Coordinated Whole-Person Care that Addresses Social Determinants of Health

DASH Communities Generate Lessons Learned about the Required Data Infrastructure and Systems

Data Across Sectors for Health

Introduction

To achieve better health outcomes at a lower cost, clinical and social service providers increasingly need access to information reflecting the social determinants of health—such as employment, housing, and education—as they have a profound impact on health.

In 2015, the Robert Wood Johnson Foundation (RWJF) launched Data Across Sectors for Health (DASH), an initiative to align health care, public health, and other sectors to systematically compile, share, and use data for understanding factors that influence health and developing more effective interventions and policies. DASH awarded ten $200,000 grants to communities across the country to use data-informed approaches to address a range of population health and care coordination challenges.

At the same time, DASH conducted an environmental scan that illuminated a number of hurdles to building community health data infrastructure for sharing data across sectors. Once communities get past initial hurdles related to speaking a common language, building trust, developing a collective vision, and signing legal agreements, they have to overcome another set of technical challenges related to lack of data standardization, the need for revised processes and workflows, and/or new software and systems. As they address technology and human capacity, multi-sector collaborations grapple with questions like:

Who needs data? What data? When? And how can it be delivered to support work processes across sectors?

Just as members of a healthcare team function best with access to shared care plans and common medication lists, a multi-sector care team can be in alignment when data are shared appropriately, and with individual consent, across sectors. Thus, some DASH grantees have implemented data infrastructure to support such coordination, including the development of shared plan of care/services documents, alerts and notifications sent across systems, and analytics that draw on multiple types of data to predict risk and identify people in need of more intensive services.

Each person on a care team needs role-based access to relevant individual-level data that is seamlessly incorporated into their work process in a way that enables them to take the appropriate actions in response to each specific situation. This issue, familiar to those in health care informatics, becomes even more complex and challenging to manage across sectors. Individuals and people in their support network, including physicians, care coordinators, family members, social workers, emergency responders, social services providers, educators, and behavioral health specialists, need the right amount of information delivered at the right time in an accessible way.

Additionally, communities across the country have access to different levels and types of infrastructure on which to build. While adoption of electronic medical records is widespread, the same cannot be said for data systems within social services agencies or participation in health information exchanges (HIE).

While there are many ways communities can integrate data to improve health, this brief focuses on five DASH-funded projects that are developing the data infrastructure to support models of coordinated care across medical and community services. These include: Altair Accountable Care Organization (ACO) in Minneapolis, MN; HealthInfoNet in Portland, ME; the Center for Health Care Services (CHCS) in San Antonio, TX; the Parkland Center for Clinical Innovation (PCCI) in Dallas, TX; and the White Earth Nation in North-Central Minnesota.

The desired outcome of these models involves system-level changes such that services provided within health care and other settings are oriented around the whole person, and not exclusively on their healthcare needs. These models of care require collaboration not just across organizations, but across sectors.

For example, grantees tested the ideas that food pantries can better serve clients by providing nutritionally appropriate options for those with chronic disease; emergency responders can act more effectively if notified of individuals who may be experiencing a mental health crisis; and long-term care providers can modify their interactions with a person with an intellectual or developmental disability who has experienced a serious life event—be it medical or otherwise.

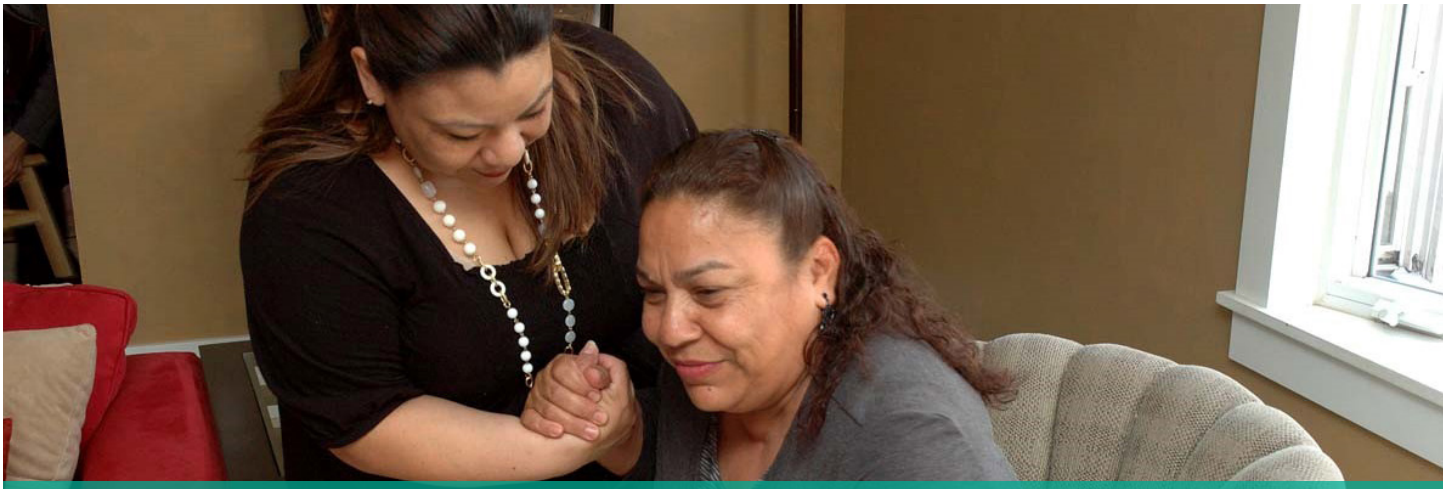
The DASH National Program Office has been eagerly following this first cohort of grantees to document their lessons learned as they address such challenges. This brief summarizes approaches and lessons learned from five DASH grantees — all of whom have unique target populations, goals, partners, and resources, yet collectively are generating lessons learned with respect to multi-sector data sharing specifically for care coordination.

The table on the following page provides a snapshot of the DASH projects featured in this brief and provides an overview of their use cases, technology, data sources by sector, and contributions to the field.

	Altair ACO	HealthInfoNet	CHCS	PCCI	White Earth
Patient population	Adults with intellectual or developmental disabilities	General safety-net	Adults with severe mental illness or substance use disorders	Adults with high blood pressure and/or diabetes	Residents of White Earth Nation
Target condition/ services	Long-term care services/ supports	Hospital readmission/ high ED utilization	High ED utilization	Food insecurity and chronic disease	Global community services
Shared data user	Multi-sector care team	ACO (hospital/ primary care) care managers	Behavioral health care managers	Food bank care managers, primary care providers	Tribal agencies, education, and child care program
Use Cases					
Alerts/notifications	✓		✓	✓	✓
Shared plan	✓		✓	✓	✓
Continuity of care		✓		✓	
Risk analytics	Coming	✓			
Technology					
State/community HIE	✓	✓	✓		
Provider portal	✓	✓	✓	✓	✓
Patient portal	✓				
Shared data system				✓	
Data warehouse	Coming		✓		
Data Source by Sector					
Medical	✓	✓	✓	✓	
Behavioral	✓	✓	✓		✓
Claims	✓	✓			
Housing	✓	via FQHC			
Nutrition	✓			✓	
Transportation	✓	via claims			
Education		via census, CAP			✓
Other community services	✓				✓
Law enforcement	In formation				

Contributions to the Field

- **Altair ACO:** Defining the multi-sector care team in an accountable care organization; Operationalizing targeted notification of life events; Behavioral health screening and referrals.
- **HealthInfoNet:** Structured social determinants of health data availability; Incorporating social determinants of health in risk analytics.
- **CHCS:** Developing and using an internal data warehouse to process alerts that are targeted and actionable.
- **PCCI:** Developing and implementing a "No Wrong Door", closed-loop, data-supported, community framework and workflows for cross-sector care coordination to address health and social needs.
- **WECARE:** Defining a process and model for universal multi-sector assessment across a tribe/reservation.



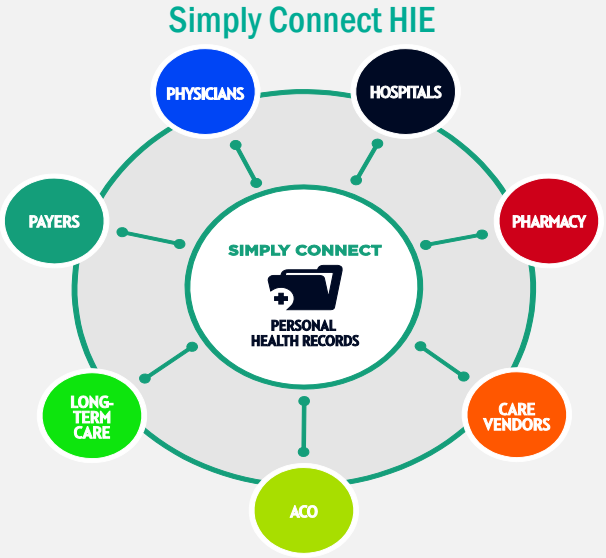
Altair Accountable Care Organization (ACO)

More information available at dashconnect.org/AltairACO

Altair Accountable Care Organization (ACO), the first social service-led ACO in Minnesota, serves approximately 7,000 adults with disabilities in the Twin Cities of Minneapolis and St. Paul. The ACO was formed to create a system that coordinates, evaluates, and plans financing for a wide range of services that impact health and quality of life. This particular ACO consists of representatives from behavioral health specialists, disability service providers (housing and employment), one primary care provider and two local public health departments. One of the core aims of the collaborative, which was supported by funding from DASH, was to develop an e-Health infrastructure that fully integrates primary care and behavioral health. Their primary partner for achieving this goal is a local Health Information Exchange (HIE), Simply Connect. HIEs allow healthcare providers and patients to access and securely share health information electronically.

One out of every three people with an intellectual or developmental disability served by Altair may also have a behavioral health issue. In addition, this population often requires long-term supportive services to avoid crisis situations and improve their quality of life. For example, loss of employment, health complications, injury or other significant life changes may compromise this population's independence and ability to actively participate in their communities.

Utilizing a partnership of multi-sector providers, Altair ACO's data infrastructure is built to assist adults with intellectual or developmental disabilities in meeting their life goals, which include stable health, safe and secure housing, and employment. Simultaneously, they work to address and/or prevent crises that could lead to setbacks that would be costly for the community as well as the individual. Simply Connect created a data sharing platform to measure and track patients' health events.



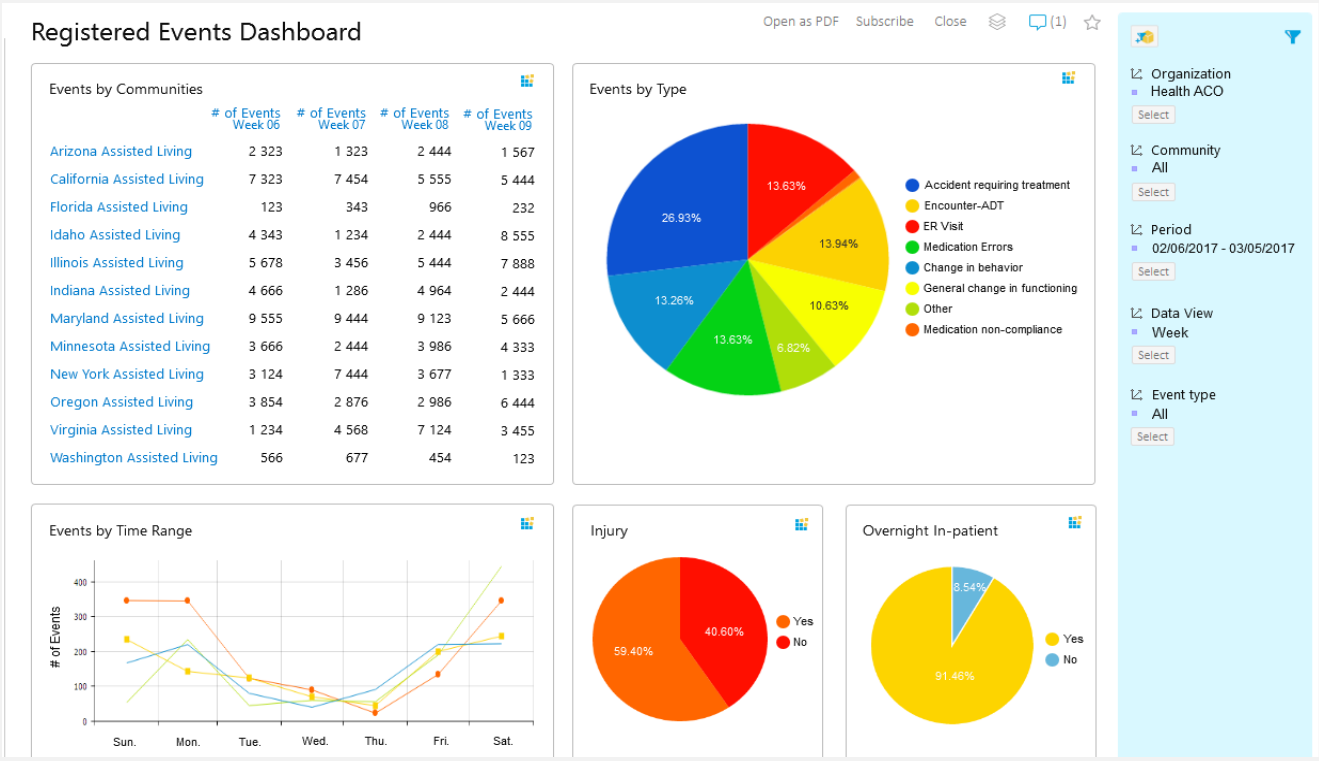
Simply Connect HIE staff collected answers to the following questions for their clients:

1. Who is part of the individual's multi-sector support team?
2. What types of events could affect the individual's ability to remain in the setting of their choice over the long-term?
3. Which members of the care team should be alerted to those events?
4. How should the receiver be guided to act on the events?

For Altair, answering these questions began with the preferences of the individual involved, which is an approach that guides their care model. Individual clients worked with their care managers and guardians to identify specific care team members and determine their roles and data access levels within the HIE. First, partners collaborated to clearly define care team roles for case managers, family members and close friends, residential and employment supports, behavioral health and primary care providers, and others identified by the individual. Similarly, the partners defined a typology of the most significant events to prioritize for triggering an alert to the care team including serious injury, illness, medication errors, screening for behavioral health risks, loss of family caregiver, and others. Each event notification or "alert" comes with guidance on how the care team member might consider responding—ranging from "urgent follow-up required," "referral for services needed," to "for information only."

Altair ACO is automating multi-sector data sharing and a collaborative planning system designed to meet both the personal preferences of the individuals served as well as those of care team members approved during the collaborative planning process. As each new organization connects to the platform, lessons learned about workflows unique to different social support services inform the next iteration of the training tools/materials for end users. The incorporation of a behavioral health assessment that identifies risk and enables more timely notifications has allowed Altair to start documenting the success of their vision, maximizing individual independence and minimizing systemic and cost barriers to effective social supports.

Analytics: Events Dashboard



HealthInfoNet

More information available at dashconnect.org/HealthInfoNet

HealthInfoNet, a non-profit designated by the State of Maine to operate the statewide HIE, links medical information from separate health care sites to create a single electronic patient health record, accessible by a patient's authorized health care providers. With funding from DASH, HealthInfoNet worked with a team of seven federally qualified health centers, three critical access hospitals and two community action agencies to add data about social needs and services so that care managers can address social determinants of health often faced by Maine residents, especially those living in isolated rural areas.

Health care providers in these areas recognize that they cannot meet their patients' medical needs without first addressing their broader social needs, including stable and safe housing, access to medical transportation, and early childhood services. Community action agencies were specifically recruited as new partners for this effort, as they are nonprofit organizations dedicated to reducing poverty by assisting low-income individuals in accessing new opportunities and services to help them achieve economic self-sufficiency.

Data about these determinants of health will be used for two main purposes:

1. To create a continuity of care document available through the HIE provider portal that integrates healthcare and social services data to help providers better understand the needs of patients.
2. To develop predictive risk analytics to identify the most complex, high-need patients and help providers intervene appropriately.

HealthInfoNet's approach to obtaining multi-sector data contrasts from that of Altair ACO's in that it focuses on identifying sources of existing data already being collected for other purposes. For example, human service and housing agencies are mandated by state and federal agencies to collect specified demographic data on the populations served, program enrollment, and services provided.

With many datasets under consideration, HealthInfoNet convened partners and data owners to determine the most useful data sets for priority integration within the HIE platform. This social services data is linked to individual health care data through the HIE's master person index, a tool that helps maintain consistent, accurate person data across various organizations, and creates a unified record on the provider portal.

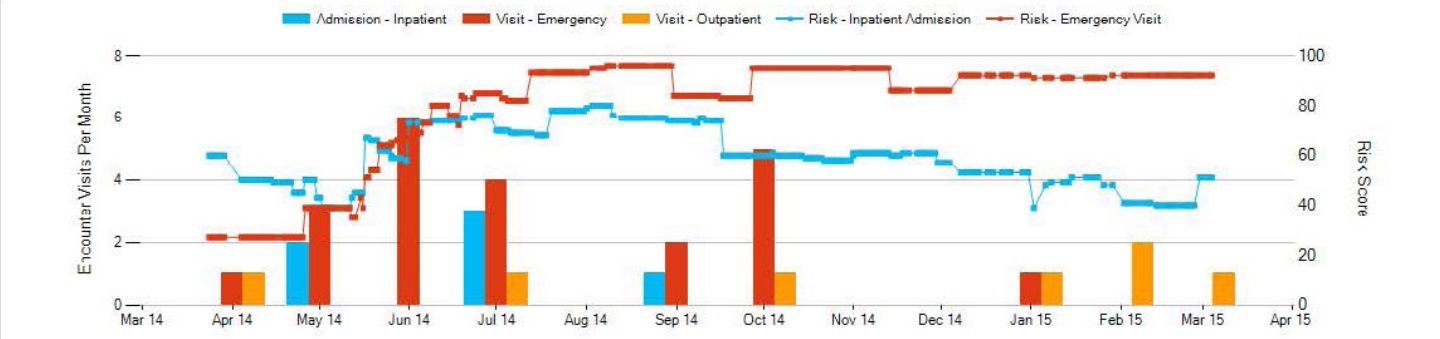
They identified the following sources which have sufficient data quality and utility:

1. **Existing social determinant of health data collected by the electronic health records of participating federally qualified health centers**, which are required to report a '[uniform data set]' on their population served to Health Resources & Services Administration (HRSA) as a requirement for their federal funding to provide comprehensive primary care regardless of ability to pay. Participating health centers are updating their existing electronic health record HIE template to ensure discreet data fields such as "housing status" are captured in the HIE database. The next phase of this work will focus on modifying federally qualified health centers' workflows to assign new procedural codes to social risks that the health centers agreed were a high priority including food insecurity, housing insecurity, and transportation.
2. **Medicaid claims data feeds.** HealthInfoNet worked with their state Medicaid agency and community action agency partners to analyze claims data for non-emergency transportation services for inclusion in the HIE provider portal. HealthInfoNet already receives regular Medicaid claims data and is now able to include use of such services on the patient's "Community Services" page available through the provider portal.
3. **Structured data available from community action agencies.** Community action agencies collect a wealth of information about the social services they provide and the clients enrolled in their programs. These partners agreed to start by focusing on Head Start data that would allow them to leverage the uniform data set, collected by early childhood providers. Every child that enrolls in Head Start undergoes an assessment process where data is collected on housing, parent education/income, and other social determinants of health. Over the course of multiple in-person meetings and phone conversations, care managers provided input that enabled HealthInfoNet and the community action agency to understand the clinical value of Head Start data for at-risk pediatric populations.

Having identified and incorporated these new data into their platform, HealthInfoNet anticipates that their innovative predictive analytics model will become more accurate at predicting patients with high risk for poor and costly health outcomes, and thereby, more useful to care managers who can target their services to those in greatest need. After adding Medicaid claims data, HealthInfoNet experienced an improvement in the risk model sensitivity and are excited to see if the social determinant data integrated through DASH provides a similar improvement in the model.

HealthInfoNet hopes to continue to convene community service providers and state government to achieve improvements to the quality and accessibility of community services data, including homelessness management information systems (HMIS) data. They are advocating for a state-level investment in software that would extract and link information on community services across programs.

Individual Patient Risk Summary



Center for Health Care Services (CHCS)

More information available at dashconnect.org/CHCS

The Center for Health Care Services (CHCS), the mental health authority in Bexar County, Texas, is leading efforts to create a connected information system where physical and behavioral health care data enables stakeholders in critical sectors—including hospitals, law enforcement, and homelessness services providers—to better serve clients.

The local HIE, Healthcare Access San Antonio (HASA), notifies CHCS case managers of client hospital and ER admissions and then case managers can locate clients in those hospitals and ERs. This allows case managers to improve their ability to reach disengaged clients and assist hospitals in discharge planning. Once a client is engaged in CHCS services, the case managers use the HIE to identify client hospitalization and crisis history to accurately assess the level of care needed. The client's authorized level of care determines which services the client can receive, how many hours per month the client should be served, and the reimbursement rate CHCS will receive.

CHCS has worked with its partners to build technology and adjust workflow that supports two primary use cases:

1. **Alerts** sent to CHCS care managers when their clients arrive at emergency departments, allowing CHCS to intervene earlier and prevent inappropriate hospitalization or incarceration, and ensure more stable follow-up.
2. **Community treatment plans** available on demand from HASA which list individual patients' medication lists and medical history. CHCS behavioral health provider names and contact information is also included so that community partners such as homeless shelters and law enforcement (with appropriate permissions) are aware of the clients' existing behavioral health and social service providers.

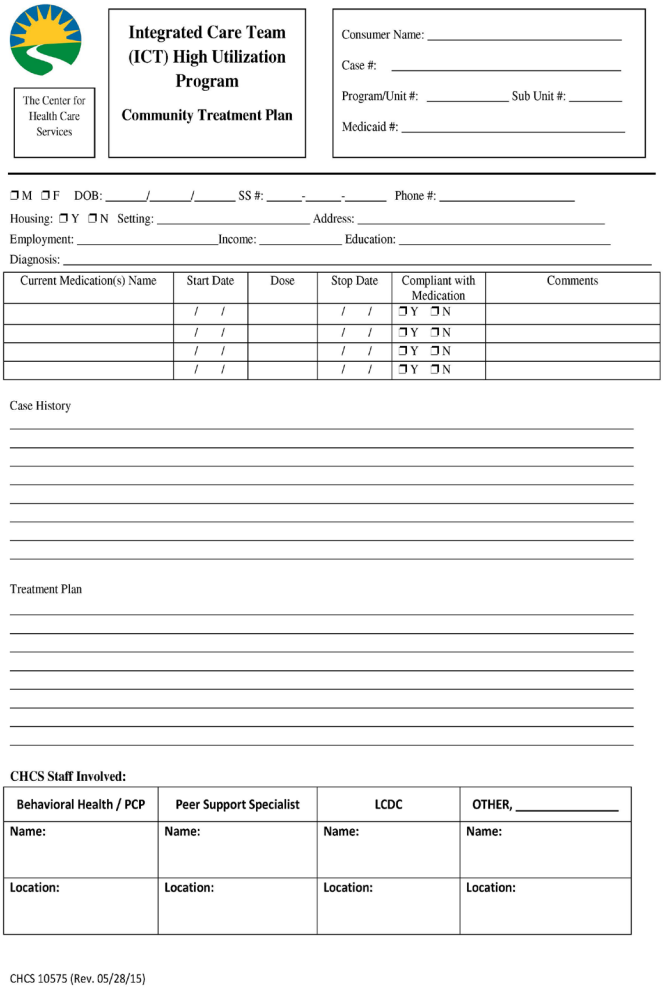
Delivering alerts in a way that is seamlessly incorporated into the provider's workflow is a common challenge for HIEs and their participating providers, even when not delivering data across sectors. As a part of this work, CHCS automated the manual data entry or list management that is often required of their case managers, saving them time to attend to clients.

On a daily basis, the CHCS data warehouse extracts information on hospital admissions from the HIE. Programmed algorithms within CHCS' data center match the HIE data to internal records, determine the appropriate case manager, and send an alert as an internal, secure email. Healthcare providers participating in the HIE must still search for specific patients on the HIE's portal to determine whether they are served by CHCS, but efforts are ongoing to integrate with the various electronic health record systems at participating hospitals and clinics.

Additional work is underway with a long-standing multi-sector organization, the Community Medical Directors Roundtable, located in San Antonio, Texas. This collaborative brings together hospitals, emergency medical services, public safety, law enforcement, homeless services, and behavioral health providers to develop a community treatment plan that would be accessible on the HIE and display a whole-person record of services and supports to authorized entities.

Currently, the community treatment plan is a static PDF document that originates from CHCS and is accessible through the HIE portal, providing authorized users access to information on the mental health status of individuals. Work is ongoing to understand and incorporate appropriate data from law enforcement, and determine how best to provide emergency responders the right information at the right time.

Community Treatment Plan



The Center for Health Care Services

Integrated Care Team (ICT) High Utilization Program

Community Treatment Plan

Consumer Name: _____

Case #: _____

Program/Unit #: _____ Sub Unit #: _____

Medicaid #: _____

❒ M ❒ F DOB: _____/_____/_____ SS #: _____-_____-_____ Phone #: _____

Housing: ❒ Y ❒ N Setting: _____ Address: _____

Employment: _____ Income: _____ Education: _____

Diagnosis: _____

Current Medication(s) Name	Start Date	Dose	Stop Date	Compliant with Medication	Comments
	/ /		/ /	❒ Y ❒ N	
	/ /		/ /	❒ Y ❒ N	
	/ /		/ /	❒ Y ❒ N	
	/ /		/ /	❒ Y ❒ N	

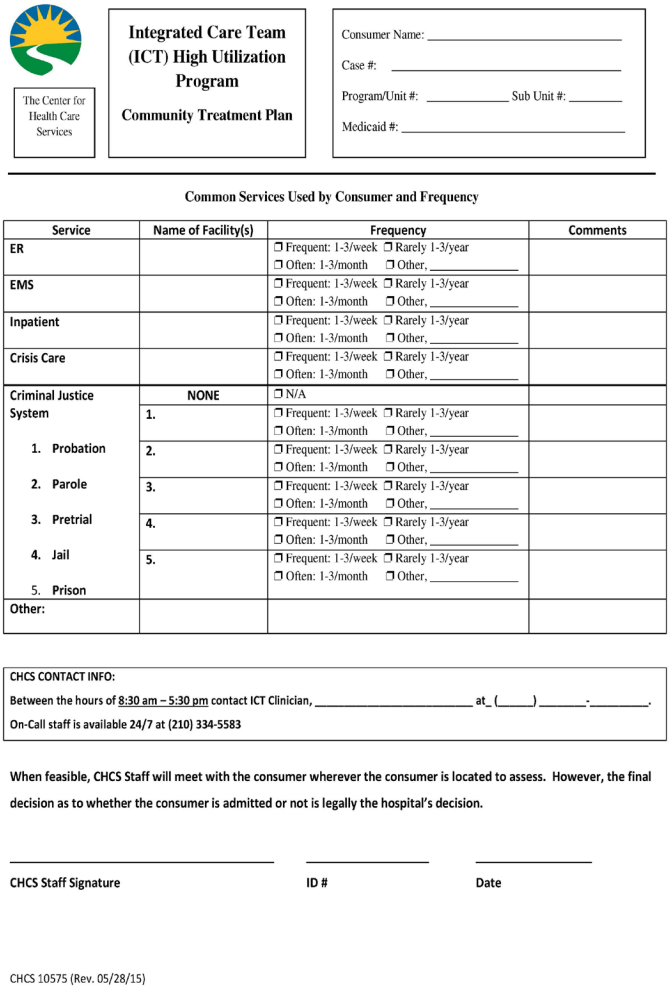
Case History

Treatment Plan

CHCS Staff Involved:

Behavioral Health / PCP	Peer Support Specialist	LCDC	OTHER, _____
Name:	Name:	Name:	Name:
Location:	Location:	Location:	Location:

CHCS 10575 (Rev. 05/28/15)



The Center for Health Care Services

Integrated Care Team (ICT) High Utilization Program

Community Treatment Plan

Consumer Name: _____

Case #: _____

Program/Unit #: _____ Sub Unit #: _____

Medicaid #: _____

Common Services Used by Consumer and Frequency

Service	Name of Facility(s)	Frequency	Comments
ER		❒ Frequent: 1-3/week ❒ Rarely 1-3/year ❒ Often: 1-3/month ❒ Other, _____	
EMS		❒ Frequent: 1-3/week ❒ Rarely 1-3/year ❒ Often: 1-3/month ❒ Other, _____	
Inpatient		❒ Frequent: 1-3/week ❒ Rarely 1-3/year ❒ Often: 1-3/month ❒ Other, _____	
Crisis Care		❒ Frequent: 1-3/week ❒ Rarely 1-3/year ❒ Often: 1-3/month ❒ Other, _____	
Criminal Justice System	NONE	❒ N/A	
1. Probation	1.	❒ Frequent: 1-3/week ❒ Rarely 1-3/year ❒ Often: 1-3/month ❒ Other, _____	
2. Parole	2.	❒ Frequent: 1-3/week ❒ Rarely 1-3/year ❒ Often: 1-3/month ❒ Other, _____	
3. Pretrial	3.	❒ Frequent: 1-3/week ❒ Rarely 1-3/year ❒ Often: 1-3/month ❒ Other, _____	
4. Jail	4.	❒ Frequent: 1-3/week ❒ Rarely 1-3/year ❒ Often: 1-3/month ❒ Other, _____	
5. Prison	5.	❒ Frequent: 1-3/week ❒ Rarely 1-3/year ❒ Often: 1-3/month ❒ Other, _____	
Other:			

CHCS CONTACT INFO:

Between the hours of 8:30 am – 5:30 pm contact ICT Clinician, _____ at_ (_____) _____-_____.

On-Call staff is available 24/7 at (210) 334-5583

When feasible, CHCS Staff will meet with the consumer wherever the consumer is located to assess. However, the final decision as to whether the consumer is admitted or not is legally the hospital's decision.

_____ _____ _____

CHCS Staff Signature ID # Date

CHCS 10575 (Rev. 05/28/15)

Parkland Center for Clinical Innovation (PCCI)

More information available at dashconnect.org/PCCI

The Parkland Center for Clinical Innovation (PCCI), an independent, not-for-profit healthcare intelligence organization in Dallas, Texas, is bringing together a network of healthcare providers who are aligned around the goal of improving multi-sector care coordination with community-based organizations seeking to better serve their clients. As a part of their DASH project, PCCI is using a cloud-based care coordination platform created in house called Pieces Iris™ and examining whether sharing information between health care organizations and food pantries will improve health outcomes of people with nutrition-sensitive chronic conditions like diabetes and hypertension while reducing costs.

By installing the data system at the hospital and at three North Texas Food Bank partner agencies, food pantry staff are able to access information from the medical records of clients seen by providers at Parkland Health & Hospital System, which will help them make food recommendations tailored to clients' needs. Food pantry staff are encouraged to remind clients of upcoming appointments at the hospital and to identify potential barriers to accessing care such as transportation. Bi-directional data flow is still being piloted, but enthusiasm is such that the hospital is already identifying other conditions where community agencies can be enlisted to address other determinants of health such as adequate housing for patients in wound care. Food bank clients are appreciative of the additional connection with the clinical provider. Although the health system originally led the effort to identify and recruit patients to participate in the program, a workflow issue emerged that changed the approach and scope of the work. On the health system side, social workers found that providers were more focused on treating patients' clinical needs and were not responsive to food insecurity screenings. Thus, PCCI staff decided to instead recruit willing participants into the study from the food pantries where individuals were more comfortable and accustomed to discussing a range of social and emotional needs with clients.

This change in approach has also created a new mechanism for community partners to educate their clients about health care services that they might not otherwise have known were available to them. For example, free and reduced-cost services are available from Parkland Health & Hospital System, but some food pantry clients were not aware of this service until they were introduced to the intervention. Additional outcomes include the development of workflow training for partner agency volunteers to remind patients of upcoming clinical appointments and training customized for community agencies on HIPAA rules and regulations.

White Earth Nation

More information available at dashconnect.org/WECARE

The White Earth Nation, a reservation in rural northwest Minnesota with a population of 9,000 members, prioritizes holistic approaches to addressing health and wellbeing for the tribal community. The reservation includes three counties, one of which is among the poorest in the state, that face disparities like high rates of diabetes and substance abuse.

Through DASH, White Earth Nation is expanding the implementation of the WECARE (White Earth Coordination, Assessment, Resource, and Education) assessment to primary care, early childhood, and human services organizations across the White Earth Nation. The WECARE assessment acts as the universal assessment tool for integrated agencies and includes several questions on four priorities that constitute the health and wellbeing of the individual: mental, emotional, physical, and spiritual.

The WECARE approach was founded on their "no wrong door" philosophy in which residents living in White Earth can enter any program and get connected to a wide range of community services to address their health and social needs. The use of WECARE across the reservation will help White Earth Nation continue building on their two-generational work as well as own, collect, and interpret tribal data to help better serve the population.

The White Earth Development Team is comprised of 15 tribal agencies and spearheaded by White Earth Public Health Services. In addition to the tribal agencies using WECARE, they are working to have the tribal K-12 school, the sole tribal college, a child care program, and the Indian Health Services clinic use and conduct the assessment. When a client takes the assessment annually, it flags the needs they express and sends a notice to the respected agencies for follow-up.

Representatives from all the services flagged as needs meet with the client to develop a shared care plan and goals among all organizations. In three months, 82 WECARE assessments have been completed and 104 referrals were made to other agencies. The team is currently working on switching to a new data system that will allow them to pull reports that track the number of shared care plans created and implemented.

In addition, WECARE is implementing a mass communication campaign to introduce WECARE to the community, recruit more organizations to implement the assessment, and encourage the White Earth Reservation Tribal Council to pass a resolution to implement the WECARE assessment reservation-wide, thus solidifying its role in improving the health and wellbeing of White Earth residents.

Lessons Learned

The five DASH grantees featured differ in terms of the population served, the specific data they are working with, the data and technology assets within their communities, as well as local community partnerships and policy environments. Yet common themes and lessons learned have arisen as grantees have implemented their DASH projects over the last 18 months.

First, an essential lesson from the original DASH environmental scan—that trusted relationships enable the success of data sharing across sectors—was demonstrated repeatedly by each data sharing collaboration. At various decision-points, the partners in these communities came together to work towards solutions in response to legal, programmatic or technological setbacks. Often a perceived setback became an opportunity for innovation.

For example, in one project, planned data sources proved to be incomplete and of poor quality, so partners worked together to identify other useful data sources, discovering a very rich alternative. In another instance, legal issues took significantly more time than expected, so partners designed a common behavioral health screening tool to be used across settings, which is now a robust addition to their collaboration.

In the above cases, partners moved forward collaboratively. Of course, collaboration cohesion varies by community. One project struggled to agree on a technical solution that would meet the workflow needs of multiple partners, at the same time that leadership transitions at a key partner organization disrupted existing relationships. This community is still working to determine an acceptable solution for partners that remain at the table and are motivated by a common commitment to the same end goals.

In terms of the technical process of incorporating data from community service providers, and dealing with the lack of standardization therein, grantees developed some approaches that may be useful in other communities:

- **Review existing data sources for new uses:** HealthInfoNet conducted a scan of available data and identified two types of data that are already collected and available within data systems that feed into the HIE (although the particular data items were not previously mapped and being submitted). These include the unique fields that federally qualified health centers collect as part of reporting to HRSA, as well as non-emergency transportation claims provided for Medicaid beneficiaries.
- **Design and collect new kinds of data:** All other grantees, including Altair ACO, WECARE, CHCS, and PCCI, have taken the approach of building common data collection forms as a strategy for gathering needed data, which could be standardized across sectors.

> ***"Building the foundation of consent, relationships, and buy-in can take years. Don't underestimate how long it takes to get your relationships in place to do the work…The fact that we had very specific partners and set very specific goals is one of the reasons we're making progress as expected."***
>
> -Katie Sendze, DASH Project Director at HealthInfoNet

The organizational underpinnings of information exchange utilized by these five DASH grantees varies based on community resources. It remains to be seen how this variation will affect future scale and spread of the specific projects. For instance, HealthInfoNet, Altair, and CHCS are leveraging HIE organizations and existing technology and platforms. This has worked well in situations where local community providers are committed to a single HIE. Altair and PCCI have demonstrated success in leveraging technology that originated in the healthcare sector to meet the needs of providers in other sectors.

Other success factors vary, based on the unique assets in each community:

- In Maine, stakeholders have supported a single HIE solution since 2006—HealthInfoNet was designated as Maine's single HIE in 2011. This has resulted in widespread adoption. Ninety-eight percent of all Maine residents have a record in HealthInfoNet, which provides an opportunity to scale the learnings of DASH to residents statewide.
- The service providers within Altair have formed a tight collaboration that reflects the sharp focus of on a well-defined population. In the formation of their ACO, Altair is building on its clear governance, a passionate and engaged advocate community, an HIE with roots in providing software solutions for their specific population, and seed money from various federal programs funneled through the State of Minnesota.
- In San Antonio, the major local health systems have recently coalesced around a single HIE. However, not all important data sharing partners are on board yet, nor are partners outside of healthcare and behavioral health convinced that an HIE will deliver data in a way that fits within their workflows.
- Without the presence of an HIE in their communities, both PCCI and WECARE are building data sharing systems without that component. WECARE is unique in that local tribal government supported the initiative to adopt a common platform across tribal government service agencies.
- In Dallas, PCCI independently developed a shared data platform for community partners, which has since been spun off into a private for-profit technology venture. Leadership there regards DASH as a test case with potential to spread to other social service providers.

> ***"You are dealing with a lot of competing priorities, especially with the amount of regulation that this sector is challenged with. So we are constantly validating and gaining understanding to ensure that we provide that education as a part of a continuous roll-out process."***
>
> -George Klauser, DASH Project Director at Altair ACO

Next Steps

The 18-month time frame of the DASH grants allowed grantees to create work plans, sign legal agreements, assess existing structured data, create data collection forms and, in some cases, build technical infrastructure. Some of the grantees are just now starting to share data with the actors meant to use it. Where data integration has begun, adapting new work flows based on integrated data and developing end user training are hot topics among this set of DASH grantees.

CHCS, for instance had a major focus on converting data from the HIE into usable and timely information for their care managers, which required considerable investment in their internal information system. Altair went live with alerts and the care plan and are now doubling back on training for participating providers around workflows to optimize use of the data in meeting the needs of clients. HealthInfoNet has non-emergency transportation data flowing to the HIE, but is still working on integration of other data. A prototype of the community services tab for the provider portal has been reviewed by partners, but they await completion of the build by the vendor before they can measure the true value of the information to care managers and their patients.

As the DASH grantees wrap up this stage of their funding relationship with the Robert Wood Johnson Foundation, the DASH National Program Office and the grantees themselves remain committed to furthering the learning and knowledge development already undertaken. These grantees expect to continue participating in the field of local multi-sector community data sharing through *All In: Data for Community Health*, a network of networks dedicated to maintaining and building the knowledge base for the field. These care coordination pioneers have generated lessons, examples and use cases that are invaluable to others in the field, and DASH and All In provide the vehicles for them to continue sharing their important and innovative stories.

To learn more, visit:

dashconnect.org and allindata.org