AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 003
(I-19)

Introduced by: Medical Student Section

Subject: Accurate Collection of Preferred Language and Disaggregated Race and Ethnicity to Characterize Health Disparities

Referred to: Reference Committee on Amendments to Constitution and Bylaws (_____, Chair)

Whereas, The Office of the National Coordinator for Health Information Technology (ONC) is the principal federal entity coordinating the electronic exchange of health information[1]; and

Whereas, The U.S. Census collects data based on racial self-identification as White, Black or African American, American Indian or Alaska Native, Asian, and Native Hawaiian or Other Pacific Islander[2]; and

Whereas, In addition to health disparities between racial and ethnic groups, health disparities also exist within U.S. Census-defined racial and ethnic groups[3,4]; and

Whereas, Disaggregating racial and ethnic data is defined for the purpose of this resolution as subdividing U.S. Census-defined racial or ethnic (i.e. Hispanic and non-Hispanic) designations into ethnic subgroups (i.e. by splitting "Asian" into Vietnamese, Chinese, Japanese, Laotian, Burmese, Pakistani, Indian, etc.)[4]; and

Whereas, A series of systematic literature reviews reported to the Robert Wood Johnson Foundation identified that within-group disparities were more accurately accounted for by research methodologies that used disaggregated racial and ethnic data among American Indian/Alaska Native (AIAN); Asian American, Native Hawaiian, and Pacific Islander (AANHPI); Latinx; non-Hispanic White Americans; and Black/African American populations[4]; and

Whereas, Despite being classified as White by the U.S. Census and other registries, several population-level disparities exist between Arab Americans and other White ethnic groups[5]; and

Whereas, Health behaviors, such as dietary practices, vary within Asian and Latino subgroups and thus require different interventions and may lead to different health outcomes[6,7]; and

Whereas, Accurate preferred language data can help identify "hot-spot" geographic areas with a high density of morbidity and could facilitate addressing social determinants of health[8]; and

Whereas, A 2017 randomized controlled trial and retrospective study at an inner-city pain clinic demonstrated improved adherence to treatment and attendance at scheduled appointments after an intervention was deployed that utilized accurate preferred language data[9,10]; and

Whereas, Race, ethnicity, and language (REL) and other socio-demographic data could be used to identify targeted interventions for high-risk patients or areas for quality improvement[11,12]; and

Whereas, Despite recognition that such data can improve care, reliable collection of REL is uncommon, even in settings that treat large minority and immigrant populations[8,11–13]; and

Whereas, Several successful systems-level interventions with evidence of improved screening for accurate REL data have been published to date[12,14]; and

Whereas, Existing guidelines for electronic health record (EHR) collection of REL data have led to inaccuracies that could reduce the effectiveness of interventions based on this data[13]; and

Whereas, Our AMA has supported reducing racial and ethnic disparities in health care by studying health system opportunities and barriers to eliminating disparities (D-350.995); and

Whereas, Our AMA has advocated for precision in racial, ethnic, and religious designations in medical records, but has not done so for preferred language (H-315.996); and

Whereas, Our AMA has supported the collection of disaggregated racial data, but current policy lacks actionable language to engage stakeholders (H-350.954); therefore be it

RESOLVED, That our American Medical Association amend Policy H-315.996 by addition to read as follows:

Accuracy in Racial, Ethnic, Lingual, and Religious Designations in Medical Records, H-315.996

The AMA advocates precision in racial, ethnic, preferred language, and religious designations in medical records, with information obtained from the patient, always respecting the personal privacy of the patient (Modify Current HOD Policy); and be it further

RESOLVED, That our AMA encourage the Office of the National Coordinator for Health Information Technology (ONC) to expand their data collection requirements, such that electronic health record (EHR) vendors include options for disaggregated coding of race and ethnicity. (Directive to Take Action)

Fiscal Note:

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RELEVANT AMA POLICY:

Disaggregation of Demographic Data Within Ethnic Groups H-350.954
1. Our AMA supports the disaggregation of demographic data regarding: (a) Asian-Americans and Pacific Islanders in order to reveal the within-group disparities that exist in health outcomes and representation in medicine; and (b) ethnic groups in order to reveal the within-group disparities that exist in health outcomes and representation in medicine.
2. Our AMA: (a) will advocate for restoration of webpages on the Asian American and Pacific Islander (AAPI) initiative (similar to those from prior administrations) that specifically address disaggregation of health outcomes related to AAPI data; (b) supports the disaggregation of data regarding AAPIs in order to reveal the AAPI ethnic subgroup disparities that exist in health outcomes; (c) supports the disaggregation of data regarding AAPIs in order to reveal the AAPI ethnic subgroup disparities that exist in representation in medicine, including but not limited to leadership positions in academic medicine; and (d) will report back at the 2020 Annual Meeting on the issue of disaggregation of data regarding AAPIs (and other ethnic subgroups) with regards to the ethnic subgroup disparities that exist in health outcomes and representation in medicine, including leadership positions in academic medicine.
Citation: Res. 001, I-17; Appended: Res. 403, A-19

National Health Information Technology D-478.995
1. Our AMA will closely coordinate with the newly formed Office of the National Health Information Technology Coordinator all efforts necessary to expedite the implementation of an interoperable health information technology infrastructure, while minimizing the financial burden to the physician and maintaining the art of medicine without compromising patient care.
2. Our AMA: (A) advocates for standardization of key elements of electronic health record (EHR) and computerized physician order entry (CPOE) user interface design during the ongoing development of this technology; (B) advocates that medical facilities and health systems work toward standardized login procedures and parameters to reduce user login fatigue; and (C) advocates for continued research and physician education on EHR and CPOE user interface design specifically concerning key design principles and features that can improve the quality, safety, and efficiency of health care; and (D) advocates for continued research on EHR, CPOE and clinical decision support systems and vendor accountability for the efficacy, effectiveness, and safety of these systems.
3. Our AMA will request that the Centers for Medicare & Medicaid Services: (A) support an external, independent evaluation of the effect of Electronic Medical Record (EMR) implementation on patient safety and on the productivity and financial solvency of hospitals and physicians' practices; and (B) develop, with physician input, minimum standards to be applied to outcome-based initiatives measured during this rapid implementation phase of EMRs.
4. Our AMA will (A) seek legislation or regulation to require all EHR vendors to utilize standard and interoperable software technology components to enable cost efficient use of electronic health records across all health care delivery systems including institutional and community based settings of care delivery; and (B) work with CMS to incentivize hospitals and health systems to achieve interconnectivity and interoperability of electronic health records systems with independent physician practices to enable the efficient and cost effective use and sharing of electronic health records across all settings of care delivery.
5. Our AMA will seek to incorporate incremental steps to achieve electronic health record (EHR) data portability as part of the Office of the National Coordinator for Health Information Technology's (ONC) certification process.
6. Our AMA will collaborate with EHR vendors and other stakeholders to enhance transparency and establish processes to achieve data portability.
7. Our AMA will directly engage the EHR vendor community to promote improvements in EHR usability.

8. Our AMA will advocate for appropriate, effective, and less burdensome documentation requirements in the use of electronic health records.
9. Our AMA will urge EHR vendors to adopt social determinants of health templates, created with input from our AMA, medical specialty societies, and other stakeholders with expertise in social determinants of health metrics and development, without adding further cost or documentation burden for physicians.
Citation: Res. 730, I-04; Reaffirmed in lieu of Res. 818, I-07; Reaffirmed in lieu of Res. 726, A-08; Reaffirmation A-10; Reaffirmed: BOT Rep. 16, A-11; Modified: BOT Rep. 16, A-11; Modified: BOT Rep. 17, A-12; Reaffirmed in lieu of Res. 714, A-12; Reaffirmed in lieu of Res. 715, A-12; Reaffirmed: BOT Rep. 24, A-13; Reaffirmed in lieu of Res. 724, A-13; Appended: Res. 720, A-13; Appended: Sub. Res. 721, A-13; Reaffirmed: CMS Rep. 4, I-13; Reaffirmation I-13; Appended: BOT Rep. 18, A-14; Appended: BOT Rep. 20, A-14; Reaffirmation A-14; Reaffirmed: BOT Rep. 17, A-15; Reaffirmed in lieu of Res. 208, A-15; Reaffirmed in lieu of Res. 223, A-15; Reaffirmation I-15; Reaffirmed: CMS Rep. 07, I-16; Reaffirmed: BOT Rep. 05, I-16; Appended: Res. 227, A-17; Reaffirmed in lieu of: Res. 243, A-17; Modified: BOT Rep. 39, A-18; Reaffirmed: BOT Rep. 45, A-18; Reaffirmed: BOT Rep. 19, A-18; Reaffirmation: A-19;

Hospital Surveys and Health Care Disparities H-450.924
1. Our AMA supports that the goal of hospital quality program assessments should be to identify areas to improve patient outcomes and quality of patient care.
2. Our AMA recognizes the importance of cultural competency to patient experience and treatment plan adherence and encourage the implementation of cultural competency practices across health care settings.
3. Our AMA supports that hospital quality program assessments should account for social risk factors so that they do not have the unintended effect of financially penalizing safety net hospitals and exacerbating health care disparities.
4. Our AMA will continue to advocate for better risk models that account for social risk factors in hospital quality program assessments.
5. Our AMA will continue to work with CMS and other stakeholders, including representatives of Americas Essential Hospitals, to address issues related to hospital quality program assessments.
6. Our AMA opposes hospital quality program assessments that have the effect of financially penalizing physicians, including those practicing in safety net hospitals.
Citation: CMS Rep. 02, I-17; Reaffirmed: CMS Rep. 10, A-19

Sharing Demographic Medicare Data with Other Public Entities by CMS H-330.934
The AMA supports continued provision of aggregate anonymous demographic information to state and local health agencies where its use will promote community health and improve utilization of health care dollars, as long as adequate safeguards to protect individual privacy are preserved.
Citation: Sub. Res. 810, I-96; Reaffirmed: CMS Rep. 8, A-06; Reaffirmed: CMS Rep. 01, A-16

Accuracy in Racial, Ethnic and Religious Designations in Medical Records H-315.996
The AMA advocates precision in racial, ethnic and religious designations in medical records, with information obtained from the patient, always respecting the personal privacy of the patient. Citation: (Res. 4, I-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CSA Rep. 8, A-05; Modified: CSAPH Rep. 1, A-15)

Race and Ethnicity as Variables in Medical Research H-460.924
Our AMA policy is that: (1) race and ethnicity are valuable research variables when used and interpreted appropriately;
(2) health data be collected on patients, by race and ethnicity, in hospitals, managed care organizations, independent practice associations, and other large insurance organizations;
(3) physicians recognize that race and ethnicity are conceptually distinct;
(4) our AMA supports research into the use of methodologies that allow for multiple racial and ethnic self-designations by research participants;
(5) our AMA encourages investigators to recognize the limitations of all current methods for classifying race and ethnic groups in all medical studies by stating explicitly how race and/or ethnic taxonomies were developed or selected;
(6) our AMA encourages appropriate organizations to apply the results from studies of race-ethnicity and health to the planning and evaluation of health services; and

(7) our AMA continues to monitor developments in the field of racial and ethnic classification so that it can assist physicians in interpreting these findings and their implications for health care for patients.
Citation: CSA Rep. 11, A-98; Appended: Res. 509, A-01; Reaffirmed: CSAPH Rep. 1, A-11)

Reducing Racial and Ethnic Disparities in Health Care D-350.995
Our AMA's initiative on reducing racial and ethnic disparities in health care will include the following recommendations:
(1) Studying health system opportunities and barriers to eliminating racial and ethnic disparities in health care.
(2) Working with public health and other appropriate agencies to increase medical student, resident physician, and practicing physician awareness of racial and ethnic disparities in health care and the role of professionalism and professional obligations in efforts to reduce health care disparities.
(3) Promoting diversity within the profession by encouraging publication of successful outreach programs that increase minority applicants to medical schools, and take appropriate action to support such programs, for example, by expanding the "Doctors Back to School" program into secondary schools in minority communities.
Citation: BOT Rep. 4, A-03; Reaffirmation A-11; Reaffirmation: A-16; Reaffirmed: CMS Rep. 10, A-19

Racial and Ethnic Disparities in Health Care H-350.974
1. Our AMA recognizes racial and ethnic health disparities as a major public health problem in the United States and as a barrier to effective medical diagnosis and treatment. The AMA maintains a position of zero tolerance toward racially or culturally based disparities in care; encourages individuals to report physicians to local medical societies where racial or ethnic discrimination is suspected; and will continue to support physician cultural awareness initiatives and related consumer education activities. The elimination of racial and ethnic disparities in health care an issue of highest priority for the American Medical Association.
2. The AMA emphasizes three approaches that it believes should be given high priority:
A. Greater access - the need for ensuring that black Americans without adequate health care insurance are given the means for access to necessary health care. In particular, it is urgent that Congress address the need for Medicaid reform.
B. Greater awareness - racial disparities may be occurring despite the lack of any intent or purposeful efforts to treat patients differently on the basis of race. The AMA encourages physicians to examine their own practices to ensure that inappropriate considerations do not affect their clinical judgment. In addition, the profession should help increase the awareness of its members of racial disparities in medical treatment decisions by engaging in open and broad discussions about the issue. Such discussions should take place in medical school curriculum, in medical journals, at professional conferences, and as part of professional peer review activities.
C. Practice parameters - the racial disparities in access to treatment indicate that inappropriate considerations may enter the decision-making process. The efforts of the specialty societies, with the coordination and assistance of our AMA, to develop practice parameters, should include criteria that would preclude or diminish racial disparities.
3. Our AMA encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality. Furthermore, our AMA supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons.
4.Our AMA: (a) actively supports the development and implementation of training regarding implicit bias, diversity and inclusion in all medical schools and residency programs; (b) will identify and publicize effective strategies for educating residents in all specialties about disparities in their fields related to race, ethnicity, and all populations at increased risk, with particular regard to access to care and health outcomes, as well as effective strategies for educating residents about managing the implicit biases of patients and their caregivers; and (c) supports research to identify the most effective strategies for educating physicians on how to eliminate disparities in health outcomes in all at-risk populations.
Citation: CLRPD Rep. 3, I-98; Appended and Reaffirmed: CSA Rep.1, I-02; Reaffirmed: BOT Rep. 4, A-03; Reaffirmed in lieu of Res. 106, A-12; Appended: Res. 952, I-17; Reaffirmed: CMS Rep. 10, A-19