Whereas, the National Center for Health Statistics maintains a National Death Index (NDI), a centralized database of death record information on file in state vital statistics offices; and

Whereas, this data can be linked to databases maintained by agencies like the Centers for Disease Control, Food and Drug Administration, and Centers for Medicare and Medicaid Services to increase the availability of information on an individual’s cause of death; and

Whereas, a key limitation of these vital statistic data is the misclassification of race and ethnicity on death certificates and in other databases (e.g., inaccurate from minority identification to white), limiting the quality and applicability of data available for racial and ethnic minority populations experiencing health disparities; and

Whereas, populations more likely to be misclassified on their death certificates include, but are not limited to, American Indians and Alaska Natives (AI/AN), Asian Americans, and Native Hawaiians and Other Pacific Islanders (NHP); and

Whereas, a retrospective linkage of regional records maintained by the Indian Health Service and Oklahoma State Health Department Vital Records reported a 29% underestimation of all-cause mortality in the AI/AN population; and

Whereas, an updated version of the National Longitudinal Mortality Study (1999-2011 decedents versus 1990-1998 decedents) found that racial misclassification remained high at 40% for the AI/AN population, improved, from 5% to 3%, for the Hispanic population, and from 7% to 3% for the Asian or Pacific Islander (API) population; and

Whereas, racial misclassification on death certificates is compounded by missing or incorrect race and ethnicity data in other databases, such as those maintained by federal health programs, hospital systems, and related entities; and

Whereas, a 2021 study of 4,231,370 Medicare beneficiaries who utilized home health care services in 2015 found substantial racial misclassification of self-identified Hispanic, Asian American, Pacific Islander, and AI/AN beneficiaries (more than 80% for AI/AN in 24 states and Puerto Rico) as non-Hispanic white; and

Whereas, a 2019 study that conducted ICD-9/ICD-10 record linkages between the Northwest Tribal Registry and Oregon and Washington hospital discharge datasets increased the ascertainment of neonatal abstinence syndrome cases among AI/AN newborns by 8.8% in Oregon and by 18.1% in Washington; and
Whereas, according to the United States Centers for Disease Control and Prevention, more
Al/AN patients are misclassified as another race in cancer registry records than patients in other
racial groups, likely from one group to identification as non-Hispanic white\textsuperscript{22-23}; and

Whereas, a 2021 prospective observational study of patients admitted to an urban Level 1
trauma center found that 45 of 98 patients self-identifying as Hispanic (45.9\%) had inaccurately
recorded ethnicity in the trauma registry\textsuperscript{24}; and

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

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

RESOLVED, that our American Medical Association amend H-85.953, “Improving Death
Certification Accuracy and Completion,” by addition as follows:

Improving Death Certification Accuracy and Completion H-85.953
1. Our AMA: (a) acknowledges that the reporting of vital events is an
integral part of patient care; (b) urges physicians to ensure completion of
all state vital records carefully and thoroughly with special attention to the
use of standard nomenclature, using legible writing and accurate
diagnoses; and (c) supports notifying state medical societies and state
departments of vital statistics of this policy and encouraging their
assistance and cooperation in implementing it.

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

3. Our AMA further: (a) promotes and encourages the use of ICD codes
among physicians as they complete medical claims, hospital discharge
summaries, death certificates, and other documents; (b) supports
cooperating with the National Center for Health Statistics (NCHS) in
monitoring the four existing models for collecting tobacco-use data; (c)
urges the NCHS to identify appropriate definitions, categories, and
methods of collecting risk-factor data, including quantification of exposure,
for inclusion on the U.S. Standard Certificates, and that subsequent data
be appropriately disseminated; and (d) continues to encourage all
physicians to report tobacco use, exposure to environmental tobacco
smoke, and other risk factors using the current standard death certificate
format.
4. Our AMA further supports HIPAA-compliant data linkages between Native Hawaiian and Tribal Registries, population-based and hospital-based clinical trial and disease registries, and local, state, tribal, and federal vital statistics databases aimed at minimizing racial misclassification.

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

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18. Friedman J, Hansen H, Gone JP. Deaths of despair and Indigenous data genocide [published online ahead of print, 2023 Jan 25]. Lancet. 2023;S0140-6736(22)02404-7. doi:10.1016/S0140-6736(22)02404-7


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]