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Eliciting Patient Past Experiences of Healthcare Discrimination as a Potential Pathway to Reduce Health Disparities: A Qualitative Study of Primary Care Staff

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Abstract

Objective: To understand if and how primary care providers and staff elicit patients' past experiences of healthcare discrimination when providing care.

Data Sources/Study Setting: Twenty qualitative semi-structured interviews were conducted with health care staff in primary care roles to inform future interventions to integrate data about past experiences of healthcare discrimination into clinical care.

Study Design: Qualitative study.

Data Collection/Extraction Methods: Data were collected via semi-structured qualitative interviews between December 2018 and January 2019 with health care staff in primary care roles at a hospital-based clinic within an urban safety-net health system that serves a patient population with significant racial, ethnic, and linguistic diversity.

Principal Findings: Providers did not routinely, or in a structured way, elicit information about past experiences of healthcare discrimination. Some providers believed that information about healthcare discrimination experiences could allow them to be more aware of and responsive to their patients' needs and to establish more trusting relationships. Others did not deem it appropriate or useful to elicit such information and were concerned about challenges in collecting and effectively using such data.

Conclusions: While providers see value in eliciting past experiences of discrimination, directly and systematically discussing such experiences with patients during a primary care encounter is challenging for them. Collecting this information in primary care settings will likely require implementation of multilevel systematic data collection strategies. Findings presented here can help identify clinic-level opportunities to do so.

Keywords: health care disparities, health equity, qualitative research, racial/ethnic differences in health and health care, primary care

What is known about the topic

- Bias and discrimination in health care settings based on race and ethnicity manifest in disparities in health care access and treatment.
- When patients perceive racial/ethnic discrimination towards them, it negatively impacts their experience of care.

What this study adds

- Conversations about racism and discrimination between providers and patients offer opportunities to improve the quality of health care.
- Collection and integration of patient-level data on past experiences of healthcare discrimination as part of patients' routine care and/or treatment-related decision making to reduce health disparities will require an organization-level data collection system.

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INTRODUCTION

It has been extensively documented that bias and discrimination in healthcare settings based on race and ethnicity manifest in disparities in health care access and treatment.[1] Prior to 2020, calls had been made to understand and reduce healthcare discrimination to reduce health care disparities.[2] However, a series of events receiving national attention in 2020 (i.e., the murder of George Floyd and other Black individuals at the hands of police), increased calls to recognize and address racism as a fundamental cause of health disparities.[3]

Earlier studies have shown that when patients perceive racial/ethnic discrimination towards them, it negatively impacts their experience of care,[2] makes them more likely to rate their care as fair or poor quality,[4] leads Black patients to trust their physicians less,[5] and lowers medication adherence among Black patients with hypertension.[6] Other work shows that providers with higher levels of implicit bias deliver lower quality care[7] and that physicians have poorer communication with patients from minoritized groups in general.[8] Additionally, providers are less likely to involve patients of color in decision-making processes.[8, 9, 10] Avoiding conversations about race prevents physicians from delivering care in context, including addressing instances of healthcare discrimination when they do occur,[11] and missing opportunities to improve health outcomes among patients from minoritized groups.[12]

In theory, providers who know about patients' past discrimination have greater potential to understand a patient's lived experience and establish a more trusting relationship with the patient (e.g., by acknowledging the impact of the experience and assuring them such discrimination would not be tolerated). This may lead to patients being more comfortable engaging in open discussion about treatment preferences and potential treatment barriers or concerns. Current research shows that Black physicians are more comfortable discussing race with their patients

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than white physicians[13]; yet many racial/ethnic minority patients will not be treated by providers matching their racial/ethnic background.[14,15]

Recent published work suggests that conversations about racism and discrimination between providers and patients offer opportunities to improve the quality of health care for patients that have experienced some form of discrimination and racism.[12, 16, 17] The challenges such conversations present to providers have also been acknowledged, and provider unpreparedness to discuss racism with patients is a salient challenge.[11, 18] In fact, the need to prepare providers to discuss racism and discrimination with their patients has prompted efforts to develop tools and curricula for that purpose.[17, 19]

The qualitative study presented here aims to add to a growing body of work by focusing on healthcare discrimination (i.e., instances of unfair treatment while receiving medical care primarily because of patient race or ethnicity). This study had two objectives: (1) examine if and how health care staff in primary care roles elicit information from patients about past healthcare discrimination; and (2) explore providers' perspectives on the utility of and potential challenges in routinely incorporating system-level data collection on past healthcare discrimination into clinical encounters to enhance treatment plans.

METHODS

Interview guide and theoretical framework

Proctor et al.'s Conceptual Model for Implementation Research[20] guided the development of the interview guide used in this study. This model posits that themes of appropriateness (i.e., perceived fit, usefulness, or relevance), acceptability (i.e., satisfaction with potential intervention), and feasibility (i.e., the practicability in real-world clinical settings) should be explored to understand the context in which an intervention may be developed – even before an

intervention is adopted.[21] This model also guided our decision to include, as study subjects, providers in primary care with heterogeneous training, clinical roles, and leadership levels, because any future interventions would require multi-level buy-in.

The interview guide gathered information on conversations about past healthcare discrimination by asking participants to describe how they elicit, learn about, and use information from patients in their current clinical work-flows, and invited them to discuss potential future strategies which could systematically elicit information on past experiences of healthcare discrimination. Interview guide questions and prompts were designed to understand how providers learned about interpersonal forms of discrimination. The intent was to also explore participants' receptivity to potential data collection strategies that could be taken at the healthcare organization level. The questions asked providers to think of their experiences treating patients with diabetes and depression, two paradigmatic chronic conditions commonly seen in primary care settings.

Participants and Data Collection

Participants were recruited via emails sent to staff with clinical and leadership roles at a hospital-based primary care clinic within an urban safety-net health care system serving a patient population with significant racial, ethnic, and linguistic diversity and a large burden of depression and/or type 2 diabetes. The email described the goals of the study, offered a $75 gift card for participation, and provided contact information for enrollment. Recruitment concluded upon reaching the target sample of 20 participants.

Twenty semi-structured qualitative interviews were conducted with providers and staff in primary care (including physicians, nurse practitioners or nurses, specialty pharmacists, social workers, complex care managers, and practice managers). All were required to be treating (e.g.,

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providers) or closely involved in delivering care to patients with diabetes and depression (e.g., complex care managers or practice manager roles). Of the twenty participants interviewed, seventeen were white, ten were female, and ten had proficiency in a language other than English. Their mean age was 45.9 years old. See Table 1 for detailed participant characteristics.

Four trained interviewers (two doctorate level researchers and two bachelor's level research assistants; three women and one man; one White, two Asian-American, and one Latina) conducted in-person interviews of approximately one hour in duration between December 6, 2018 and January 23, 2019. All participants provided written informed consent for their participation. Interviews were audio-recorded and professionally transcribed. All aspects of the study were approved by the health care system's institutional review board.

Data Analysis

The four members of the study team trained in qualitative interviewing and coding independently coded the 20 interviews using thematic analysis and Dedoose Qualitative Software.[22] A qualitative code "tree" was generated deductively by the senior qualitative researcher (DEC) using the interview guide domains. Coders reviewed each interview using the code tree and generated summary analytic memos for each interview. Additional codes were generated inductively during coding sessions. This allowed for identifying and adding codes that emerged from the interviews. This resulted in the final coding tree (see Table 2) that was used to code the study data from the qualitative interviews.

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After the coding team engaged in reflexivity activities— to identify potential coding biases that could interfere with the process of preserving intended meanings of the collected narratives— two coders independently coded each interview. Upon completing independent coding of each interview, each pair of coders reviewed, compared, discussed applied codes to resolve discrepancies. These reconciled coded interviews were then analyzed thematically.

RESULTS

Objective 1: Examine if and how health care staff in primary care roles elicit information from patients about past healthcare discrimination

Theme 1: Providers rarely ask about or learn about patients' past experiences of healthcare discrimination

Almost no providers reported initiating conversations with patients about past experiences of healthcare discrimination. As they reflected on this question, some noted that they should make it a point to ask patients about their experiences of discrimination in the healthcare system, but acknowledged that they found it difficult to ask these questions directly. The providers that reported that they have asked patients about healthcare experiences of discrimination, noted that this typically occurred in the setting of subspecialist care or referred medical care. They also reported that patients returning after a referral tend to voluntarily report negative experiences, if encountered. The following quotations illustrate these findings:

"…when someone does bring it [prior experience of discrimination] up spontaneously, it's significant, and they mention it because it's very significant to them or they had a bad experience. It's hard to interpret, honestly, the patient telling you that. What it tells me is that they've had a bad experience and that it sounds like it may be legitimate. It's very hard for me to tell whether it's based on discrimination for any of those factors you mentioned or not." (ID 14)

"I suppose, if someone was in one of … an identified group, that has suffered discrimination in healthcare. I suppose there could be a discussion brought up about it. If it was something that was considered really appropriate and necessary when working with the patient. I suppose we could proactively bring up the conversation."- (ID 12)

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Other providers indicated that they would ask about healthcare discrimination only if patients themselves initiated conversations about such experiences. Having a long-term relationship with patients provided opportunities for providers to engage in conversations that may uncover past experiences of healthcare discrimination.

"I think that patients on chronic opioids have said that ["I feel that I was discriminated against."] to me routinely. In the context of diabetes and depression, I'm not sure that it's been stated quite that way." (ID 6)

"… it's a thing I talk about patients who I know well and open up to me about all this stuff just in a normal fluid conversation, but I don't think regularly it's a thing I'm just checking to screen for, or I'm asking about." (ID 3)

"…sometimes it's [experience of discrimination] volunteered. For patients I know, it's fine. Often it's volunteered something from conversation, "Hey, I went to this emergency room. It was terrible. They didn't use an interpreter. I didn't know what was happening. Can you find out what happened? I don't know what happened?"" (ID 18)

Theme 2: The relevance and impact of asking patients about experiences of healthcare discrimination for treatment purposes

Providers had mixed views on the utility of inquiring about patients' past experiences of healthcare discrimination for treatment purposes. While most thought that knowing about past discrimination may strengthen their understanding of the patient's experiences, concerns about feasibility, appropriateness, and potential unintended consequences of inquiring about this sensitive topic made it difficult for providers to judge the utility of asking about healthcare discrimination outright. Others said that asking such questions could cause harms or would not change the way they treat their patients and thus not be useful:

"Some of the things [discrimination experiences] we've talked about can be pretty traumatic in nature and I think, not cognizantly [sic] addressing the traumatic experience [by the provider]

for a patient is not a safe proposal. So that's one of the things I would worry about in this context to do that kind of disclosure in a trauma in an informed way." (ID 18)

"…I don't see those conversations being super-productive for me, because I'm treating them [patients] the same way. I would hope to be treating this patient the same way, so regardless if they told me that they had that bad experience before…" (ID 2)

Finally, providers also shared how asking patients about past experiences of healthcare discrimination could enhance their therapeutic alliance. According to them, such conversations have the potential for strengthening the patient-provider relationship via advocacy on behalf of the patient and an opportunity to build more trust between patient and provider.

"It makes me more of an advocate for them. …It makes us more sensitive to their needs and maybe [the] reason that they're not trusting you or maybe the reason that they're not following a certain treatment plan. …it could explain hesitance for certain kinds of treatments or...just some lack of trust and why they have [a] lack of trust, and then you just mark it higher on your scale of things to attend to would be the trust issue." (ID 10)

"He was kind of feeling like, "Well, sometimes when I go to the emergency room, they don't take it seriously." That prompted me to ask more and say, "Why, why, why?" And I actually in my head was saying I want to figure out if he feels discriminated against. And then finally after I heard him say a few things I asked him more explicitly, "Do you feel like you're being discriminated [against]." I think that he said he did, and we talked about that, and explained we made a plan that if he goes to the emergency room I would call ahead and explain that I was worried about the pain and explain the background of it a more. And I think he felt a little bit more trusting of the healthcare system just because I think he had heard some things that people thought he was just making it up and stuff like that. So, for someone to understand he was having a lot of pain was helpful for him…" (ID 3)

Objective 2: Explore providers' perspectives on incorporating system-level routine data collection on past healthcare discrimination to enhance treatment plans.

Theme 1: Providers differed about the extent to which it is appropriate and useful to elicit data on discrimination

Providers' responses to questions about the usefulness of collecting data on past experiences of healthcare discrimination in the future fell under three categories: (1) some providers supported

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collecting such data to strengthen the patient-provider relationship, while others supported collecting these data if scientific evidence supports a positive impact of such data on treatment plans; (2) other providers did not see value in collecting such data, due to three reasons: inability to act upon data collected, system-wide data collection challenges, and potential for undermining the patient-provider relationship; and (3) a third group of providers expressed ambivalence about the usefulness of such data for treatment purposes.

Those providers favoring collection and use of these data indicated that collecting the information would allow the provider to be more sensitive and responsive to their patients' needs; to uncover factors impacting adherence to treatment; and to establish a two-way trustworthy relationship.

"If they [the patients] are feeling like the healthcare system is prejudiced against them, or that it's not a safe place for them, then I would feel more ownership in making safe space for them. It might be on my radar and I would be checking in on it, and if there were providers who continue to discriminate against them or something like that, I would be changing their doctors, I would be complaining about the doctors who are discriminating. With that information I'd be more active about trying to get rid of that discrimination and making them have a better experience." (ID 3)

"I think that obtaining someone's preferences is useful all the time because [of] respect. That seems morally correct." (ID 18)

Theme 2: Certain factors would impact acceptability and feasibility of collecting and using data on discrimination in real-world settings

Providers saw challenges to routinely collecting data on discrimination. For example, they indicated that the 15–20-minute medical visit is not conducive or ideal to hold extensive conversations about past experiences of healthcare discrimination as such conversations warrant more time and depth. In addition, many providers expressed that they are not appropriately equipped to elicit that information on past experiences of discrimination as they did not know

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what to do about that information. Provider feedback indicated that routinely eliciting structured information about patients' healthcare discrimination experiences would require a multi-level system-wide approach to address time constraints in primary care. They recommended that other staff collect that information and that support systems be implemented to provide appropriate remedies or interventions.

"…As with anything, collecting information without having a team-based approach to addressing it is not a worthwhile endeavor. So, I think it's only useful in the context of a team approach… I struggle with figuring out how it fits into an already extremely over-pressured visit." (ID 6)

"I don't know if it would be useful [collecting the data]. Because, I can usually figure it out by discussing with the patient, within a pretty short time frame of meeting with them. Or, based on their history…" (ID 12)

"... I mean, that comes out in the interview. I wouldn't want to put resources into an extra screening tool for that kind of thing. ...I would say more information is not necessarily what I need." (ID 17)

"I'm not sure what I would do with that information, if they just said, "Yeah, I've been discriminated a lot because I speak funny." (ID 10)

Providers also felt that, even if the data were collected via a survey rather than during a visit, both patients and staff at the health system were over-burdened by surveys. With regards to conversations about past experiences of discrimination, some providers shared that asking patients about past experiences of healthcare discrimination could potentially strain their relationship with patients who have experienced healthcare discrimination because providers and other staff will be more likely to avoid situations that could be mistakenly characterized as discriminatory. One provider, shared this view about such possible situations:

"I can see that [collecting data about past healthcare discrimination] as being helpful. I could see the opposite side of the coin, which is if that information was available to a provider, could a certain provider feel anxious or worried or judged or walking into the trap of being misinterpreted and feeling so highly sensitive around interactions with patients that it actually would be harmful rather than helpful? I mean, I guess I can see it through both lenses." (ID 19)

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Providers were also concerned that asking about past discrimination (either as part of the visit or via a structured method like a survey) could be disturbing or upsetting to the patient. However, some providers expressed that these conversations about discrimination are very likely to create an urgency to mend the healthcare delivery system, pointing to important future changes. The quotation below illustrates this point.

"I guess it [collecting data about past healthcare discrimination] would make me more cognizant of what I'm saying to the patient, or am I behaving in an open way towards this patient? Or am I presenting preconceived notions of who the patient is? That's not necessarily a bad thing. ...Let's say someone were walking into the clinic and they have that on their problem list of, "Patient was treated unfairly in the past." That gives you a sense of, "Oh, I need to be careful of this patient in some way." I could hypothesize." (ID 9)

Finally, there were providers who expressed that routine data collection of discrimination experiences made sense at a conceptual level, but felt that collecting and acting upon the data would be challenging. In order to be convinced that the challenges were worth the effort, these providers said they would want to see scientific data showing that collecting and using such information improves treatment outcomes.

"I think that for me to answer that question, I would need you to actually solve that problem and then say to me, "We've used this survey and here's what the validity is and here's how we matched it up with patient preference during talk interviews. And here's how we match it with doctors' assumptions of patient preferences and look out how these things line up beautifully so we can take out the middle man of all these other things, and now you can just use this survey." I'm a naysayer at baseline, and I make data driven decisions." (ID 19)

"I think finding how it would improve the treatment plan, that's the trick. How would this, okay, now that we have this information, how do we use this to improve treatment plans and stuff. I don't know, but certainly having the information gives you some place to start." (ID 15)

DISCUSSION

Engaging patients in conversations about past experiences of healthcare discrimination was uncommon among providers interviewed in this study. Providers acknowledged challenges initiating conversations with patients about past experiences of health care discrimination, which

is consistent with other studies that have found that providers have difficulty discussing race or racism in clinical encounters.[23,24]

While interview prompts focused on interpersonal experiences of discrimination (primarily based on race/ethnicity), findings suggest the need for organizational-level data collection solutions to address healthcare discrimination in clinical encounters. Providers in our study were open to considering gathering and integrating information on past experiences of healthcare discrimination as part of patient routine care and/or treatment-related decisions. However, providers also mentioned specific concerns and challenges about collecting these data, especially related to time constraints during medical visits in a primary care setting. Their feedback suggests that survey(s) to elicit experiences of healthcare discrimination should be administered in a manner that helps patients feel comfortable divulging potentially sensitive information and takes into account time burdens. To support providers, healthcare organizations will need to develop workflows to deliver interpretable data confidentially and quickly to providers.

Providers questioned what to do with the data once collected, and expressed that the manner in which these data are integrated into treatment planning should be guided by evidence that collection of these data would improve patient outcomes. Providers were concerned about how the experiences of healthcare discrimination might adversely impact subsequent experiences of care and trust in providers[5]. Some providers interviewed felt more prepared to alter their engagement with patients who have experienced discrimination without further guidance. However, the fact there were providers that felt unprepared to do this without system-wide or team-based support, and that others had concerns about potential unintended consequences such as further traumatizing patients, suggests the need for system-wide strategies.

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Findings indicate that providers should be offered training to effectively engage in these sensitive conversations. As noted by others,[17, 25] curricula already exist and several frameworks, including trauma-informed care, that could be more broadly used in medical school and residency programs than they currently are and integrated in post-graduate medical training of primary care physicians. The use of a trauma-informed care framework to guide training on how to approach these conversations is recommended due to the risk of patient re-traumatization when discussing past experiences of healthcare discrimination.[25] However, timely trauma-informed follow-up with some patients may also be needed.

Provider training would likely need to include a focus on self-awareness about personal biases providers explicitly and implicitly bring to patient-provider encounters and equip providers to address the social and medical needs that impact health outcomes and contribute to racial and ethnic disparities.[23,26] Health system responses will also need to be designed in ways that ensure they help enhance, rather than erode, health system trust for patients. More research is needed to establish, for example, whether eliciting information on past discrimination can help inform treatment decisions in primary care settings and, ultimately reduce the current racial and ethnic inequities in care.

Recently, health care systems have developed systems to measure and act on social determinants of health (SDOH) data (i.e., social, economic, environmental and health education data collected in the electronic health record) to improve quality of care.[27] SDOH data collection tools usually include features such as workflows with linkages to appropriate staff resources, actionable steps, electronic health record integration[27], and even collection of data on treatment preferences.[28] Systemic approaches to address SDOH could serve as models for collecting information about healthcare discrimination, and could help healthcare systems understand the

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extent to which their patients' experiences of interpersonal racism are linked to health care outcomes. Since these interviews were conducted, there has been progress to improve upon existing measures of healthcare discrimination[29] and to develop validated patient-reported measures.[30, 31] Such measures, however, would need to be evaluated before they are implemented. For example, it is important to be cognizant of the fact that the use of screening tools for SDOH and healthcare discrimination could have the unintended consequences of alienating patients if they are not approached using a health equity lens and approach through which they feel respected and validated.[32] SDOH measures are also starting to be used for value-based payment (VBP) and pay-for-performance initiatives around risk adjustment. Because many questions remain about implementing VBP in low-resource, safety net settings (whose patients face many structural and social challenges), adjusting for measures of SDOH has been one approach to attempt to not penalize those systems that already care for the most vulnerable patients. Increasingly, VBP-based reforms are looking to also address health equity including incentivizing the reduction of racial/ethnic disparities. Thus, controversial or not, it is likely that health systems will see increased interest in routine data collection around racial/ethnic disparities and social determinants that may specifically impact different racial/ethnic groups, such as discrimination.[33]

Whether or not health systems collect and act upon these data, patients are already sharing this information via peer networks and online reviews.[34,35] This demonstrates that patients value the collecting and reporting of this information to help them make decisions about where to seek care. Approaches to collect and respond to these data, may help ensure that reported discrimination does not continue and mitigate the harm caused to individual patients. Such approaches will likely have broad-reaching impacts on perceptions of healthcare quality

and willingness to seek care at specific institutions by other groups from marginalized backgrounds.

This study has several limitations that should be noted. The data reported here are qualitative in nature and not designed to provide empirical generalizability and statistical representation.[36] The findings of this study represent the views and experiences of providers that were recruited within a single primary care clinic located within a safety-net, urban healthcare system. Those who chose to participate may have had special interest in the topic of healthcare discrimination. Also, providers were asked to provide input on a hypothetical systemic collection of data on discrimination; therefore, the data reported here summarize providers' anticipated barriers.

As health systems move to consider and develop data collection system-wide approaches to help increase provider awareness of and comfort addressing experiences of healthcare discrimination, implementation frameworks that have a specific focus on health equity may be helpful to guide intervention development. For example, the Health Equity Implementation Framework is centered around interventions delivered during a clinical encounter between a patient and provider (e.g., eliciting information about past healthcare discrimination and engaging in shared decision-making to take appropriate action to mitigate its potential impacts to patients or on their patient care).[37] Consistent with findings reported here, this framework highlights the role of multiple spheres (e.g., patient factors, provider factors, and the characteristics of the intervention or innovation) of influence to ensure such interventions are both implemented successfully and lead to improvements in health equity. Also, intervention developers would need to take into account factors at the local level and healthcare system level to ensure that developed interventions are a fit within a given healthcare organizational context.

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Our study provides some strategic directions for addressing challenges at these levels and suggests some key characteristics of a potential innovation (e.g., provider training, fitting a data collection approach into primary care constraints, and team-based or system-based support for addressing discrimination that is uncovered). Building from these findings, we recommend additional research to refine knowledge about how these factors may impact an intervention's potential to be implemented successfully *and* to positively impact the patient experience.

Since these interviews were conducted, the disproportionate impact of the COVID-19 pandemic on racialized and minoritized groups heightened demands to eradicate longstanding racial and ethnic discrimination and associated health inequalities.[38] In addition to considering the development of specific interventions at the level of a healthcare organization, eliminating healthcare disparities will require dismantling system-wide practices that perpetuate disparities,[39] including eliminating racial/ethnic/identity bias in care delivery through quality improvement initiatives with a focus on equity and root cause analyses.[40] Patients' racialized experiences are a clinically relevant treatment-decision component[41] which thus far are not routinely considered in primary care encounters. Collecting information on patient past experiences of healthcare discrimination is likely to elicit instances of experiences of both interpersonal and structural racism. Therefore, healthcare systems committed to address the impact that these experiences have on patients will be required to devise and implement interventions aim at remedying both levels of experiences. Structural instances of racism reported by the patient will require system-level intervention to address factors contributing to SDOH, whereas interpersonal instances of racism and bias will require interventions involving provider education.

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Table 1. Study Participant Characteristics

Characteristic	**No. (%)**
Primary professional role	
Primary Care provider (MDs and primary care nurse practitioners)	12 (55)
Primary care leadership or management specialist (e.g., director, manager, integration specialist)	3 (15)
Clinical social worker and/or case manager	3 (15)
Clinical pharmacist	2 (10)
Female	10 (50)
Non-Hispanic White	17 (85)
Proficient in language other than English	10 (50)

Table 2: Code Tree Related to Healthcare Discrimination

INTERVIEW DOMAIN	LEVEL 1 CODE	LEVEL 2 CODES	LEVEL 3 CODES
Domain: Healthcare discrimination			
Patient experiences of discrimination/ unfair treatment	**Eliciting narratives of past discrimination/unfair treatment**	Advantages, Disadvantages, No, Triggers leading to conversation, Yes	
	Views about discrimination in health care settings	Happens often generally, Rarely happens	
Domain: Barriers and facilitators to incorporating systematic data collection			
Eliciting data about past healthcare discrimination to improve treatment plans	**Usefulness of discrimination data**	Advantages Disadvantages Relative importance	Responsiveness to patient needs Inability to respond to patient needs
How to improve elicitation of discrimination at healthcare organization	**Survey implementation**	Challenges	Confidentiality concerns, How to use data, Impairment due to mental illness, Implementation logistics, Individual-level approaches, Literacy issues, Patient burden, Staff burden, System-wide approaches

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