Incorporating Community Perspective Into Health Information Exchange
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The purpose of this document is to share the value of more consistently collecting, exchanging, and operationalizing standardized social health information – the individual-level health risks, conditions, and outcomes influenced and impacted by the social, economic, and political circumstances of the communities in which we live. Focusing on these underlying conditions represents a critical paradigm shift in redefining the model of how care is delivered by seeking to bridge clinical and community settings.

Expanding the Clinical Definition of Health and Healthcare

Over the last several years, identifying strategies for the successful collection, exchange, and operationalization of 'social determinants of health' data sets has become a top priority for stakeholders in pursuit of the Triple Aim. Nowadays, nearly everyone working to improve the way care is delivered to individuals who overlap diverse systems can cite the World Health Organization's definition of the term. These stakeholders recognize the importance of better understanding this body of work – and specifically its data-driven technological underpinnings – as a way of beginning to discover how to improve the health, wellness, and wellbeing of individuals and their communities.

The effort to more effectively and efficiently make use of social health information has advanced as a result of increased recognition that the status of an individual's health is more than just the sum of their clinical encounters; that medical care alone cannot always account for what makes us healthy. Instead, a broad, community-wide focus on the underlying social conditions in which individuals live must also be considered. The Robert Wood Johnson Foundation estimates that only 20% of health outcomes can be attributed to medical care; upstream factors account for the other 80%, including social and economic factors (40%), physical environment (10%), and health behaviors (30%).

The Complex State of Social Health Information

Cracking this social-health-information nut is challenging. First and foremost, it's challenging because the term 'social determinants of health' is a loaded, often misused, concept imbued with both theoretical and practical interpretation. For it to be applied effectively, it must simultaneously consider the macro (society-level), mezzo (community-level), and micro (individual-level) processes and their respective idiosyncrasies that are interrelated and in constant flux. Which is why the misnomer is best used when not used at all in sweeping applications, but instead as three separate classifications: 'structural determinants' (macro), 'social determinants' (mezzo), and 'social risk factors' (micro).

Secondly, it's challenging because many stakeholders in the field are offering comparable, though differing, technological and operational solutions to overcome the inherent complexity of managing social health information. There currently exist a variety of social risk screening tools and other such workflows that focus on certain risk domains but not others, measure certain risk factors but not others, integrate with certain electronic health record systems (EHRs) but not others, and, perhaps most importantly, are promoted and endorsed by certain federal, state, and/or community reporting programs but not others. As a result, the burden of operationalizing available outputs from these tools and workflows is great for not only the medical stakeholders required to implement them, but also the staff-, time-, and resource-constrained community-based partners hoping to benefit from their outputs.

Bridging Clinical and Community Settings to Advance Cross-Sector Collaboration

'Health Information Exchange' (HIE) as a concept is an example of the kind of health information technology ecosystem that could expand the way care is delivered to individuals who overlap diverse systems. Though, because HIE is synonymous with the medical field, adopting the legacy term to describe the level of cross-sector collaboration required to address upstream factors is seen as a risk to over-medicalizing

socioeconomic hardship and alienating the community-, social- and population-based stakeholders that healthcare systems depend on to deliver the necessary supports and services. For that reason, the concept of '*Community* Health Information Exchange' (CHIE) has been more widely accepted and adopted.

The CHIE vision expands on the traditional HIE model through the creation of an ecosystem comprised of network partners (i.e., stakeholders from diverse systems of care), a shared language (e.g., The Gravity Project's recommendations, the USCDI version 2 standard) and an integrated technology platform (i.e., to support the creation of a longitudinal health record and the availability of other related value-add services). The resulting network then compiles and aggregates individuals' social risk factor information with their relevant medical record information to inform person-critical care coordination, communication, and management solutions.

In Maine, there are active efforts aimed at identifying the state's unified approach to building a CHIE system that could benefit cross-sector stakeholders in the value of patient care and population health. Largely, the committee is working to address the barriers and challenges required to establish the appropriate data governance (e.g., patient consent, privacy and security, data authorization and provenance) and technical infrastructure (e.g., interoperable technology, CHIE function design, analysis and evaluation, etc.) necessary to support the CHIE's model of proactive, collaborative care delivery.

While this statewide vision continues to develop, HealthInfoNet is bettering its own expertise and experience with social health information by working with the medical community to understand how such information stored in clinical data sets can be transmitted and leveraged within the HIE to support and enhance providers' strategies for improving health equity. This endeavor was greatly energized through a recent partnership with the Maine Primary Care Association in which related processes and workflows for a subset of the state's Federally Qualified Health Centers were examined in detail.

The objective of our efforts is twofold: (1) actively engage with and respond to the medical community's pressing need for more comprehensive information encompassing the health, wellness, and wellbeing of the individuals they serve, and (2) become better prepared to support the state's broader vision for a CHIE model. In both cases, the work is the result of Maine's progressive track record of collaboration to pioneer novel ways to improve care delivery and close health disparity gaps, and represents what will certainly be only the initial phase of social health innovation in the state.

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