AHIMA Public Policy Statement: Health Equity

AHIMA's Position:

AHIMA supports the use of public policy to reduce and eliminate health disparities and inequities, both in the face of the COVID-19 pandemic and in healthcare more broadly. Health information professionals have the knowledge and expertise to help inform ongoing public policy discussions. To meet the needs of diverse populations and reduce and eliminate health disparities and inequities, AHIMA believes that public policy must:

1. **Encourage the standardized collection of accurate and complete patient demographic and social determinants of health data** in ways that are culturally competent to better understand the communities being served and their related needs. This includes supplementing demographic information with more granular collection of data regarding race, ethnicity, sexual orientation, gender identity, and intersex status using standardized categories to enable individuals to self-identify and increase the utility of the data for the entity collecting them.

2. **Guarantee the right for all to have access to affordable, high-quality health coverage,** including addressing current coverage gaps to achieve comprehensive health coverage for all. This includes individuals with multiple chronic conditions, those experiencing challenges in access to care, and underinsured and uninsured individuals.

3. **Promote the leveraging of technology to analyze quality-of-care and outcomes using both patient demographics and clinical data to identify and address health disparities**. This includes promoting the development, piloting, and testing of machine learning and artificial intelligence technologies and solutions that identify and address biases in the data and avoid exacerbating existing health disparities and inequities. Building health equity into program and system design should also be considered.

4. **Promote healthcare delivery and finance models and quality measures that focus on promotion and prevention strategies to reduce health inequities and disparities**. This includes promoting delivery and finance models such as CMS' CMMI Accountable Health Communities (AHC) Model that are designed to reward efforts to reduce health disparities and improve equity by addressing social determinants of health. Development and use of disparities-sensitive quality measures, including measures that assess whether interventions promote health equity, are also critical to reducing health disparities and inequities. Further evaluation of accounting for social risk factors in risk adjustment is also needed.

5. **Address human capital and educational needs of the healthcare workforce** including how to consistently and accurately collect, use, and maintain patients' demographic information in ways that are culturally sensitive. Investment in a diverse, culturally competent professional workforce is also needed to foster an inclusive approach to addressing health disparities and inequities.

6. **Identify and support efforts to overcome historical mistrust in healthcare institutions** including encouraging strong patient-provider relationships, creating

opportunities for community leaders to be engaged and part of the decision-making process, identifying and dismantling policies that support structural racism and discrimination, and fostering a commitment to improving the patient experience of marginalized communities.

Background:

Health equity is the attainment of the highest level of health for all people.[1] Health disparities are differences in health outcomes and their causes among groups of people.[2] The underlying causes of health disparities are complex and involve social determinants of health, differential access to high-quality care, individual behavior, and biology.[3] Today, communities including racial and ethnic minorities, sexual and gender minorities, individuals with disabilities and those living in rural areas experience a disproportionate share of acute or chronic diseases and adverse health outcomes compared to their non-minority counterparts.[4] This disproportionality is reflective of the health inequities that exist in our healthcare system today.

Addressing health disparities is not only necessary to address health inequities but to improve overall quality of care, population health, and reduce costs. Studies suggest that disparities cost an estimated $93 billion in excess medical costs and $42 billion in lost productivity per year as well as economic losses due to premature deaths.[5]

Key Points:

Benefits associated with reducing and eliminating health disparities and inequities include:

- Improved access and quality of care for patients;
- Empowering individuals and their caregivers to become more engaged in their health and healthcare;
- Decreased cost of care due to duplicative tests as a result of miscommunications, medical errors, lengthy hospital stays and avoidable readmissions; and
- Improved population health as a result of more targeted and effective community-based and health-system interventions.

Key challenges to reducing and eliminating health disparities and inequities include:

- Lack of quality data on health disparities as a result of inaccurate, incomplete, and non-standardized demographic data and social determinants of health;
- Lack of standardized processes and definitions for the collection of patient demographic data and social determinants of health;

---

[1] Available at: https://www.cdc.gov/minorityhealth/publications/health_equity/index.html.
[2] Available at: https://www.cdc.gov/healthequity/features/reach-health-equity/index.html.
[3] Available at: https://jamanetwork.com/journals/jama/fullarticle/2766098.
[4] Available at: https://www.cms.gov/files/document/paving-way-equity-cms-omh-progress-report.pdf and https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5398183/.
[5] Available at: https://www.kff.org/racial-equity-and-health-policy/issue-brief/disparities-in-health-and-health-care-five-key-questions-and-answers/.

- Limited gains in health coverage due to recent changes in federal health policy;
- Ongoing disparities in socioeconomic factors including but not limited to: income, education, health literacy, and housing;
- Limited adoption and implementation of cultural competence techniques, including workforce education and training as well as a diverse and culturally competent workforce to empower healthcare professionals to work effectively in cross-cultural situations;
- Technology limitations, including the inability to accurately capture demographic information and social determinants of health, as well as lack of infrastructure, such as broadband access in rural and urban areas, to support digital health technologies;
- Limited understanding by healthcare professionals and patients as to why patient demographic data and social determinants of health are collected and used; and
- Lack of trust due to history of mistreatment of disenfranchised minority populations.

Current Situation:

Despite recent improvements in population health, health disparities and inequities persist. In 2010, the Affordable Care Act (ACA) created new coverage options, including an expansion of Medicaid and health coverage marketplaces. Implementation of the Medicaid and marketplace expansions led to considerable coverage gains across racial and ethnic groups.[6] Other provisions of the ACA also focused on reducing disparities, including promoting workforce diversity and cultural competence, increased funding for cultural competence training and education materials, and enhanced data collection and research efforts. Since then, the US Department of Health and Human Services (HHS) has focused on several initiatives seeking to address health disparities and inequities. This includes Healthy People 2030, which as a key objective seeks to eliminate health disparities, achieve health equity, and create social, physical, and economic environments that promote the full potential and well-being for all.[7]

At the same time, states and local communities have undertaken a number of efforts to reduce health disparities including Medicaid expansion, measures development and data collection, data analysis and creating financial incentives to address upstream nonmedical factors such as social determinants of health and chronic disease management.[8] These efforts are ongoing.

More recently, the COVID-19 pandemic has revealed and exacerbated existing health inequities in the US. Latino and Black Americans exposed to COVID-19 have experienced disproportionally higher infection and mortality rates.[9] Reports early on in the pandemic also indicated that racial and ethnic data was missing from the Centers for Disease Control and Prevention (CDC) for cases, hospitalizations, and deaths. Guidance issued in June 2020 specified that certain demographic data, including but not limited to race and ethnicity, be

[6] Available at: https://www.kff.org/racial-equity-and-health-policy/issue-brief/disparities-in-health-and-health-care-five-key-questions-and-answers/.
[7] Available at: https://health.gov/healthypeople/about/healthy-people-2030-framework.
[8] Available at: https://www.kff.org/racial-equity-and-health-policy/issue-brief/disparities-in-health-and-health-care-five-key-questions-and-answers/.
[9] Available at: https://jamanetwork.com/journals/jama/fullarticle/2766098

reported to HHS by laboratories along with COVID-19 test results beginning August 1, 2020. However, racial and ethnical data was still missing for 33 percent of COVID-19 cases reported between December 2020 and February 2021.[10] The CDC has also reported that racial and ethnic data is missing for approximately 48 percent of persons vaccinated against COVID-19 in the first month roll-out of the vaccine, whereas only 0.1 percent and 3 percent were missing data respectively on age and sex.[11]

In January 2021, President Biden issued an Executive Order on "Ensuring an Equitable Pandemic Response and Recovery." As part of the Executive Order, President Biden established a COVID-19 Health Equity Task Force to develop recommendations to mitigate health inequities caused or exacerbated by the COVID-19 pandemic and to prevent such inequities in the future. As part of this effort, the Task Force is expected to make recommendations for expediting data collection for communities of color and other underserved communities to enable development of short-term targets for pandemic-related actions for such communities and populations. The Task Force is also expected to develop longer-term recommendations to address these data shortfalls and other foundational data challenges, such as those related to data intersectionality, to better prepare for and respond to future pandemics. Accurate data is essential to developing policy solutions. As policymakers continue to consider efforts to address health disparities and inequities, AHIMA stands ready to lend its expertise and perspective to the conversation.

[10] Available at: https://www.minorityhealth.hhs.gov/Assets/PDF/21_C19%20health%20equity%20TF_krieger_slides_feb%2026_final_0223_508.pdf

[11] Available at: https://www.minorityhealth.hhs.gov/Assets/PDF/21_C19%20health%20equity%20TF_krieger_slides_feb%2026_final_0223_508.pdf.