AHIMA Recommendations to Further Health Equity in US Federal Policy
Updated: Fall 2022

Background

The US health system continues to work to close the gap on health inequities through multiple policy pathways. As part of this work, the US Department of Health and Human Services (HHS) has undertaken a cross-agency focus to resolve issues related to health inequities, including in the space of health data, information management, and technology. AHIMA, as the leading professional association representing those managing data and information at the intersection of healthcare and technology, continues to work to close the equity gap across all of healthcare. AHIMA continues to advocate on health equity related issues on multiple fronts, but the priorities below represent the key areas where AHIMA and its members' expertise are best suited to help close the health equity gap.

1. **Advance the consistent and standardized collection of Social Determinants of Health (SDOH) data in the care setting.** This includes advocating for the development and widespread use of ICD-10-CM Z-Codes, as well as for implementation strategies to address challenges pertaining to SDOH documentation and coding.

2. **Develop inclusive and complete data standards that ensure SOGI and REL data accurately reflect the patient's background and demographic information.** The healthcare system should utilize existing standards development and government processes to create, vet, and implement standards that reflect modern vocabularies on patient focused data elements, such as those that represent sexual orientation and gender identity, as well as race, ethnicity, and language. The US Government should also examine and update all data categories to ensure they are reflective of wider societal norms, such as updating the OMB REL data elements.

3. **Close the healthcare access gap by maintaining permanent, widespread access to telehealth services.** The COVID-19 Public Health Emergency (PHE) allowed for multiple flexibilities in how patient care can be delivered and received. Patients who previously were unable to access care, needed to travel great distances, or spent significant amounts of time traveling to obtain care, were able to access primary and specialty care services with limited complications due to telehealth flexibilities granted under the PHE. Those services should remain accessible on a permanent basis to ensure time and/or distance are not limiting factors in obtaining the care patients need, especially with studies indicating access to telehealth could close disparities in care[1].

4. **Narrow the digital divide that hinders the ability for patients to research, shop for, and attain care nationwide.** Access to affordable high-speed stable broadband internet has been classified as a "super determinant of health[2]" and when patients are unable to access the internet their health

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[1] https://clarivate.com/lp/realizing-telehealths-potential-to-reduce-healthcare-disparities/?campaignname=Telehealth_Report_Patient_Centricity_LeadGen_DRG_Global_2021&campaignid=7014N000 0001YXGM&utm_campaign=Telehealth_Report_Patient_Centricity_LeadGen_DRG_Global_2021&utm_source=earned_c overage&utm_medium=press

[2] https://www.countyhealthrankings.org/online-and-on-air/webinars/broadband-a-super-determinant-of-health

suffers. In order to take advantage of other equity improvement activities, such as expanding telehealth and improving health literacy, the federal government must work to decrease the digital divide by increasing the ability for a patient to access the internet. Access to information is also crucial to identifying and supporting activities related to overcoming historical mistrust in the healthcare system, a barrier that continues to prevent patients from seeking care they need. The digital divide will remain one of the largest roadblocks to nationwide health equity improvement if it is not addressed through a whole of government approach.

5. **Address patient identification and matching to ensure patients are accurately matched to their health record.** Non-white patients are mismatched at a significantly higher rate than white patients. Algorithms for matching are often written in ways that overlook BIPOC populations' physical living experiences and familial naming conventions leading to higher rates of patient misidentification in non-white patients. The US Government and industry stakeholders should work together to address patient identification and matching without bias that ensures a 99.9% patient match regardless of race, ethnicity, or background.

6. **Bias must be accounted for in the development of Artificial Intelligence (AI) and other physician assisted technologies.** As healthcare continues to advance and implement new technologies, it is crucial for those who develop, train, and implement those technologies appropriately account for bias during operational activities. If a diverse set of experts are not present at every step of the development process, then AI and other physician assistive technologies will be implemented with unintended biases. Ensuring there is diverse representation throughout all steps of the development and implementation process will assist in limiting the presence of unintended bias in next generation healthcare technologies.

7. **Further the use of quality measures and payment models that prioritize addressing inequities in healthcare.** This includes promoting delivery and finance models such as CMS' Center for Medicare and Medicaid Innovation (CMMI) Accountable Health Communities (AHC) Model[3] 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.

8. **Ensure the healthcare workforce is properly equipped to understand and handle current day health equity challenges.** This includes ensuring the workforce is trained on how to consistently and accurately collect, use, and maintain patients' demographic information in ways that are culturally sensitive. Institutions should also be incentivized to create a diverse, culturally competent professional workforce that fosters an inclusive approach to addressing health disparities and inequities**.**

AHIMA will be releasing additional learnings and information on the collection and use of SDOH data in 2022 and 2023 that will continue to shape the above recommendations and we look forward to sharing these learnings with CMS in the near future. These recommendations will be updated as necessary at the appropriate time.

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[3] https://innovation.cms.gov/innovation-models/ahcm