

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 407
(A-24)

Introduced by: Medical Student Section, American Association of Public Health Physicians

Subject: Racial Misclassification

Referred to: Reference Committee D

- 1 Whereas, the National Center for Health Statistics maintains a National Death Index (NDI), a
2 centralized database of death record information on file in state vital statistics offices¹⁻²; and
3
4 Whereas, this data can be linked to databases maintained by agencies like the Centers for
5 Disease Control, Food and Drug Administration, and Centers for Medicare and Medicaid
6 Services to increase the availability of information on an individual's cause of death¹⁻⁵; and
7
8 Whereas, a key limitation of these vital statistic data is the misclassification of race and ethnicity
9 on death certificates and in other databases (e.g., inaccurate from minority identification to
10 white), limiting the quality and applicability of data available for racial and ethnic minority
11 populations experiencing health disparities⁶⁻⁷; and
12
13 Whereas, populations more likely to be misclassified on their death certificates include, but are
14 not limited to, American Indians and Alaska Natives (AI/AN), Asian Americans, and Native
15 Hawaiians and Other Pacific Islanders (NHPI)^{6,8-13}; and
16
17 Whereas, a retrospective linkage of regional records maintained by the Indian Health Service
18 and Oklahoma State Health Department Vital Records reported a 29% underestimation of all-
19 cause mortality in the AI/AN population⁶; and
20
21 Whereas, an updated version of the National Longitudinal Mortality Study (1999-2011
22 decedents versus 1990-1998 decedents) found that racial misclassification remained high at
23 40% for the AI/AN population and changed from 5% to 3%, for the Hispanic population and from
24 7% to 3% for the Asian or Pacific Islander (API) population¹⁴⁻¹⁵; and
25
26 Whereas, racial misclassification on death certificates is compounded by missing or incorrect
27 race and ethnicity data in other databases, such as those maintained by federal health
28 programs, hospital systems, and related entities¹⁵⁻¹⁹; and
29
30 Whereas, a 2021 study of 4,231,370 Medicare beneficiaries who utilized home health care
31 services in 2015 found substantial racial misclassification of self-identified Hispanic, Asian
32 American, Pacific Islander, and AI/AN beneficiaries (more than 80% for AI/AN in 24 states and
33 Puerto Rico) as non-Hispanic white²⁰; and
34
35 Whereas, a 2019 study that conducted ICD-9/ICD-10 record linkages between the Northwest
36 Tribal Registry and Oregon and Washington hospital discharge datasets increased the
37 ascertainment of neonatal abstinence syndrome cases among AI/AN newborns by 8.8% in
38 Oregon and by 18.1% in Washington²¹; and

1 Whereas, according to the United States Centers for Disease Control and Prevention, more
2 AI/AN patients are misclassified as another race in cancer registry records than patients in other
3 racial groups, likely from one group to identification as non-Hispanic white²²⁻²³; and
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5 Whereas, a 2021 prospective observational study of patients admitted to an urban Level 1
6 trauma center found that 45 of 98 patients self-identifying as Hispanic (45.9%) had inaccurately
7 recorded ethnicity in the trauma registry²⁴; and
8

9 Whereas, decedent race and ethnicity may be subject to bias as a 2018 project by the National
10 Consortium for Urban Indian Health found that 48% of surveyed funeral directors were recording
11 an individual's race on death certificates by observation of the individual rather than asking their
12 next of kin^{9,25}; and
13

14 Whereas, mortality-related research data, combined with other clinically-based registries, is a
15 fundamental tool for establishing public health priorities (e.g., advocacy, resource allocation,
16 stakeholder engagement) at the local, state, tribal and federal level and is an important part of
17 Indigenous Data Sovereignty (H-460.884)²⁶; therefore be it
18

19 RESOLVED, that our American Medical Association amend H-85.953, "Improving Death
20 Certification Accuracy and Completion," by addition as follows:
21

22 Improving Death Certification Accuracy and Completion H-85.953

23 1. Our AMA: (a) acknowledges that the reporting of vital events is
24 an integral part of patient care; (b) urges physicians to ensure
25 completion of all state vital records carefully and thoroughly with
26 special attention to the use of standard nomenclature, using legible
27 writing and accurate diagnoses; and (c) supports notifying state
28 medical societies and state departments of vital statistics of this
29 policy and encouraging their assistance and cooperation in
30 implementing it.

31 2. Our AMA also: (a) supports the position that efforts to improve
32 cause of death statistics are indicated and necessary; (b) endorses
33 the concept that educational efforts to improve death certificates
34 should be focused on physicians, particularly those who take care
35 of patients in facilities where patients are likely to die, namely in
36 acute hospitals, nursing homes and hospices; and (c) supports the
37 concept that training sessions in completion of death certificates
38 should be (i) included in hospital house staff orientation sessions
39 and clinical pathologic conferences; (ii) integrated into continuing
40 medical education presentations; (iii) mandatory in mortality
41 conferences; and (iv) included as part of in-service training
42 programs for nursing homes, hospices and geriatric physicians.

43 3. Our AMA further: (a) promotes and encourages the use of ICD
44 codes among physicians as they complete medical claims, hospital
45 discharge summaries, death certificates, and other documents; (b)
46 supports cooperating with the National Center for Health Statistics
47 (NCHS) in monitoring the four existing models for collecting
48 tobacco-use data; (c) urges the NCHS to identify appropriate
49 definitions, categories, and methods of collecting risk-factor data,
50 including quantification of exposure, for inclusion on the U.S.
51 Standard Certificates, and that subsequent data be appropriately
52 disseminated; and (d) continues to encourage all physicians to
53 report tobacco use, exposure to environmental tobacco smoke, and
54 other risk factors using the current standard death certificate format.

1 4. Our AMA further supports HIPAA-compliant data linkages
2 between Native Hawaiian and Tribal Registries, population-based
3 and hospital-based clinical trial and disease registries, and local,
4 state, tribal, and federal vital statistics databases aimed at
5 minimizing racial misclassification. (Modify Current HOD Policy)
6

Fiscal Note: Minimal - less than \$1,000

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RELEVANT AMA Policy

H-315.963 Accurate Collection of Preferred Language and Disaggregated Race and Ethnicity to Characterize Health Disparities

Our AMA encourages 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, ethnicity, and preferred language. [Res. 03, I-19]

H-350.950 Tribal Public Health Authority

Our AMA will support; (1) the Department of Health and Human Services issuing guidance, through the Centers for Disease Control and Prevention and the Indian Health Service, on Public Health and Tribal-affiliated data-sharing with American Indian and Alaska Native Tribes and Villages and Tribal Epidemiology Centers; and (2) the use of data-sharing agreements between local and state public health departments and American Indian and Alaska Native Tribes and Villages and Tribal Epidemiology Centers. [Res. 206, A-23]