EHR developers are the lynchpin of any successful digital health technology implementation, including technologies to advance the wellbeing of communities and the social needs of patients. Software developed by EHRA member companies is used worldwide to deliver integrated telehealth visits, store data collected from remote monitoring devices and health trackers, and exchange complete patient records when needed at the point of care.

Successful models and promising candidates within the U.S.

- The **ClinicalConnect Health Information Exchange** (HIE), in Pittsburgh PA, connects almost 100 provider organizations exchanging information on behalf of millions of patients, and to other state-based HIEs to further interoperability.
- The North Carolina Department of Health and Human Services’ **Healthy Opportunities Pilot Programs** tests the viability of non-medical interventions to reduce costs and improve outcomes for Medicaid beneficiaries, including funding services to address housing, food, transportation, and safety issues. Health plans and providers screen for social determinants of health (SDOH) and refer qualifying patients to appropriate community-based organizations (CBOs).
- The New York State Department of Health’s Value-Based Payment program requires participating health systems to screen and implement at least one SDOH intervention, and contract with at least one CBO to implement that intervention.

These models are successful because they take a systematic and standards-based approach to screening, interventions, and interoperability. More specifically, they:

- Adopt system-level governance models that allow for the centralized establishment of policies and procedures guiding the network. Privacy and consent expectations are established for the system, and requirements flow down to participants.
- Leverage standards-based approaches to data exchange, building upon interoperability standards that have been used for years with proven scalability throughout the healthcare industry.
- Fund providers and CBOs to take on this extra work of coordinating care and services for their patients. CBOs are given the support needed to adopt technology that allows effective communications with their healthcare counterparts.

Scaling these models, however, will require:

- A way to identify patients/citizens that allows for a single, longitudinal record of health and community care,
- Reducing state-by-state variations in laws and regulations to allow organizations to more easily coordinate health and social care across state lines,
- A shared governance model that can set a common floor for policies and procedures across multiple health and social networks. The Trusted Exchange Framework will eventually be the best-positioned entity to create and administer this governance model.
• Development and maturation of standards for social determinant domains, screener assessments, and closed-loop referrals between healthcare systems and CBOs. OSTP should also support existing efforts in this area.
• A more mature, connected technological underpinning for a wider range of CBOs.

Current barriers to digital technology adoption in community health settings, and potential government actions to address them
In many ways, the technological state of CBOs today resembles the landscape of provider EHR adoption 15 years ago: many CBOs lack the resources or knowledge to adopt technology, and instead subsist on a combination of paper and spreadsheet software. OSTP has the opportunity to work with the ONC, CMS, and HRSA to explore this parallel in more detail and adapt targeted initiatives based on the successes of the HITECH Act, which was largely responsible for widespread interoperable EHR adoption.

For example, a successful strategy might:
• Incentivize adoption of interoperable technology by CBOs through direct subsidies or funding and inclusion of CBOs in larger value-based care models,
• Promulgate standards-oriented technology-specific guidance to support further digitization of CBOs and social services agencies, including exploring ways open APIs can be helpful in making information available,
• Develop and establish vocational programs to produce more available staff with the core competencies needed for a more connected environment,
• Establish regional entities that can help social services agencies understand and choose and implement technological options,
• Finalize the HIPAA Coordinated Care NPRM issued in 2021 to enable increased interoperability among all stakeholders, including more sensitive social care entities,
• Reduce individual state-by-state variation in privacy laws,
• Embrace the existing work done through TEFCA to prioritize future adoption of social care use cases, as standards mature and trading partners come online.

Such an approach would ensure that the country builds upon the existing healthcare technology ecosystem, folding community care into the larger healthcare picture, to interoperate fully and with ease. While standards are still maturing through initiatives such as the HL7 Gravity Project, these policy and funding efforts could begin now with a possible rollout over the next 3-5 years.

Trends from the COVID-19 pandemic
EHRA members supported our collective clients across the country from the beginning of the pandemic in a number of ways:
• Clinical decision alerts to optimize patient care and ensure clinicians were aware of evolving best practices,
• Reporting to multiple public health entities requiring different data elements,
• Documenting SDOH data helpful to decisions during the care process and public health analysis of disease trends.

There have been numerous studies stemming from the allowances and payment adjustments that made
the dramatically expanded use of telehealth feasible. It did not increase costs, and proved highly efficient and effective, particularly for mental health treatment and other such clinical use cases. A fundamental reason for the increase in telehealth utilization is pay at parity with in-person visits. If that is undone at the end of the PHE, use of remote technologies will drop in parallel.

Most CBOs and social service agencies working to increase health equity and address SDOH did not benefit in the same way as traditional care environments. The same barriers to a connected environment in which healthcare providers and CBOs work together with bidirectional information exchange have affected the inclusion of those organizations in the expansion of telemedicine.

The pandemic has highlighted health inequity issues, resulting in recently passed laws that have begun to acknowledge the need for public health agencies to adopt standards-based technologies.

The burden of reporting on COVID-19 activity amongst our clients - and us in supporting them - could be significantly lessened if the technologies used to collect data relied on standards-based approaches, as opposed to proprietary softwares with siloed and distinct thinking on the best data to collect and how to collect it.

While the Federal government has worked to standardize SDOH code sets and vocabularies, those same approaches to consistency are not yet taken by all public health organizations or data registries. This presents a tremendous opportunity for improvement. The EHRA strongly encourages the CDC to require any municipal investment request for funding be accompanied by a plan explaining their standards-based approach to public health information exchange and commitment to maintaining and modernizing as technologies evolve.

**Ensuring an equitable approach**

Any initiative aimed at improving the community-wide care of patients through technology must monitor and measure the impact across race, ethnicity, and socioeconomic status. The EHRA encourages OSTP to establish transparent and accountable key performance metrics and quality measures from the outset and plan to stratify and break down performance on those metrics by citizen demographics. There is currently little consensus among federal agencies as to how race, ethnicity, and preferred language are codified. Moreover, such information is not always consistently or accurately captured due to a lack of organizational incentive and patient reluctance. We encourage OSTP to work with ONC, who is leading the investigatory effort to address this problem in health systems. A standardized code set and best practices for capturing information can be established and applied to community-based services and other settings.

While it is clear that digitization must occur among CBOs and social services agencies, advancing technology adoption in community healthcare depends on the health IT ecosystem that supports delivering safe, cost-efficient, and citizen-centric services. The EHRA and our members are well-positioned to offer insight into existing technologies, strategies, and opportunities. We look forward to continuing to collaborate with you and other federal stakeholders in this important effort.