Racial and ethnic minoritized populations bear a disproportionate burden of illness and death as the COVID-19 pandemic continues in the U.S. These inequities are caused by larger determinants of health, such as lack of access to care, cultural bias in clinical decisions, structure of delivery systems, and structural racism. To begin to tackle inequities in care, health systems and medical groups must understand whom they are serving, the collection of accurate sociodemographic data, such as race and ethnicity data is critical.

“Disproportionately affected populations such as Black, Latinx, Asian and Native American adults are less likely to have their blood pressure controlled,” Christopher Holliday, PhD, MPH, director of Population Health and Clinical-Community Linkages at the AMA, said during a recent Target: BP™ webinar. “These health inequities are the result of longstanding structural factors, such as racism, that restrict or deny access to optimal social determinants of health, increasing risk and creating a disproportionate burden of disease.”

“To achieve blood-pressure control for all patients, health care disparities must be identified and addressed,” said Holliday. “The first step in achieving health care equity is to capture accurate and complete race and ethnicity demographic data.”

In the webinar, David R. Nerenz, PhD, director emeritus of the Center for Health Policy and Health Services Research at Henry Ford Health System in Detroit, shared best practices for collecting data on race, ethnicity and preferred language.

**Train staff**

Start by asking, “Who is going to be involved in collecting the data?” There may be a few possibilities: medical assistants, nurses, people involved in registration of patients in a clinic or physician office, or
another option.

“In any organization, you have to start with this first question of who is going to be involved in doing this, and that determines then what sort of training is needed,” said Nerenz.

At Henry Ford, an AMA Health System Program Partner, “the current, more rigorous, standardized data collection was a change for a lot of people,” he said. Training was not “quite half a day, but they were much longer than 20- or 30-minute sessions” that included didactic and hands-on learning.

Once some experiences and data are in hand, organizations can monitor who is doing well and who is not. From there, remedial training can be completed where needed.

Discover the keys to address high BP, stroke among your Black patients.

Create scripts and procedures

When determining how to ask patients questions about ethnicity and race, there are different routes to take. However, Nerenz recommends saying, “We want to make sure that all our patients get the best care possible. We would like you to tell us your racial and ethnic background so that we can review the treatment that all patients receive and make sure that everyone gets the highest quality of care.”

That is because this statement “talks about how this data collection may reflect the patient or someone like him or her,” he said, adding that “when you describe it to patients or plan members—the reason for asking these questions—it’s really about quality of care and it’s about personalized care.”

“It’s not about government requirements. It’s not about some obscure backroom analysis,” said Nerenz.

Learn more about race and ethnicity data collection essentials from Target: BP, including how to use scripts.

Provide information to patients

Patients should also be informed about data collection. To reach patients, share important information about race and ethnicity data collection through posters, threefold fliers and other educational materials. For example, in a folded handout include actual questions that patients can respond to and turn in to the office staff. There can be different variants of the material to meet the individual needs of patients.

URL: https://www.ama-assn.org/delivering-care/hypertension/gathering-race-ethnicity-info-can-help-fight-inequity-how-do-it-well
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“If you hand these out, it takes a little bit of burden off the health professional who might be involved in doing this work instead of just starting from scratch and explaining,” said Nerenz. “The handouts quickly explain with a phrase and with a nice visual to capture the why question—why are we doing this? We ask because we care.”

Learn more about how to improve health equity by collecting patient demographic data.

**Ask patients to self-report**

Before the current process was put in place, “in our organizations and many others, there was a place in the registration system to record race or ethnicity, and it was very often done simply by a visual inspection of the patient,” said Nerenz. The question was not asked of the patient directly.

“You want patients to tell you this. Yes, visually it might be obvious that they belong to one category and another, but the true authorities really are the patients themselves,” he said. “Therefore, they should be asked about race and ethnicity either verbally or in the form of some kind of written document and the response options…can be offered.” There are also examples where these questions can be presented in the patient portal as part of a pre-visit questionnaire.

There may be some challenges that come up, though. If a patient refuses, Nerenz recommends providing a script or some “back-up questions” to help guide health professionals in understanding how to respond.

The AMA has developed online tools and resources created using the latest evidence-based information to support physicians to help manage their patients’ high BP.

The AMA has developed online tools and resources created using the latest evidence-based information to support physicians to help manage their patients’ high BP. These resources are available to all physicians and health systems as part of Target: BP, a national initiative co-led by the AMA and American Heart Association.

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