AMA
AMERICAN MEDICAL ASSOCIATION

JAMES L. MADARA, MD
EXECUTIVE VICE PRESIDENT, CEO

ama-assn.org
t (312) 464-5000

October 31, 2016

Ms. Katherine K. Wallman
Chief Statistician
Office of Management and Budget
1800 G Street NW, 9th Floor
Washington, DC 20503

Re: Docket No. OMB-2016-0002

Dear Ms. Wallman:

On behalf of our physician and medical student members, the American Medical Association (AMA) is grateful for the opportunity to offer comments to the Office of Management and Budget (OMB) in support of the changes OMB has proposed to the 1997 federal standards for collecting race and ethnicity data. We support these changes as a step in the right direction to ensure that our physicians are able to provide quality health care that is safe, timely, effective, efficient, patient-centered, and equitable.

In 2002, the Health and Medicine Division of the National Academies of Sciences, Engineering, and Medicine published a scientific review titled, *Unequal Treatment*, which found that minorities are less likely than whites to receive needed services, including clinically necessary procedures, even after correcting for access-related factors, such as insurance status. Disparities were found even when clinical factors, such as stage of disease presentation, co-morbidities, age, and severity of disease are taken into account and were found across a range of clinical settings, including public and private hospitals, teaching and non-teaching hospitals. The authors recommended raising awareness of these disparities by collecting and monitoring data on patients' access and utilization of health care services by race, ethnicity, and primary language. This recommendation is based on the fundamental proposition that to eliminate disparities in care one must first be able to detect them. Detecting disparities requires three steps: (1) collection of valid and reliable data on the demographic characteristics of patients receiving care; (2) collection of valid and reliable data on the quality of care delivered; and (3) stratification of the quality data by the relevant demographic subgroups.

With improved standardized collection of these key patient demographics, physicians can better assess if there are gaps in performance measures by stratification of these measures by race and ethnicity. The AMA supports both collection and analysis of data on the health status of minorities, and advocates for standards that can be linked to health outcomes and access to care.

With regard to *the use of a combined question to measure race and ethnicity*, the AMA supports the recommendation in the Centers for Medicare & Medicaid Services report, "2010 Census Race and Hispanic Origin Alternative Questionnaire Experiment," which addressed the separate versus combined question to measure race and ethnicity. Specifically, the AMA supports the implementation of further

tests of combined race and Hispanic origin question refinements, paying special attention to research in improving detailed Asian and detailed Hispanic reporting. This recommendation supports all four objectives by increasing reporting within standard OMB categories, decreasing item nonresponse, improving accuracy and reliability, and increasing detailed reporting for a number of groups. Any changes in moving from separate to a combined question should be accompanied by a study and assessment of how that change impacts trends in health care data currently broken out by the existing race and ethnicity categories. This process is standard practice for federal agencies when data definitions or standards are modified.

Using information from the U.S. Census Bureau, the Department of Homeland Security's Yearbook of Immigration Statistics, and the World Bank's annual remittance data, the Migration Policy Institute reported in 2015 that approximately 1.02 million immigrants from the Middle East and North Africa region resided in the United States, representing 2.5 percent of the nation's 41.3 million immigrants. These data demonstrate that inclusion of *the classification of a Middle Eastern and North African group and distinct reporting category* may improve the current classification system by allowing it to be more reflective of the changing demographics of our country.

With regard to *the salience of terminology used for race and ethnicity classifications and other language in the standard,* the AMA advocates that data collection needs related to standards must not result in undue administrative burden on physicians. To this end, we recommend reporting categories that are consistent across sectors and support a universal standard for *the description of the intended use of minimum reporting categories*.

Physicians benefit from collecting accurate patient demographic data as this information can be used to accomplish high-value performance improvement projects. We applaud OMB's efforts to improve upon the existing standards. A revised classification system can help our nation move towards the elimination of health care disparities, an important national goal. By revising the standards to more accurately reflect our changing demographics and how our patients self-identify, we can examine quality data stratified by race and ethnicity with improved accuracy.

The OMB has the scientific evidence and the authority it needs to revise the Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity. The OMB's proposal, based on reasoned and sound science, should be finalized without further delay.

Thank you for considering our comments. Should you have any questions, please contact Margaret Garikes, Vice President of Federal Affairs at margaret.garikes@ama-assn.org or 202-789-7409.

Sincerely,

James L. Madara, MD