AHIMA Policy Statement: Social Determinants of Health

AHIMA's Position:

AHIMA supports the use of public policy to encourage the collection, access, sharing, and use of social determinants of health (SDoH)[1] to enrich clinical decision-making and improve health outcomes, public health, and health inequities in ways that are culturally respectful. To inform policy development, Health Information (HI) professionals have considerable knowledge and expertise in protecting, managing, and ensuring the accuracy of data about individuals. To improve the collection, access, sharing and use of SDoH data, AHIMA believes that public policy must:

1. **Establish global standards to promote the capture, use, maintenance and sharing of social determinants of health data.** Policy must identify a set of standard concepts and definitions for SDoH. Identification of existing medical coding vocabulary gaps is also needed to document and capture standardized SDoH data elements. Policy must also ensure that the processes for updating vocabularies and code sets routinely includes consideration of SDoH data needs. Finally, policy must prioritize a set of standardized data elements to be included in electronic health records (EHRs). This includes the development and testing of consensus-based standards to enable the electronic exchange of SDoH data.

2. **Promote health care delivery and financing models designed to integrate social determinants of health data into the clinical setting in ways that are culturally respectful.** Policy must leverage patient-centered care models such as CMS' CMMI Accountable Health Communities (AHC) Model to incentivize the incorporation of SDoH data into care decisions.

3. **Build patient trust and foster positive patient-provider relationships to encourage patients to share their social challenges.** Policy must encourage providers to be transparent and communicate clearly about the purposes for which SDoH data is being collected and used, while raising awareness of how different patient populations may participate in the collection and use of SDoH data.

4. **Enhance the sharing of social determinants of health data across clinical and community-based organizations and service providers.** Generation of SDoH data is not exclusive to clinical settings. As clinical and non-clinical settings increasingly share data, policy must encourage a digitally secure infrastructure to support functional, structural, and semantic interoperability between both settings. In addition, policy must embrace data governance policies to support data sharing and data integrity, while promoting positive referral feedback loops to enhance care coordination.

5. **Prioritize privacy.** Sharing of SDoH data across clinical and non-clinical organizations requires consideration of privacy issues, including consent management and the

---

[1] Social determinants of health are "conditions in the environment in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of life outcomes and risks."

appropriate sharing of information (while ensuring that only the minimum necessary information is exchanged and limited to the specific transaction in question). This includes consideration of privacy and security issues that arise when collecting and sharing electronic health information outside of the scope of HIPAA. Policy must also consider addressing the problem of patient identification to ensure the confidentiality, privacy, and security of an individual's clinical and non-clinical information.

6. **Recognize workforce training needs,** including how to accurately and consistently collect and ask about such information with cultural humility and sensitivity; how SDoH data should be used in the clinical setting; and how to maintain confidentiality when working with community based-organizations and service providers.

7. **Promote the ethical collection and use of SDoH data.** Developing social risk profiles based on SDoH data may lead to discrimination, stigmatization, and implicit bias. It could also limit access to care options, exacerbate poor outcomes and existing health inequities, and impede data integrity. Policy must safeguard against the perpetuation or aggravation of such occurrences.

8. **Embrace the role of health information professionals.** New standards and approaches must recognize the crucial role of HI professionals in the standardization, capture, exchange, use, and analysis of SDoH data to improve the health of individuals and communities while ensuring privacy and security protections.

Background:

Social determinants of health are "conditions in the environment in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of life outcomes and risks."[2] A growing body of evidence suggests that these upstream factors impact the health of individuals and communities. To improve outcomes and health equity, more attention must be given to social determinants. The recent shift in healthcare towards value-based care models that incentivize prevention and promote improved outcomes for individuals and populations offers an opportunity to consider approaches and partnerships that address health-related factors upstream from the clinical encounter.

However, the appropriate capture, use, exchange and sharing of SDoH data remains a challenge. Social risk factors are often not documented in the EHR and existing codes to capture SDoH data are not widely used.[3] This includes connectivity and integration between EHRs and community-based organizations and service providers which remains limited. As policymakers seek to address this critical issue, AHIMA members have the expertise to offer insight.

Key Points:

Improving the capture, sharing and use of social determinants of health data could result in a number of benefits, including:

- Enhanced acute and chronic disease prevention, treatment, and health promotion;

---

[2]Available at: https://health.gov/healthypeople/objectives-and-data/social-determinants-health.
[3] Available at: https://www.annfammed.org/content/16/5/399.

- Increased point-of-care data exchange between clinical and social services providers;

- Improved population health management though more targeted interventions;

- Improved referral feedback loops and care coordination between clinicians and social services providers;

- Enhanced targeting and allocation of resources by community-based organizations and service providers to support individuals and communities;

- Faster, more targeted federal, state, local, tribal, and territorial responses and interventions to disease outbreaks and pandemics; and

- Strengthened research on interventions to mitigate health impacts.

To realize the benefits of SDoH data, certain challenges must be addressed including:

- **Lack of data standards to encourage the collection and use of SDoH data.** Enhanced interest in leveraging SDoH data has led to more measures of different social risk factors and indicators. However, lack of agreement on which data to collect and lack of data standardization has limited the collection and sharing of SDoH, often leading to confusion about the tools available to providers. New approaches must prioritize which social risk factors should be captured for interventional purposes, how they should best be captured using the various medical coding vocabulary standards and promulgated as an industry standard for capturing the social risk factor in question.

- **Lack of digital infrastructure and robust technical capabilities to support functional, structural and semantic interoperability across clinical and community-based organizations and service providers.** Successful approaches today that integrate social needs with clinical care are often manual information exchanges, human-capital intensive, involve unstructured data, and may lack consistency or data standardization within or between health and social care settings.[4]

- **Protecting privacy.** New approaches must maintain the ability of providers to be good stewards of patient information including identifying patients accurately and ensuring that data sharing supports patient privacy, while allowing for appropriate sharing of information with community partners in ways that are respectful of individuals' privacy and are culturally sensitive.

- **Implications for workforce.** New approaches to integrating SDoH into healthcare delivery may require additional workforce training as well as a more diverse and culturally competent workforce.

- **Ethical collection and use of SDoH data.** New approaches must expressly prohibit the use of social risk profiles or other information to be used for discriminatory purposes, stigmatization, implicit bias, or in decisions that limit care options, lead to poor outcomes and exacerbate existing health inequities.

---

[4] Available at: https://www.nationalacademies.org/our-work/integrating-social-needs-care-into-the-delivery-of-health-care-to-improve-the-nations-health.

Current Situation:

Leveraging SDoH data to improve health outcomes and address health inequities is increasingly a focal point for policymakers. A number of national efforts are currently underway to advance the collection, use, and exchange of SDoH data. These include:

- [Healthy People 2030](), led by the US Department of Health and Human Services which seeks to promote a shared understanding of social determinants of health, including how SDoH data may be leveraged.

- [The Gravity Project](), a multi-stakeholder initiative focused on developing structured data standards to reduce barriers to documentation and exchange of SDoH data within and across clinical settings and community-based organizations and service providers.

- [CMS' CMMI Accountable Health Communities (AHC) Model]() which seeks to test whether systematically identifying and addressing the health-related social needs of Medicare and Medicaid beneficiaries' through screening, referral, and community navigation services will impact healthcare costs and utilization.[5]

- State Medicaid programs seeking to address SDoH in innovative ways through their managed care contracts and other mechanisms such as Section 1115 Demonstration Waivers. For example, the [state of North Carolina]() leverages public-private partnerships to support high-need Medicaid beneficiaries. By identifying interventions that will address SDoH factors such as housing instability, transportation insecurity and food security, the state of North Carolina can deliver a package of services tailored to a Medicaid beneficiary's specific needs.

In December 2018, the HHS Office for Civil Rights (OCR) [solicited input]() from the public on how HIPAA could be modified to promote coordinated, value-based care. This included specific feedback on whether OCR should modify the HIPAA Privacy Rule to clarify the scope of covered entities' ability to disclose PHI to social services agencies and community-based support programs to facilitate treatment and coordination of care when providing other services to the individual.

More recently, the Office of the National Coordinator for Health IT prioritized the integration of health and social services data in its [Draft 2020-2025 Health IT Strategic Plan](). The draft plan includes calling for strategies that strengthen communities' health IT infrastructure by facilitating bi-directional, secure data exchange across clinical and non-clinical settings; foster greater understanding of how to use health IT to asses and address unmet health and social needs of individuals and communities; capture and integrate SDoH data into EHRs to assist in care delivery, including clinical decision support and integration of medical and social care; and address health disparities in a manner that is ethical and consistent with routine patient care.

As healthcare increasingly seeks to leverage the sharing and use of SDoH data, AHIMA and its members stand ready to lends its expertise and unique voice to the conversation.

---

[5] Available at [https://innovation.cms.gov/innovation-models/ahcm]().