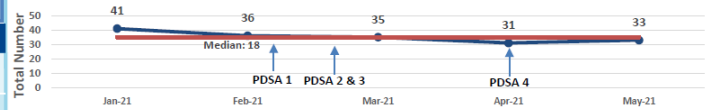
Process Measure Chart Percentage of MD Calls to In-House Radiology & NexxRad (March – June 2021)



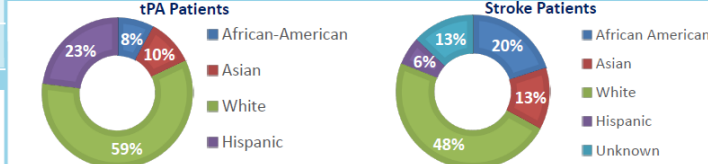
Outcome Measure Chart Median Door to CT Interpretation (in minutes)



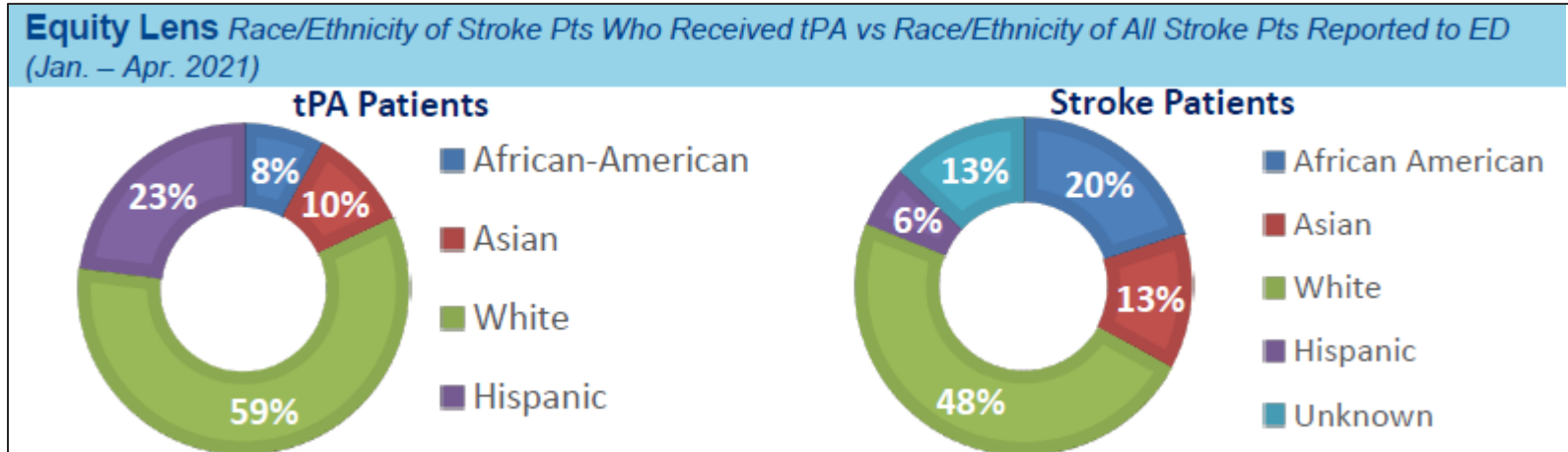
Balancing Measure Chart Total Number of Strokes (January 2021 – May 2021)



Equity Lens Race/Ethnicity of Stroke Pts Who Received tPA vs Race/Ethnicity of All Stroke Pts Reported to ED (Jan. – Apr. 2021)




Performance Improvement



What could have contributed to some of these differences?

Performance Improvement

Project Title: Improving Nurse Communication on Unit 8200
Project Leader: Inowen Idahosa, ADN
Project Sponsors: Braulio Cosme-Thormann, MD, CQO, Elizabeth Udej, AED, Angela Edwards, RN, CNO, Dayna Villafana Bey, CXO
Team Members: J. Magno, HN, D. Morales, RN, M. Huggins, HN, K. Benitez, Nurse Ed., Y. Loja RN, E. Rodriguez PCA, A. Castillo RN, B. Castillo Unit Clerk, M. Cales, QI, Dayna Villafana Bey, CXO, Elizabeth



AIM STATEMENT
Primary: Increase top box score for HCHAPS Communication with Nurses domain by 16 percentage points from 64% (Q2 21) to 80% on Unit 8200 by Q4 21.
Secondary: Increase top box score for HCAHPS Communication with Medicines domain by 29 percentage points from 51% (Q2 21) to 80% on Unit 8200 by Q4 21.

AIM

Increase top box score for Communication with Nurses domain by 16 percentage points from 64% (Q2 21) to 80% on Unit 8200 by Q4 2021

Primary Drivers

- Nurse/Patient Communication
- Medication Administration
- Communication & Education about Medicines


Secondary Drivers

- Improve nurses' verbal and non-verbal communication with pts
- Enhance nurses' active listening skills
- Ensure nurses administer medications safely at pts bedside
- Improve education and communication about medicines in a way pts understand

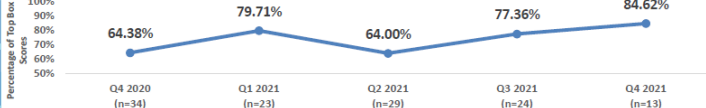
Change Ideas

- Educated nurses on how to effectively communicate with pts – verbally and non-verbally
- Ensured nurses provided at least 5 minutes of uninterrupted listening to each patient throughout the day
- Each nurse to ask patient "How can we make your stay better today?" and document on whiteboard each day
- Educated all nurses on importance of safe bedside med. administration
- Secret shopper performed audits to monitor compliance w/ safe med. administration & med. education
- Educated nurses to utilize plain language when explaining meds to pt & provide written education appropriate for pts education level

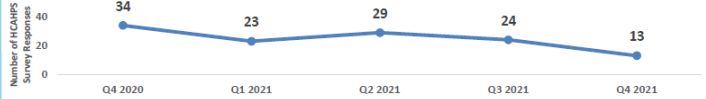
Process Measure Percentage of Patients Who Reported Nurses Listened to Them Without Interrupting (Source: Unit Pulse Check Survey as of 12/10)



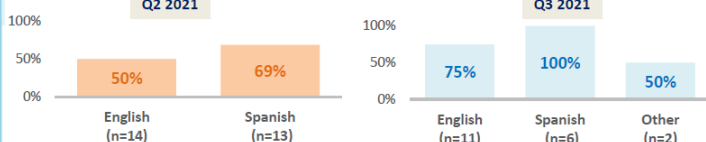
Outcome Measure Percentage of Top Box Score in HCAHPS Communication with Nurses Domain



Balancing Measure Number of HCHAPS Survey Responses



Equity Lens % Top Box Score in "Nurses Listen Carefully to You" Stratified by Language Mainly Spoken at Home by Patient (Q2 2021 vs Q3 2021)

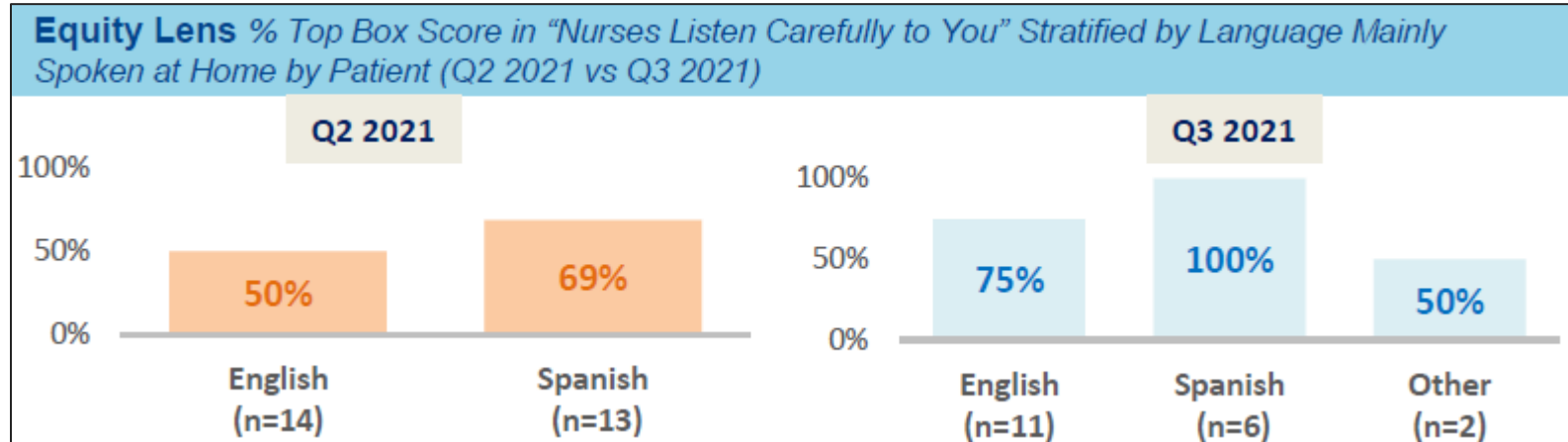


PDSA / ACTION PLANS		PERSON
1	Performed pulse check surveys to evaluate for uninterrupted listening and if patient reported understanding of medication education	8200 Nursing Staff
2	Monitored for whiteboard compliance and provided 1:1 education for non-compliant staff	I. Idahosa
3	Create secret shopper audit tally sheet to monitor compliance of safe medication administration and education	K. Benitez, I. Idahosa

Long-Term Sustainability Plan

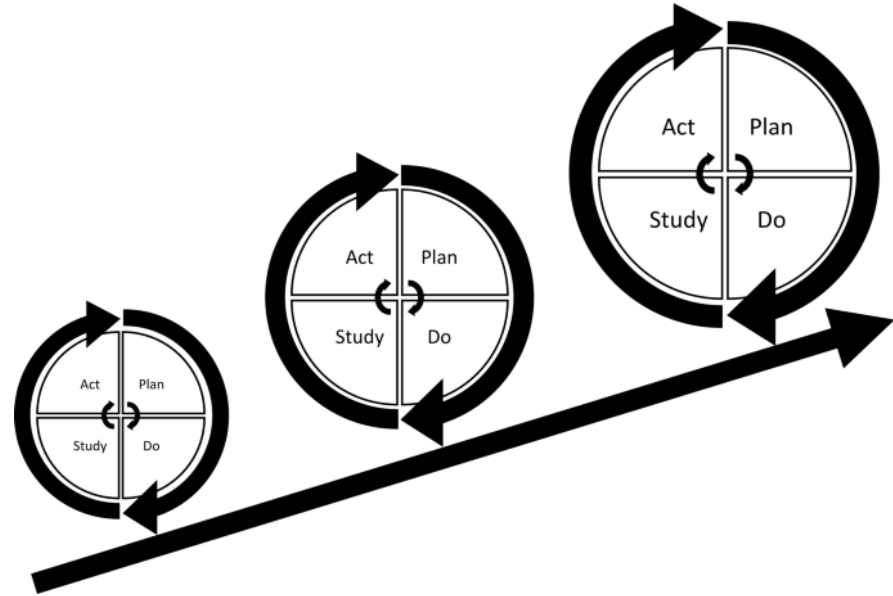
- Continue engaging staff and patients to improve HCAHPS scores
- Conduct secret shopper audits to monitor compliance with bedside medication education
- Keep consistently rounding using pulse check surveys and collecting data to identify additional opportunities for improvement

Performance Improvement



Climb the PDSA Hill

- Equity lens applied to process and outcome measures
- Design PDSA cycles addressing disparities as they are identified
- New PI projects where AIM directed at closing health disparities



System-wide Learning

- PI projects with equity lens presented at:
 - Departmental QAPI
 - Facility QAPI
 - System Board QAPI
- All balanced-scorecard PI projects included in quarterly QAPI reports to Governing Body
- Uploaded into System PI Searchable Database

Project Name	Created	Facility	Modified	Aim Statement	View
Spinal Muscular Atrophy (SMA) Preconceptual/Prenatal Carrier Screening Safety Project	Michael Sherman	Jacobi	11/08/2021	Identify and address 100% of abnormal SMA results that were inadvertently missed from March 2020 - June 2021 because they	Show More
Improving the Quality of Quality: Co-creating our Environment and Increasing the Technology Capabilities	Michael Sherman	Jacobi	11/08/2021	Improve the Environment and increase the Technological and Facilitation Capabilities of the Jacobi Quality Team by Sept. 1 2021.	Show More
Optimizing the Utilization of Stroke Order Sets in Patients Admitted with Stroke	Michael Sherman	Jacobi	11/08/2021	Increase the use of stroke order sets in patients admitted with stroke to >90% by June 2021.	Show More
Implementing a Social Media Presence for NYC H+H / Jacobi / North Central Bronx	Michael Sherman	North Central Bronx	11/08/2021	To create Social media profiles for NYC H+H, Jacobi and North Central Bronx and average over 50,000 impressions/month by	Show More
Utilizing concurrent and retrospective review to support clinical decision making that prevents C. Diff infections	Michael Sherman	Jacobi	11/08/2021	Implement interventions related to use of empiric antibiotics to prevent C. difficile infection in admitted adult patients by 5%	Show More

Exercise 2

- Brainstorming potential equity lens to apply to supplied PI project prompts (small group exercise)
- Each group report out



Addressing Equity as a System: Medical Racism

Live Your Healthiest Life. **NYC
HEALTH+
HOSPITALS**

Thursday, February 11, 2021

Abolishing Race Based Medicine for Kidney Function, VBAC and More

NYC Health + Hospitals Office of Quality & Safety, in partnership with the Equity & Access Council, has embarked on an effort to abolish race based medicine from our medical practices across our health system.

NYC Health + Hospitals is proud to be leading the nation in removing race based practices in the delivery of care. We stand resolute in treating our patients as individuals and targeting our treatments and guidance based on their specific biology and unique social and life experiences, not simply their race or ethnicity.

Removing eGFR

NYC
HEALTH+
HOSPITALS

MEDICAL ERACISM – ENDING RACE BASED eGFR

August 2020



CONTEXT

- When calculating a patient's kidney function (GFR), we often use a set of calculations based on various factors to estimate their glomerular filtration rate or eGFR
- Traditionally, these risk factors include serum creatinine, age, sex and **race (Black vs. non-Black)**
- The equation reports out two values. For **Black patients it increases the estimated GFR by 16-21%** to account for their "increased muscle mass", though no robust scientific evidence exists to support this claim
- **The unintended consequence is to assert and propagate a biological cause for Black bodies being different from all non-Black bodies, a popular eugenicist view**

CONTRIBUTING FACTORS

- African Americans have a **3x** and Hispanics **1.5x higher risk** of developing kidney failure than White Americans¹
- By having higher eGFRs, Black patients might have delayed referral to specialty services, dialysis and transplantation



KEY TAKEAWAYS

- The inclusion of race is fraught with bias and has lasting deleterious implications for our Black patients. **For a multitude of social and scientific reasons, the Nephrology workgroup feels strongly that the inclusion of subjective race (a social construct) as an objective (biologic) proxy for creatinine generation / clearance in the biomedical environment does not meet the scientific rigor required at NYC Health + Hospitals for our diagnostic screening tools.**



PLANS FOR CORRECTIVE ACTION

- Lab Services - Standardize all eGFR calculations to use CKD-EPI eGFR(Cr) where results will be reported without race adjustment based on serum creatinine, age, sex, and is normalized to 1.73m² body surface area
- Epic – Work to ensure raced based eGFR is no longer reported out as 2 different values to our clinicians and patients
- Approved by Nephrology Workgroup, IM Council, ICU & OB/GYN leadership, Quality & Safety, Medical & Professional Affairs, Equity & Access Council, Clinical Lab Council, CMO Council**



1. <https://www.kidney.org/news/establishing-task-force-to-reassess-inclusion-race-diagnosing-kidney-diseases>

2. <https://tinyurl.com/3ke5bpc>

VBAC Counseling

NYC
HEALTH+
HOSPITALS

MEDICAL ERACISM – STOP RACE-BASED VBAC COUNSELING

November 2020

CONTEXT:

- + Clinicians may use a risk tool – known as **Vaginal Birth After Cesarean-section (VBAC)** calculators – to estimate the risk and likely success of a trial of labor for a vaginal delivery after an earlier C-section in a prior pregnancy.
- + Formulated in 2007, the VBAC calculation includes risk factors, such as age, BMI, and clinical history of delivery. These algorithms also consider whether the patient is of **Black race** or **Hispanic ethnicity**. For **Black women** it decreases the estimated success rate of vaginal deliveries by **67%** and for **Hispanic women** by **68%**.
- + The functional consequence is to insinuate a biological cause for Black & Hispanic women's bodies being fundamentally different from a "normal" body. This reinforces the false idea that race itself is a biologically significant risk factor for illness and minimizes the real effects of racism and health inequity on minoritized people.

CONTRIBUTING FACTORS:

- Black women remain **3x – 4x** more likely to die from pregnancy-related causes than White women in America.¹
- While both the clinician and patient decide together whether a TOLAC or elective CS should be performed, the decision to pursue either may be influenced by medical bias.

KEY TAKEAWAYS:

- The Women's Health Council feels strongly that the inclusion of race as an objective proxy for a patient's VBAC complication risk calculation does not meet the scientific rigor required at NYC Health + Hospitals for our diagnostic screening tools.
- The Women's Health Council applauds NYC Health + Hospitals clinicians for forgoing the use of the race-based VBAC calculators in their VBAC counseling. Additionally, the American College of Obstetricians & Gynecologists also stresses that individual complications must be assessed on a case-by-case basis.

PLANS FOR FURTHER ACTION:

- We must continue to eliminate health inequities from within Women's Health in the United States. A key first step is identifying how implicit biases affect the way we view, interact with and counsel our patients. De-implementation of race-based clinical calculators in favor of more equitable approaches that address both women's social determinants of health (e.g. insurance type, zip code, low income, racism) and their biological clinical measures (e.g. prior labor course, age, BMI).
- This is evidenced in NYC H+H's Cesarean-section rates below the NY state average (**19%**, vs. **22.9%**) and successful VBAC rates greater than the NY state average (**19%**, vs. **13.3%**). NYC Health + Hospitals remains committed to using the most empirically-relevant information to inform our diagnostic screening tools.

1. <https://doi.org/10.1016/j.whi.2019.04.007>

CERCA

NYC Coalition to End Racism in Clinical Algorithms



Michelle Morse, MD, MPH

Call to Action

- Apply the bias and equity prompt to the next adverse event in your area/hospital/system
- Apply the prompt to the next patient complaint/grievance
- Incorporate an equity lens into your CQFP capstone QI project
- Are you able to apply equity filter to quality metrics in your area/hospital/system?
- Do you have reliable REAL SOGI data for your patients?

Acknowledgements

- Dr. Lou Hart
- Dr. Linelle Campbell
- Dr. Komal Bajaj – CQFP alumni
- Dr. Harry Cho – CQFP alumni
- Dr. Natalia Cineas
- Yvette Villanueva
- Matilde Roman
- Dr. Michelle Morse

Resources

- **Jones CP. Levels of racism: a theoretic framework and a gardener's tale. *Am J Public Health*. 2000;90(8):1212-1215.**
- **Wyatt R, Laderman M, Botwinick L, Mate K, Whittington J. *Achieving Health Equity: A Guide for Health Care Organizations*. IHI White Paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2016. (Available at ihi.org)**
- **Salas RN. Environmental Racism and Climate Change - Missed Diagnoses. *N Engl J Med*. 2021 Sep 9;385(11):967-969.**

Resources

- Bailey ZD, Feldman JM, Bassett MT. How Structural Racism Works - Racist Policies as a Root Cause of U.S. Racial Health Inequities. *N Engl J Med*. 2021 Feb 25;384(8):768-773.
- Ghandi T. Achieving Zero Inequity: Lessons Learned from Patient Safety. *NEJM Catalyst*. 2021 May 27.
- Dzau VJ, Mate K, O'Kane M. Equity and Quality-Improving Health Care Delivery Requires Both. *JAMA*. 2022 Feb 8;327(6):519-520.
- Nundy S, Cooper LA, Mate KS. The Quintuple Aim for Health Care Improvement: A New Imperative to Advance Health Equity. *JAMA*. 2022 Feb 8;327(6):521-522.