# Greater Houston Coalition on the Social Determinants of Health

## Summary Report: February 19th, 2020 Convening

## Contents

*What follows is a synthesis of the convening as per recorded transcript.*

# Executive Summary of the Greater Houston SDoH Coalition Convening

On February 19th, 2020, the Greater Houston Coalition on the Social Determinants of Health convened executive leadership from a core group of 20 healthcare and social service institutions that serve the region. Building on more than a year of research and deliberation, **this convening set out to affirm the Coalition's purpose and principles, to explore the challenges that will be faced in pursuing the mission, to align around a path forward, and to guide the development of the Coalition's charter**. Over the course of the day, the group reached two formal decision points: 1) *clear consensus* was achieved on the coalition's statement of purpose, principles, and priorities, and 2) *rough consensus* (i.e. significant support, some concerns, but no hard objections) was reached to develop 'Community Information Exchange' infrastructure in order to facilitate 'warm referrals' and 'closed loops.' The purpose of this report is to synthesize key themes and points of agreement from the day.

First and foremost, the Coalition's foundational collective agreement was reviewed and affirmed: to work together to build a future of health equity for all Greater Houston residents, seeking to do this by developing a sustainable, data-driven, human-centered ecosystem of care that addresses the social determinants of health among Greater Houston's communities. Applying a collective impact lens, the Coalition affirmed the principles of a) centering people's needs (and their agency) in all its efforts, b) aligning diverse institutional stakeholders around common goals, c) building upon the assets already in the community, d) measuring progress, and e) ensuring that no harm is done along the way.

While the Coalition has identified a range of short-term objectives and long-term goals, the convening strategically focused on one specific priority: enabling care providers in the region, across institutional and technological boundaries, to **make "warm referrals"** of people (patients/clients) to other providers, to **"close the loop"** by sharing information about outcomes, and to **evaluate the effectiveness thereof**.

Toward that end, participants reviewed a set of possible scenarios for the development of these data exchange capacities. **Resolution was reached to pursue a specific scenario: the development of a healthy data exchange ecosystem starting with a Community Information Exchange (CIE) infrastructure.** This infrastructure should a) facilitate collaboration in care among non-HIPAA covered entities, b) enable coordination of care between these social care systems and healthcare institutions (leveraging the Greater Houston Healthconnect), c) enhance ability to analyze and evaluate programmatic effectiveness and unmet needs, and d) establish accountability and good governance for all of the above by centering the perspectives and needs of providers and clients.

Moving forward, a set of resolutions has been made: **First**, membership in the Coalition should entail a commitment to contractually require all related software and technology vendors to incorporate interoperability for data exchange, subject to monitoring by the Coalition.

**Second**, in the coming year a charter will be developed and at least one "proof of concept" will be supported which involves a minimum of one programmatic intervention that conducts multi-lateral client data exchange among Coalition members, with preference for the data partnerships that are already

emerging from within the Coalition. The criteria for this proof of concept are that it should a) leverage the region's HIE technology and assess how it might need to evolve, b) develop data partnership agreements and processes that are shareable and potentially replicable, c) test the viability of stakeholder participation (patients/clients and providers) in design and evaluation, d) measure activities and evaluate outcomes, and e) generate actionable proposals to guide the Coalition's next phase of development.

**Third**, the Coalition backbone — synthesizing outputs from this convening along with feedback from the membership at large — will draft a proposed charter to specify processes of membership development, decision-making, standard-setting, and monitoring and evaluation. This charter should specify processes by which the Coalition's priorities, activities, and outcomes will be developed in accordance with the preferences of those whose interests are at stake, including providers and clients.

The following sections present a synopsis of the opportunities and considerations that repeatedly emerged and are central to the success of the Coalition's efforts:

- **The interests of people, and their communities, should be central to this work**.
- **Healthcare and social service agencies' incentives need to be aligned.**
- **Emerging technologies should work together and be accountable to their users.**
- **The work of partnership needs to be sustainable in the long-term.**

**Note from the backbone leads**: Between the time that this meeting was held and today, the COVID 19 pandemic has gripped our nation and our communities and changed our world. The COVID 19 pandemic has further exacerbated the issues of unemployment, food insecurity, lack of access to healthcare, and other social determinants of health in our communities. The impact of this will unfortunately last for years to come. Now more than ever we need a strong, nimble and people-centric technology-based data exchange infrastructure to meet the needs of the community where they are. For example, a robust community information exchange could allow for coordination of care for multiple social needs of an individual at any given time. Targeted efforts to meet the needs of the most vulnerable could be deployed strategically and rapidly. Further, social service agencies could learn, strategize, and align to better meet the needs of the community, and these data could be used to promote advocacy efforts on behalf of our community members. We believe the time for action to build this data exchange infrastructure is <u>now</u>.


| | | |
|---|---|---|
| Shreela Sharma, PhD | Heidi McPherson, MPH | Tanweer Kaleemullah, JD, MBA |
| UTHealth | American Heart Association | Harris County Public Health |

# Attending Organizations

| ORGANIZATION |
| --- |

1. Houston Methodist Hospital
2. Baylor College of Medicine
3. Texas Children's Hospital
4. Harris Health System
5. Legacy Community Health
6. Houston Food Bank
7. Memorial Hermann Health System
8. BakerRipley
9. Combined Arms
10. University of Houston College of Medicine
11. UT Physicians
12. Patient Care Intervention Center
13. United Way of Greater Houston
14. Greater Houston Healthconnect
15. Welnity
16. Hope Clinic
17. City of Houston Health Department
18. Episcopal Health Foundation
19. HCA
20. University of Texas MD Anderson Cancer Center

| BACKBONE ORGANIZATION LEADERSHIP |
| --- |

American Heart Association
Harris County Public Health
University of Texas Health Science Center at Houston (UTHealth)

# Convening Agenda

What follows is the agenda for the February 19th, 2020, convening of the Greater Houston Coalition on the SDoH. The subsequent report is organized per the key agenda items for the day.

| TIME | ACTIVITY |
|---|---|
| **9a** | **Reviewing and Affirming the Coalition's Purpose, Principles, and Priorities** |
| **10a** | **Reviewing and Enhancing Our Understanding the Landscape**<br>**"Speed Geeking" table to table with technology providers in the room** |
| **11a** | **Pre-Mortem: why might we fail? What should we do to mitigate the risk of failure?** |
| **12:30 – 1.30pm** | **Metrics of Success** |
| **1:30pm** | **Reviewing Scenarios for Action and Criteria for Success** |
| **3:10p** | **Mapping roles and responsibilities, setting criteria for governance** |

# Session: Affirming Principles and Priorities

During the convening stakeholders reflected on the first page of the proposed charter draft (included below), which reiterates the Coalition's vision and mission. The draft also captures the principles, values, short-term objectives, and long-term goals. When asked for feedback, the group consensus was that these sections accurately reflected the collective desire and there were no articulated points of contention. From stakeholders and small group discussions, there were quite a number of recommendations which emerged for how to make this vision come alive. These recommendations included the following:

- The proposed data exchange ecosystem needs to be built on trust—trust between organizations, trust between providers, and trust fostered between organizations/providers and patients/users.
- The developing data exchange ecosystem needs to be built based with input of the patients/users and should foster patient/user agency and capacity to self-navigate.
- There needs to be a thoughtful, inclusive, and shared informed consent process.
- Data possession (or ownership) should transition to the shared perspective of data belonging to "the patient/users" - not owned by organizations.
- Health equity and measurable health outcomes need to be explicitly built into the data exchange ecosystem.
- The human infrastructure of a healthy data exchange ecosystem is complex and requires significant investment alongside the technology infrastructure.
- A successful proof of concept (or the model on which sustainability should be based) should provide value which results in resources that allow for secure sustainability and processes that account for organizational change.
- Utilize solid, data-driven, evidence-based practices with realistic ideas for impact.
- Develop a feasible warm loop referral system that addresses the community's needs and accounts for the complexity, resources, and health and social services current state.

# Our Purpose in the Greater Houston Coalition on the SDoH

| Mission | Vision |
|---|---|
| To establish a sustainable, data-driven, human-centered data exchange ecosystem of care that equitably addresses the social determinants of health among Greater Houston's communities. | A future in which the Greater Houston community fosters health equity for all of its residents. |

| Principles (ways we commit to do this work) | Values (good things we bring into the world) |
|---|---|
| Respect all stakeholders' perspectives. | Shared agency. |
| Center people's needs. | Dismantled barriers. |
| Seek alignment of systems and interests. | Interconnectedness. |
| Build upon existing strengths and assets. | Fair allocation of resources. |
| Measure impact. | Transparency and accountability. |
| Do no harm. | Harm prevention, reduction, and redress. |

| Short-term objectives (what we want to do) | Long-term goals (what we want to achieve) |
|---|---|
| Enable health and social service providers to make 'warm referrals' and 'close the loop.' | Ensure patients/clients have 'no wrong door' — seamless access to care among providers who can effectively coordinate with each other. |
| Establish common framework — shared criteria & metrics — for social determinants, associated needs, and program effectiveness. | Demonstrate improved outcomes re diabetes, obesity, mental health, food insecurity. |
| Establish common legal, operational, and ethical framework for data exchange, usage, monitoring, and sanctioning. | Ensure responsible use, while mitigating risks and preventing/reducing/redressing harm to individuals, groups, and communities. |
| Establish access to common resource directory | Improve service discoverability by ensuring reliable information about available resources is accessible in any appropriate channel |
| Promote coordinated advocacy for policy, culture, and organizational change. | Effect systemic changes that positively impact the social and structural determinants of health. |
| Design / support / monitor specific interventions for health equity. | Cultivate a community of practice that fosters a culture of health. |
| Demonstrate proof of concept then path to scale. | Develop sustainable infrastructure & operations. |

# Session: Reviewing and Enhancing Our Understanding of the Landscape

This session included two components: 1) speed geeking sessions and 2) the unveiling of the landscape scan which maps organizational technology utilization and partnerships.

The speed geeking sessions provided deeper insight into four technologies currently used by various organizations in the Greater Houston Area. Representatives from each organization provided a short technology overview and answered questions from the convening participants. A summary of each organizational overview is provided here:

**Greater Houston Healthconnect (GHHC)**

- GHHC is the regional health information exchange (HIE) serving Southeast Texas, connecting nearly 95% of the clinical systems in the Greater Houston area. They have a master patient index with approximately 8 million patients. GHHC is a "non-profit organization facilitating clinical integration across the care continuum by connecting disparate electronic health record systems" across clinical care provider networks.

**Combined Arms**

- The mission of Combined Arms is to unite the community to accelerate the impact of veterans on Texas. Combined Arms is using technology to connect veterans to the social services they need to thrive by using a collective impact model. Their integrated technology platform connects veterans and their families to 70+ service organizations providing 400+ customized resources. Combined Arms has a public-facing portal which allows users to self-navigate to resources they are interested in with system-designed follow up for anyone who does not complete navigation to care on their own. All service providers are expected to "close the loop" within 96 hours and most close the loop within half that time.

**Open Referral**

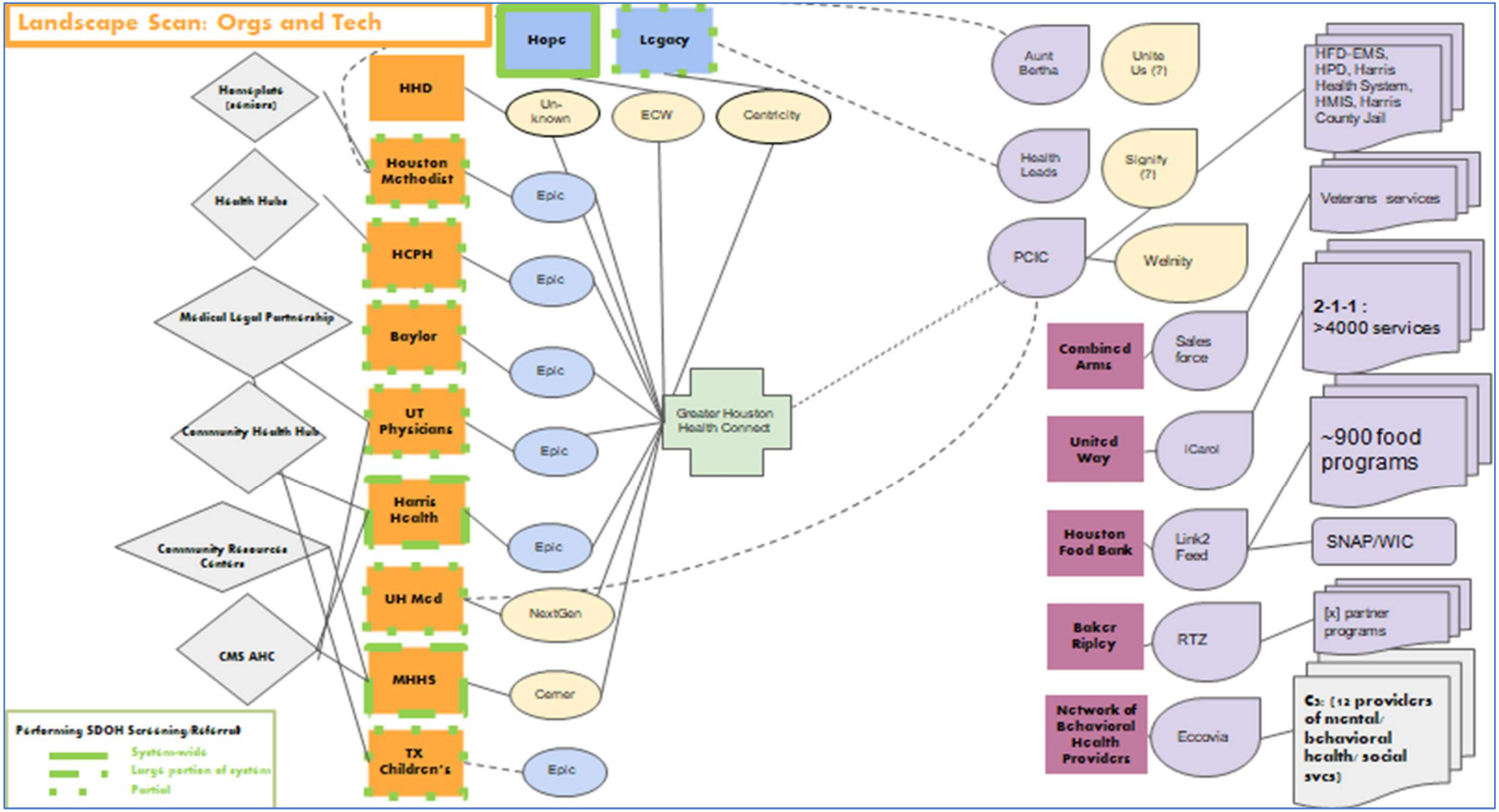
- Open Referral's mission is to develop data standards and open source tools that make it easier to share, find, and use information about health, human, and social services. This social services data sharing standard has been widely adopted nationally by 2-1-1 systems, food bank networks, etc. Open Referral developed a data exchange format so that different systems have a common language, similar to HL7 but for information about services themselves. Now, it's the industry standard, endorsed by Alliance of Information and Referral Systems.

**Patient Care Intervention Center (PCIC)**

- The mission of PCIC is to improve healthcare quality and costs for vulnerable community members through data integration and care coordination. PCIC offers care coordination, data analysis, and technology solutions through its unified care continuum platform. In serving the highest risk patients, PCIC has been able to save millions of dollars and reduce ER visits by 37% among its graduated clients.

# Landscape Map

Prior to this meeting, a stakeholder map of data and technology connections was developed through surveying and gathering information from participating Coalition organizations. This “Landscape Scan” is included below. During the convening, this map was shared in order to gather additional input to continue its refinement, as well as to serve as a foundation for the conversations on which to base scenario options for further improvement of this data exchange ecosystem.



# "Moving the Work Forward: Challenges and How to Deal With Them" (Pre-Mortem)

For this agenda item, participants broke out into small groups to discuss barriers and failure scenarios ("coming up with stories of how we have failed 5 years from now"). Subsequently they were tasked with identifying mitigation tactics to address these scenarios. A synthesis and thematic analysis of the failure scenarios and corresponding risk mitigation tactics are presented below in Table 1. Recurrent themes for failure scenarios are bolded. In summary, factors such as **lack of governance, failure to set it up as a public good, lack of trust, funding challenges, lack of interoperability between technology platforms, and failure in demonstration of implementation, adoption and effectiveness**, were identified as primary reasons for potential failure of the effort.

Table 1. Synthesis and Key Themes for failure scenarios and related mitigation strategies

| Failure Scenario | Risk Mitigation |
|---|---|
| ● **Governance**/ who (as a neutral party) "owns" this?<br>● Coalition falls apart due to lack of role clarity<br>● Project initially takes off but because of one funder there is no sustainability | ● Phase 1 Proof of Concept Agreement – should include governance. This will subsequently evolve upon learnings from phase 1.<br>● Role definition (assign roles)<br>● CEO sign off needed – need buy-in at the highest level<br>● Accountability for all (shared accountability)<br>● Set up transparency<br>● Diverse funding and ownership |
| ● **Failed to set it up as a public good**<br>● System designed without end user in mind, does not work for the end user. | ● No one should own the data (other than the patient)<br>● Incorporate human-centered design of the technology<br>● Convene front-line staff to obtain ongoing feedback<br>● Intentionally inclusive design team – geography, culture, ethnicities etc.<br>● Partner with trusted community organizations/institutions |
| ● **Lack of trust** | ● Establish trust within the community. Community must embrace and support effort.<br>● Establish trust between organizations through strong, ethical governance. Hold ourselves and each other accountable.<br>● Marry community success with agency success (shared goals, objectives) |
| ● **Funding challenges** | ● Establish diverse, long-term funding portfolio with a strong concurrent governance for allocating funds.<br>● Social services should not be expected to "pay to play".<br>● Healthcare currently gets reimbursed by payers for services rendered. Similarly, social services should be reimbursed for services rendered (consider establishment of a community trust fund for reimbursement of CBO service). |

| | |
|---|---|
| • There was not sustained institutional buy-in.<br>• Imbalanced or lacking value-proposition across sectors<br>• **Implementation did not happen as planned. Lack of adoption.** | • Transparent organizational level commitment (e.g. Board Adoption)<br>• Explicit attention to framing the work as broadly popular priorities (policies)<br>• Develop education/TA opportunities so that implementation is seamless.<br>• Leave flexibility for change and innovation<br>• Line up resources that are less sustainable to "shifting winds" (e.g. changes in political dynamics or leadership)<br>• Leadership from sectors establish how to develop a system and processes that supports and provides value for each sector |
| • Lack of infrastructure (pre-condition of **interoperability)** | • Set up foundation<br>• Interoperability, common use is a pre-condition of data structure |
| • **Lack of demonstration of effectiveness** - Evaluation (Testing and metrics)<br>• Lack of ROI<br>• No one size fits all solution<br>• The approach was not thoughtful (learning)<br>• Too broad, in 5 years the needle has not moved on any outcomes, tried to "boil the ocean" | • Scientifically valid, well-designed, phased implementation plan inclusive of robust evaluation (including patient focus groups)<br>• Select a population for test case scenarios. Choose inclusive population that most/all organizations are wanting to address (e.g. diabetes).<br>• Within theory of change, the logic model must include all players' parts (inclusive of consumer role)<br>• Develop metrics at the individual, community, and organizational level<br>• Develop a tiered system for engagement and a metric for that engagement (e.g. at the bronze level, silver level, gold level) – a commitment level for all<br>• Consult stakeholders (outside of Houston) |
| • **Sustainability is not thought through** | • Philanthropic engagement in addressing the problem (Invest in the problem, not investing in one organization).<br>• Funders incentivize adoption<br>• Payer engagement<br>• Data-driven advocacy<br>• Establish a "trust fund" where healthcare providers, philanthropic entities, and payers can provide funds to pay for the data exchange ecosystem infrastructure, plus reimburse social services for their service.<br>• Create and share best practices so success can be replicated, but not duplicate services. Develop education/TA opportunities to support implementation and replication. |

## What one thing do you consider essential to move this work forward?

All participants provided input on the key ingredients essential to move this work forward. The responses included the following:

- ❖ Community voice and community members at the table
- ❖ Data sharing and democratizing data
- ❖ Sustainability plan from the get-go, including funding
- ❖ Interoperability
- ❖ Clarity and plan on how the data and information shared will be used
- ❖ Get started - "not get bogged down in decision making for perfection" – learn as you go
- ❖ Share best practices and usable solutions that benefit the community (need to know and understand how the community is benefitting)

# Metrics and Priority Indicators of Health Outcomes

This agenda item centered around the consideration of short and longer-term goals and outcomes to be measured as part of this work. It is not sufficient to only to have "warm referrals" and "closing the loop." It must be understood and measured if these investments are having an impact on the community. If so, what are the metrics with which to measure this impact? **Both community-based organizations and healthcare organizations are interested in assessing the impact of their investments on health outcomes, so that end game should be kept in mind when building the technology infrastructure.**

**Key metrics of interest from participants**:

- Food insecurity, a priority metric for the proof of concept, is the metric that will be intervened upon but may not be the best outcome measure because it is subject to many factors (e.g. hurricanes, political will, etc.) that are not under control of the coalition member organizations.
- Social capital, social connectedness
- Healthcare utilization - % patients who see a PCP each month, ER visits
- Patient-provider engagement (or clinic-patient engagement)
- Health outcomes:
    - Diabetes - HbA1c
    - Pre-diabetics and decrease number of new diagnoses of diabetes
    - End Stage Renal Disease

**Process metrics: Metrics of warm referrals and closing the loop**

- Process metrics measure a system, operation, and/or potential infrastructure that does not currently exist and should indicate a value-added function that will positively impact health. Examples include:
    - Response time from referral to uptake
    - Of those screened, how many are referred

    - Of those referred, how many followed through with "treatment"
    - Use referral data to inform upstream intervention
- Score card or indices to determine an overall metric of implementation

- Interventions should:
    - Connect patients to resources that increase access to food and nutrition education as well as other SDoH related interventions.
    - Be technology enabled.
    - Be tested in a scientifically valid manner so outcomes can be attributed to the interventions.
- Since it is known that SNAP is an evidence-based intervention proven to reduce food insecurity, how can reducing the SNAP gap be supported in the community (e.g. SNAP enrollment agencies in areas with the greatest SNAP gap).

# Reviewing Scenarios for Action and Criteria for Success

Four information exchange scenarios were presented. In an open discussion after having reviewed each of the scenarios, the various ways that these scenarios align (or do not align) with the Coalition's agreed-upon principles and values were considered. Detailed pros and cons of each of the scenarios are presented below. **During an informal poll of the group at the end of the discussion, Scenario #3 (developing a Community Information Exchange (CIE)) received strong support from about a quarter of stakeholders in the room with none opposed**. Other scenarios had no strong support. There is a significant desire for a CIE among the CBOs. However, further discussion is needed to articulate the structure and components of the information exchange ecosystem.

**Scenario One: One software platform that "everyone" uses**
In this scenario, the Coalition would reach consensus upon one "resource referral" software platform, invest in it, and hope a critical mass of health and social service agencies start using it.

*Advantages*: This is a simple solution and appears to be expedient. Technologically, a single vendor holds all responsibility for managing secure data exchange among institutions.

*Disadvantages:* First of all, different organizations are already committed in different degrees to different technology vendors; requiring all Coalition members to use one 'centralized' software would incur significant loss of one kind or another to each existing prior investment. This path also 'locks in' all local stakeholders to a single proprietary system; this 'monopoly model' is in various kinds of tension with the values and principles established by the Coalition, arguably creating big new barriers to care, and denying agency from any stakeholders who are not a part of this single platform or in support of the decision.

*Suggested changes:* The technology vendor could be regulated like a utility (which some participants observed has still yielded inequitable outcomes in other fields); data assets could be placed in a 'trust,' so that the vendor's rights to use them are carefully prescribed and monitored; a contract could be designed to prevent lock-in by requiring interoperation via nonproprietary data protocols, and preserving the ability to remove the vendor if it fails to uphold key standards and agreements.

**Scenario two: HIE only - HIE evolves to support exchange w/ non-HIPAA entities**

In this scenario, the Coalition would work with the Greater Houston Healthconnect (GHHC) to develop capacities to support 'client data exchange' among non-HIPAA-covered entities and associated platforms. Coalition members could each choose separate platforms (or build their own) and each platform can interact via the HIE.

*Advantages:* This approach leverages existing technology (GHHC already has a 'master-patient index' and secure data-exchange technology), with proven functionality, and adoption throughout the healthcare sector. It can also be implemented fast(er) than other scenarios.

*Challenges:* GHHC currently has not enabled linkage to social services. A model that requires an upfront financial investment may be expensive and not feasible for many CBOs. Currently, a better understanding of the various adoption/utilization results across current healthcare providers is needed. FQHCs (Federally Qualified Health Center) report difficulty getting good data back. Overall, there is a concern that this scenario will likely favor hospitals, marking CBOs as a lower class of membership (governance will need to address CBO "seat at the table" such as board participation at GHHC). Coalition members would like to know the benefits the HIE provides to its current participating organizations: Are there case studies that can be shared? What is the exact number of patients in the master patient index?

*Suggested changes:* The HIE would need to have capacity to focus on the needs of CBOs and the ability to meet them. A different kind of pricing model would be needed. The governance model would need parity for CBOs. A new consent management process would also need to be developed.

*What does success look like:* The HIE develops cost structure so CBOs do not have to pay themselves. Also, the challenge of government entities paying is addressed. A governance model has been incorporated which engages CBOs and clients. HIE helps establish a shared revenue incentive to pay for CBO services. CBOs can access data as well as clients.

**Scenario Three: Coalition develops Community Information Exchange (CIE) that links with the HIE.**

In this scenario, the Coalition develops a "CIE" that facilitates warm referrals and closed loops among non-HIPAA-covered entities. The CIE could also facilitate interactions with healthcare institutions via the HIE.[1]

*Advantages:* Building this can drive buy-in. Easier to develop in accordance with the needs and interests of front-line staff of CBOs. Dedicated CIE may be easier to separate from HIPAA requirements.

*Disadvantages:* This could require intensive time and resources; and has no clear sustainability model. There is no prior experience developing it. Building a CIE from scratch requires consensus; how to prioritize needs amid competing organizational priorities?

*Suggested changes:* Establish stewardship model for collective ownership with a responsible party to the bottom-line. Articulate the limitations and requirements. Do not assume agencies will create their own connections. Assume it will be built in pieces, not all at once.

[1] A software platform in Scenario 1 is one particular type of software with a specific set of functionalities while the CIE is infrastructure that would allow for multiple software and functions

**Scenario Four: Distributed Network with Common Protocols**

Suggested by the Houston Food Bank, this scenario would not entail any centralized infrastructure at all, but rather *ad hoc* integrations between coalition members in accordance with the needs of their respective partnerships.

*Advantages:* This is happening now, and it represents organic growth. Data integrations can be custom built by those who want them, each responsible for own. Lack of centralized infrastructure may lead to cost savings and also adaptability and resilience.

*Disadvantages:* If this is the status quo, it is not clear how this moves us toward the goal. It is unclear who would ensure quality and consistency, especially with regards to data for analytics and evaluation?

*Suggested changes:* By requiring 'standard protocols' across this distributed ecosystem, the coalition could ensure some measure of capacity for collaboration and research across sectors. This may also be considered a promising variation on Scenario #3, in which the CIE would not necessarily be 'centralized' infrastructure that 'everyone' has to use, but rather shared capacities to facilitate and monitor distributed data partnerships.

## Technology Discussion - Reviewing Scenarios for Action and Criteria for Success

*Current Technology Ecosystem:* In reflecting on the map of technologies, the technology group shared that quite a number of connections were already underway within those represented in the discussions, and more discussions were already happening around how to grow and strengthen these connections. The group agreed that there are currently many technology solutions for building the technology infrastructure of this ecosystem with more developing quickly. There was strong consensus that the biggest challenges are not with the technology itself - but with governance of the ecosystem.

*Criteria for Success:* This collective effort needs a clear, shared governance approach. It will require clear data standards such as clinically used HL7/FHIR and the community services equivalent. In fact, a community equivalent to HL7/FHIR is currently under development through The Gravity Project . There are significant challenges in building systems that share data across HIPAA and non-HIPAA protected organizations. In building a comprehensive SDoH ecosystem, there are more data sharing regulations that will need to be addressed beyond HIPAA.

It is technically feasible to connect clinical and community data through the Greater Houston Healthconnect, but this would require new business agreements and/or data use agreements as well as new informed consent processes. There was also discussion that building this connection through a community information exchange (CIE) would be slower but more scalable.

Finally, this data ecosystem needs to be built considering factors such as a clear user consent process that promotes equitable improvement in health outcomes. The system should include capacity to report on:

- % of referrals which are user driven
- % of referrals which are network driven
- % of referrals which are human service driven

# "Working Towards" Mapping Roles, Responsibilities, and Governance

This agenda item focused on participants mapping out critical components of roles and responsibilities in order to successfully collaborate in the charter and create a healthy information exchange ecosystem, as well as potential deal breakers for collaboration. Participants were divided into two groups - health services organizations and CBOs (including government organizations). The main themes across both groups are presented in the table below. Across the two groups, the overlapping common themes were: **Interoperability, legal considerations, clarity on data ownership and access to data, and overall governance.**

**Last, but not least, there was robust discussion among CBOs that social services would not be required to "pay to play" in regards to the care coordination technology platform, and furthermore, it is important to consider the establishing sustainable funding streams and resources to allow for social services to be reimbursed for services provided** (e.g. a community trust fund to pay social services in a fee-for-service model). While healthcare organizations have a framework in place for reimbursement of services, currently no such model exists for the CBOs which needs to be established.

| Health services organizations | Social services organizations |
|---|---|
| Roles responsibilities and agreements | |
| Interoperability between care coordination platforms specified in RFPs and contracts<br><br>Appropriate adjustment of referrals to account for CBO capacity issues | Where are the monies coming from to fund the work of the charter? Healthcare partners could potentially provide some of the funding.<br><br>Additional referrals will require joint planning and financial support to deal with increased capacity needs, which will differ depending on the CBO |
| Protection for liability. Strong BAA/MOU with social services. | Social services need to be reimbursed for services provided. Consider development of a community trust fund that reimburses social services for care.<br><br>Legal services and costs should be covered by healthcare.<br><br>Ensuring that the BAA/MOU covers the social services and not just healthcare |
| Data ownership and use of data for research with unbiased 3rd party evaluation<br><br>Collection, use, and interpretation of patient/user data ethically (being responsible stewards of the data) | Data ownership (such that social services are not dependent on healthcare for outcomes data) and use of data for research with 3rd party evaluation<br><br>Collection, use, and interpretation of patient/user data ethically (being responsible stewards of the data) |
| Overarching agreed upon principles by all | Defining accountability for all and operationalizing it |
| HIPAA compliance, ethics | Ethical code of conduct |
| Engaging payers | |

| Charter requirements | |
|---|---|
| Interoperability | Metrics and accountability– must be developed with transparency and buy-in |
| How organizations access, use and analyze data | Access to data in a timely manner (social services are not dependent on healthcare for outcomes data) |
| MOU with commitment of appropriate resources for the proof of concept (staff, services etc.) | MOU with commitment of appropriate resources |
| Governance – who is the governing body?<br><br>Data decisions including hosting, rights to use, ethics, right to interpret, publish | Governance, data management structure, other infrastructure needed for success.<br><br>Training and technical support; quality control |
| **Deal breakers/Concerns** | |
| Concern – other coalitions in the county have failed. What to do so as not to repeat the same mistakes? | Deal breaker - Expecting social services to pay to play.<br><br>How do you "fail fast"? |

# Recommendations and Next Steps

The Coalition's six workgroups (Metrics and Framework, Data, Policy, Communications, Food insecurity, and Coalitions Alignment) and Steering Committee will be aggregating information, planning, and conducting landscape scans to help inform the broader Coalition and Charter's efforts. In addition to this work, the following are recommended next steps:

1. **Setting the infrastructure for success and sustainability**
    - Develop interoperability advice/language guidance as Coalition partner organizations conduct technological deliberations
    - Determine infrastructure and interoperability gaps and deficiencies and develop mitigation plans or solutions accordingly
    - Increase engagement of and include behavioral/mental health partners in planning
    - Select exec representatives from health and social services sectors to establish balanced plans and expectations for value and outcomes that represents needs for both sectors
    - Interface with health plan/payors on care and sustainability planning
    - Organizations should attempt to consolidate intra- and inter-referral and close loop efforts to avoid more duplication and splintering
    - In an effort and spirit of collaboration, Coalition members should share efforts to develop mid to large-scale referral, close loop, HIE, and/or CIE to avoid continued silo effect
    - Engage philanthropic partners to foster interest and eventual support. Establish sustainable models of funding for the technology infrastructure, and a framework that would allow a fee-for-service reimbursement model for CBOs to reimburse them for services provided.

2. **Develop a proposal for the next iteration of the charter to proceed with the proof of concept**
    - Scope and design of the charter proof of concept
        - This will be informed by input from the community voice
    - Membership
    - Leadership and Governance
        - Based on lessons learned from communities around the country, the governance of how organizations will share data and work together is more critical than the technology, which fosters trust and collaboration rather than "siloes of excellence" illustrated on the Landscape Scan.
        - Being cognizant of developing an framework to institute ethical processes and decisions driving community benefit.
    - Leveraging broader Coalition's workgroups
        - SDoH Frameworks & Common Metrics
        - Data Sharing Ecosystem
        - Food Insecurity
        - SDoH Policy
        - Coalitions Alignment
        - Communications
    - Develop a workgroup for Charter members that become part of Phase 1 proof of concept
    - Community representation
    - Resource data supplier
    - Technology infrastructure
        - Interoperability
        - Standards
        - 'Trustees': empowered vendors, researchers, and other users whose use is prescribed by policy, monitored, and sanctioned

3. **Scope development of Community Information Exchange capacities.**
    - Assessment of HIE to identify unmet needs for SDoH platform providers, community anchors like Food Bank and United Way's 2-1-1.
    - Explore CIE development options (e.g. models, vendors)
    - **To develop proofs of concept, first consider supporting existing partnerships among members of the community.** Facilitate at least one partnership's engagement with existing HIE, learn from their experience, articulate necessary criteria for enabling CIE, articulate necessary institutional design for collective data ownership, and develop a proposal for scaling capacity and processes.
    - Deliberate on the tradeoffs between centralized infrastructure (which would hold some common pool of clients' data) and distributed or federated infrastructure (in which clients' data is exchanged among member organizations yet not centrally stored).

4. **Link with other coalitions and institutional initiatives** to align with their strategic priorities and identify mid-term priorities.

5. **Both CBOs and HCOs are interested in understanding the impact of their investments on health outcomes so that end game should be kept front and center while building the information exchange infrastructure (i.e.**

**HIE and CIE are linked).** Accountability and common metrics, milestones and objectives should be established at each level to demonstrate implementation success, and achievement of outcomes.

6. **Consider establishing stewardship of shared resource directory infrastructure** using data standards and open source tools that make it easier to share, find and use information about health, human, and social services. A key component of this mission is shared access to up-to-date information about the availability of health, human, and social services. But this information changes often and is costly to maintain. The Coalition should consider establishing shared access to an up-to-date resource directory by designating an institutional steward that will maintain an up-to-date resource data available in open infrastructure. This resource data should be openly available for use in any of the information systems used by members.

**Resources**

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