Applying An Equity and Anti-racist Lens to Quality Metrics and Data

This resource is an abridged version of Arrington, Lauren, Kramer Briana, and Serena Michelle Ogunwole, et. al, "Interrupting False Narratives: Applying A Racial Equity Lens to Healthcare Quality Data," *BMJ Quality & Saf*ety. Vol. 33, No. 5 (April 2024):340-344.

Introduction

Global awareness of racial and ethnic health inequities is increasing, prompting healthcare systems to address them. Many healthcare teams are encouraged to stratify quality metrics by race and ethnicity to identify and eliminate inequities. However, challenges arise due to the lack of standardized definitions for race and ethnicity, as well as concerns that focusing on those categories might inadvertently reinforce the misconception that racial differences are biological. That lack of standardization risks apathy or misdirected efforts that focus on the individual rather than systemic issues. To counter the absence of standardization, healthcare teams are urged to adopt anti-racist data practices and use a racial equity lens when presenting data to address the root causes of structural racism.

The Problem with Default Data Presentation

When stratifying data by race and ethnicity, practitioners are engaging in a practice that has historically been used to justify racism. White physicians once used health data to rationalize European imperialism and the trans-Atlantic slave trade, attributing poorer health outcomes among colonized and enslaved groups to supposed genetic and behavioral flaws.[1] Because racial categories stem from race-based oppression, stratifying health data by these categories is not neutral. This process, known as racialization, assigns social and political significance to physical differences, thereby reinforcing systemic racism.[2] While identifying racial inequities is necessary, relying on racialized data can inadvertently perpetuate harm; "Through racial categories, racialized individuals are recognized as belonging to a specific racial group, which simultaneously affirms that racism is real and reinforces the idea that race is indelible."

Recommendations for Presenting Inequities Data

Presenting patient data through a racial equity lens requires recognizing that data shape powerful narratives and influence perceptions. Practitioners dedicated to racial equity should share data in a way that highlights the need to address unjust systems and behaviors, rather than blaming individuals for issues like mistrust in healthcare, which are symptoms of those larger problems. Recommended practices for data presentation should incorporate choosing reference points equitably, presenting the most specific level of aggregation available, and consistently stating the root causes. Equity dashboards, used to monitor and share quality and outcome data, should be designed thoughtfully, as they can either perpetuate harmful racial narratives or counteract them when viewed through a racial equity lens. For examples of how to implement the above recommended practices, see **Table 1** below.

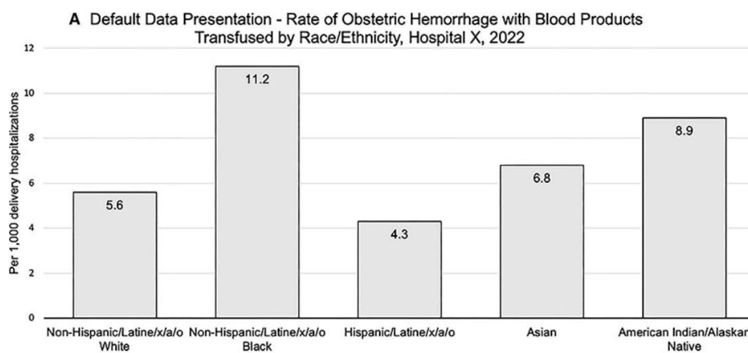
[1] Roberts Dorothy E., *Fatal Invention: How Science, Politics, and Big Business Re-Create Race in the Twenty-First Century* (The New Press: New York, 2012).

[2] Lamont Michèle, Beljean Stefan, and Matthew Clair. "What Is Missing? Cultural Processes and Causal Pathways to Inequality," *Socio-Economic Review*, vol. 12, no. 3 (July 2014): 573–608. https://doi.org/10.1093/ser/mwu011.

Examples from Perinatal Care of Presenting Data with a Racial Equity Lens

(#) Practice	Data presentation that risks reinforcing racism	Data presentation with a racial equity lens
(1) Choose reference points equitably	Black patients were 8% more likely and Asian patients were 3% more likely to have a low-risk primary caesarean birth than their white counterparts at Hospital X in 2021. **NOTE**: This data presentation sets the caesarean birth rate of white patients as the benchmark for other groups, implying that the outcomes of white individuals set the standard for other groups.	The rate of low-risk primary caesarean birth was 35% at Hospital X in 2022, 11.4% higher than the Healthy People 2030 target of 23.6%. The 37% low-risk primary caesarean birth rate for patients identifying as Black demonstrates the greatest need for improvement, but Hospital X did not meet its target for patients identifying as Asian or white (32% and 29%, respectively) either.
(2) Present the most specific level of aggregation	Satisfaction scores among Hispanic/Latine/x/a/o patients at Hospital X met the hospital benchmark in 2022. **NOTE**: Presenting data aggregated into broad groups can obscure within-group heterogeneity and inequities.	Satisfaction scores among patients identifying as Hispanic/Latine/x/a/o were disaggregated by self-reported geographical/cultural origin in 2022. While satisfaction scores for the overall group met the hospital benchmark, scores among Mexican American patients were significantly lower than the group mean, demonstrating a within-group inequity.
(3) State the root cause	In 2022 at Hospital X, Black patients were moderately to severely anemic on admission twice as often as white patients. **NOTE**: In this data presentation, the cause of anemia is unclear. Viewers may attribute the finding to genetic differences or a social flaw (i.e., unwillingness to take iron supplement or schedule an iron infusion).	In 2022 at Hospital X, patients identifying as Black were admitted with severe anemia twice as often as patients identifying as white. Root cause analysis showed that most patients identifying as Black with severe anemia did not receive an IV iron infusion prenatally and were seen at Antenatal Clinic A, where patients with severe anemia are only referred for IV iron if PO iron is not tolerated. Most patients identifying as white were seen at Antenatal Clinic B, which routinely referred severely anemic patients for IV iron infusion.
(4) Use a strengths-based approach: report actual values for positive outcomes rather than inequities	During the third quarter of 2022 at Hospital X, Hispanic/ Latine/x/a/o patients received timely treatment for hypertension 15% less often than white patients. **NOTE**: This data presentation focuses on care deficits and defines them as a deviation from care received by white patients. This practice draws attention away from the practice of timely treatment that can be expanded, sets the experience of white patients as the norm and ignores the gap in timely treatment for white patients.	During the third quarter of 2022 at Hospital X, patients identifying as Hispanic/Latine/x/a/o (across all racial groups) received timely treatment for hypertension 60% of the time and patients identifying as white and not Hispanic/Latine/x/a/o received timely treatment for hypertension 75% of the time.

(5) Use a strengths-based approach: look within groups and identify protective factors	In 2022 at Hospital X, 48% of Asian patients at Clinic A did not attend their postpartum follow-up appointments. **NOTE**: This data presentation perpetuates blame narratives by describing the patients' attendance as a deficit and not describing root causes.	In 2022 at Hospital X, 86% of patients identifying as Chinese and 34% of patients identifying as Vietnamese attended their postpartum follow up appointments at Clinic A. Ninety percent of the patients identifying as Chinese live in zip code 12345, which has several bus lines that stop at Clinic A. Eighty-five percent of the patients identifying as Vietnamese live in zip code 23456, which is considered a transit desert.
(6) Measure racism, not race	In 2022 at Hospital X, 67% of Black patients reported they were highly likely to recommend the hospital compared with 94% of white patients. **NOTE**: This data presentation focuses on the relationship between an outcome and race, implying that one drives the other. By not naming the healthcare institution's role in this outcome, this data presentation can result in inaction.	In 2022 at Hospital X, patient and family demographic factors were reviewed for the 27 security calls for a combative or violent person on the maternity unit in 2021. Patients identifying as Black were three times more likely than patients identifying with other racial groups to experience a security call. Cases with patients identifying as Black were reviewed—only 2 cases involved a threat of physical harm, while the other cases involved patients expressing dissatisfaction with hospital services, care providers, or a desire to leave the hospital and receive care elsewhere.
IV, intravenous; PO, oral.		



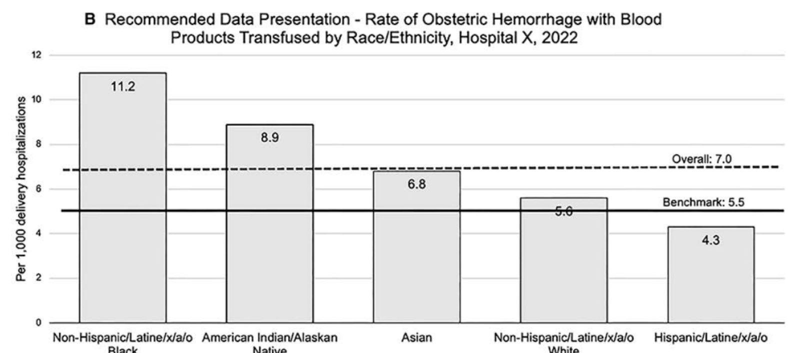


Figure 1 Graph A is a fictional example of a data presentation that risks reinforcing racism. Graph B is a fictional example of data presentation with a racial equity lens. In Graph A, the outcomes of white patients are presented first, implying that their outcomes are the default standard for other groups. In Graph B, racial and ethnic groups are listed in alphabetical order and compared to a benchmark standard instead of the outcomes of one group. To reduce the risk of implying that differences in outcomes are due to biological factors, we recommend including a legend that explains how data were collected and reminds viewers that race is a social construct. For example, *race and ethnicity were self-reported at the time of admission for delivery. Categories reflect Hospital X's current data collection practices, which utilize the Office of Management and Budget race and ethnicity definitions.*

Note: Race and ethnicity are social, not biological constructs. Race is often a proxy for racism.