How HIM Influences Social Determinants of Health

By Matt Schlossberg

Social determinants of health (SDOH) is the next big thing in healthcare. It's difficult to find a conference, technology solution, or plucky startup these days that doesn't extol SDOH as a panacea for rising costs and widening care disparities.

One of the big challenges in SDOH is data—acquiring, analyzing, and applying information from a variety of sources to care plans, population health, care management and coordination, and other health interventions.

Joe Nicholson, DO, a board-certified physician and Chief Medical Officer of CareAllies, a subsidiary of Cigna that partners with providers in the transition to value-based care, says that complex organizations entering value-based payment models need connective infrastructure to support network-wide performance.

Health information management (HIM) team will be positioned as a key stakeholder in formulating an interdisciplinary data and documentation strategy; measuring the effectiveness of care interventions and outcomes; and aligning problem-solving methodologies with organizational initiatives to reduce cost, improve quality of care, and foster a patient-centered experience that is broadly accessible and equitable to the communities a health system serves.

"For HIM professionals, SDOH is a conversation about big data management," Dr. Nicholson said. "I would be looking for all of the touchpoints—pharmaceutical data, EHR data, patient survey data—that can better inform an algorithm and will allow organizations to step into something that feels more like predictive modeling."

In this interview, Nicholson explores how the strategic incorporation of social determinants data—often from multiple, disparate and siloed sources—can drive innovations in whole-person healthcare. This conversation was edited for clarity.

JAHIMA: What's driving the practical applications of SDOH as a piece of holistic healthcare?

Dr. Nicholson: Part of it is the general turn toward population health management. Another piece is our shift to value-based models of care designed to lower overall costs while improving quality. At the micro-level, providers realize that we need to address community-based factors in order to better manage overall health.

JAHIMA: Whatever the influence SDOH has on health outcomes, the immediate challenge is acquiring data from sources outside the hospital, which may be unstructured, fragmented, or inconsistent. How do HIM professionals address this at the systemic level?

Dr. Nicholson: I think you start with whatever data you have access to— whether it's pharmaceutical data, EHR data or patient survey data. Any of these things alone is going to be flawed, but I think the more data points that you can get better informs an algorithm.

It's the stickiest part of this conversation because it's a sea of data. Ultimately for people in the HIM space, this is a conversation around big data management. Where I would like to see this go is data collection that has standardization and rigor, which will allow us to step into something that feels more like predictive modeling.

JAHIMA: Part of surfacing actionable intelligence from that 'sea of data' is knowing what to what to look for. How can HIM professionals surface information germane to SDOH?

Dr. Nicholson: Sometimes it's the lack of data, right? When HIM teams are looking to tackle SDOH data, it's going to be a matter of pulling together a disparate team, with pharmacists and social workers and doctors to help define the kind of data that you're going to leverage to create the sort of data-driven opportunities to identify at-risk patients.

That's going to be an iterative process. Every team must aggregate their best guess at metrics that are deemed to be impactful. Once you define the data list that you think might be impactful, the next step is to look at which [data sets] are actionable.

JAHIMA: Can you talk about your perspective on overcoming the challenge of working with information that is so different from what hospitals have been accustomed to in the course of a patient journey?

Dr. Nicholson: It's a matter of collecting unconventional data points that become very impactful in terms of approach to the solutions set for that unique patient. For some of these data points, there is no code. It's not something clean, but some of these atypical data points become inflection points for activity-driven solutions.

JAHIMA: Where do you think that the electronic health record (EHR) is in the social determinants ecosystem?

Dr. Nicholson: That's a fascinating question. When you think about it, the set of data in the EHR is the cohort of patients that are showing up for healthcare. Our cohort in SDOH doesn't always include those people. There might be lots of reasons for SDOH opportunities to be completely absent from EHR data. Sometimes [patients] are not showing up in our data at all, because either they don't have a car to get to a health system or they live in a ZIP code where there are zero healthcare providers.

Clearly, a critical partner in this whole area are the community-based organizations and faith-based organizations, the nonprofits. The data that they have access to is more likely to be highly impactful in SDOH than the data in an EHR.

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