



Data Across
Sectors for Health

Interconnected: Data, Knowledge, and Action for Community Health



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Ten Mentee Spotlights Illustrating
Lessons Learned from the DASH
Mentor Program and Multi-Sector
Data-Sharing Efforts

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Data Across Sectors for Health (DASH) is a national initiative of the Robert Wood Johnson Foundation (RWJF), led in partnership by the Illinois Public Health Institute (IPHI) and its Michigan counterpart, MPHI. For more information, please visit DASHconnect.org



A Note from the Program Director

Data Across Sectors for Health (DASH) is a national initiative that looks for new and better ways to share data across different communities.

DASH is funded by the Robert Wood Johnson Foundation, which enables the initiative to serve as a connection point for learning and innovation.

Our funding includes a \$650,000 Mentor Program that reaches 104 communities across 38 states. This program offers coaching and peer-to-peer learning so that Mentee organizations can forge multi-sector partnerships. We deliver the program through a total of three funding rounds.

In this publication, we feature ten Mentee collaborations from the first two rounds of the program. We share case studies to highlight how Mentee communities can make progress in using their voice to shift power and build trust among partners and across sectors.

More critically, these examples illustrate how sharing data has real-world effects. We show how a magical transformation occurs when digital bits of information improve the health and well-being of real people in real communities.

However, this work is not without its challenges. A common difficulty in this field comes from bridging understandings.

Communities and sectors have different objectives, and they possess different types of knowledge. Differences in priorities and jargon are inevitable, so much so that using distinct terminologies creates a “language barrier” within a shared spoken language.

To overcome these barriers, DASH decided to break communities out of their silos. A simple solution coming out of the first two rounds of the program was for DASH to require two to four organizations to participate in the program activities.

In other words, DASH has shifted from “matchmaking” to “translating.” As a result, DASH now prioritizes a greater diversity of applicants from education, housing, early childhood development, and other health-focused sectors.

Data helps us “look under the hood” and see what truly impacts community health. Ultimately, data helps us refute myths that are perpetuated by pain and privilege, so we may construct better narratives built on facts and empathy.

Similar to the effects of data sharing, COVID-19, too, has stripped away semblances. As harrowing as the pandemic has been, it has helped us gain a deeper understanding about the threats that structural and systemic discrimination pose to Black and brown communities.

It’s fair to say that COVID-19 has further solidified our determination to elevate innovation in the public health space and to amplify the impacts of sharing data across communities.

As DASH closes the third cohort of the Mentor Program, we are now exploring ways to sustain our momentum.

We hope to expand our reach in funding to include more community-based, Black- and brown-led organizations that understand the potential of data sharing to dismantle systemic racism and other forms of oppression.

We thank you for sharing your time, energy, and effort with us and hope that this publication will offer insights, ideas, and inspiration to you and your community.

Should you have questions or want to learn more about DASH and the Mentor Program, please visit dashconnect.org. You can also email us at info@dashconnect.org, or connect with me directly at anna.barnes@jphionline.org.

Anna Barnes, MPH
Program Director

Data Across Sectors for Health (DASH)

A national program of the Center for Health Information Sharing and Innovation at the Illinois Public Health Institute

About DASH and the DASH Framework

The Data Across Sectors for Health (DASH) initiative helps organizations in the public health, social services, and health care sectors share data with one another. Sharing data across sectors informs policies and practices, which then contribute to better health and racial equity in the nation.

The Illinois Public Health Institute (IPHI) leads the initiative in partnership with the Michigan-based public health institute MPHI. Together, IPHI and MPHI make up the Program Office of DASH, which is funded by the Robert Wood Johnson Foundation.

DASH provides funding, resources, and tools to organizations to increase their capacity to use data to improve the health of communities.

More specifically, we support projects that collect granular and timely data, make information available to community residents, inform policy changes, and address systemic barriers to health. Our end goal is always to help people and their communities as we build the evidence base for a national movement.

We offer multiple funding opportunities through DASH, and this publication details case studies and learnings from our Mentor Program. Under this funding program, seven experienced organizations help small groups of Mentee organizations develop their own data sharing abilities.

We've learned a lot since the early days of DASH. We've come to appreciate the critical importance of involving people with lived and learned experiences in order to address the structural and social factors that impact people's health. And we've learned more about the complex issues of financing and managing data.

Our Program Office captured these learnings in our recently updated DASH Framework. In short, the Framework highlights factors we found to be essential for sharing and using data across sectors.

These factors include building strong community foundations by sharing power among communities, building trust and partnerships, and creating a shared vision.

Mapping out and maintaining the various elements of our data ecosystem are also critical. The main considerations include human and organizational capacities, accessible technology, data standards and governance, sustainable financing, and an intentional approach to centering equity across the data lifecycle.

Finally, our framework recognizes the importance of contextual factors, which include state and federal policies, as well as various market forces.

Naturally, different factors come to the fore depending on the specific requirements of each data sharing project. You will see references to how a community made progress along the Framework domains in each Mentee spotlight.

This progress comes from self-reported survey data collected at the end of the project where Mentees reflect on the extent to which they made advancements — to “some extent” or “a great extent.” These data points should help our readers learn from each Mentee and, we hope, connect with them to inform future data sharing projects.



Generate Health

St. Louis, Missouri

THE CHALLENGE

Black women and birthing people in the United States are nearly three times more likely to experience pregnancy-related deaths than their white counterparts. They experience higher rates of pregnancy complications, infant loss, and miscarriage.

Sadly, the numbers rise above the national average in the state of Missouri. According to the [2018 Missouri annual report](#), Black women and birthing people in the state are four times more likely to die in childbirth than white women.

When we focus on the city of St. Louis specifically, we find that infant death rates in parts of the city and the county are worse than in some developing countries. It is odd to see so much pain and suffering in a city that's home to some of the best medical care in the country. So, what explains the disconnect?

“Let’s be clear,” says Sarah Kennedy, Senior Manager of Epidemiology & Evaluation at Generate Health. “This is not a poor problem or a genetic problem. It is a race problem. It is about the stress of being Black in America. Trauma transferred over generations. That has an effect. Systemic racism. That has an effect. If we were going to change things in St. Louis, these are the things we have to change.”

Black pregnant and parenting families have been historically left out of decision-making in their communities. The disconnect between health systems and the community members they serve is a direct result of this exclusion.

Community Snapshot

Organization: Generate Health

Partners: Organizations and community members involved in FLOURISH St. Louis

Community: St. Louis, Missouri

Capacity Built / Progress Made in following DASH Framework Domains:

Shared power with community | Standards

Mentor Round 1: The Civic Canopy

Mentor Round 2: Elevate Health

About the Mentee

Generate Health improves birth outcomes, promotes healthy families, and builds healthy communities. They advocate for the redirection of resources in order to eliminate racial disparities in infant mortality and maternal health. The organization catalyzes action and advances regional accountability for equitable systems.

“COVID derailed our plans, but having someone to **explore and work** through different topics related to data and evaluation was **invaluable** for advancing our project.”

Sarah Kennedy, Senior Manager of Epidemiology & Evaluation, Generate Health

Generate Health works to correct these historical injustices by building a community where Black moms and babies can thrive. The organization now advocates quality healthcare access before, during, and after pregnancy for expecting mothers. These are non-negotiable terms in making sure that Black babies are born healthier.

“We really were taking the lead from the ‘Forward Through Ferguson’ report for creating a path toward racial equity,” explains Kennedy. “The goal was to eliminate infant mortality by 2033 addressed through a racial equity lens looking out one generation beyond Michael Brown.”

THE EXPERIENCE

As part of the DASH Mentorship Program, Generate Health has developed goals to help community-based organizations. Their work focuses on disaggregating and analyzing the data these organizations hold.

This, in turn, helps the organizations understand where they can improve, how they can better share data, and how they can learn more about what contributes to the challenges in their region.

Generate Health partnered with DASH Mentor Elevate Health during the mentorship program. Elevate Health is based in Tacoma, Washington. Their work weaves together health systems’ data with public health and population health information to create a complete picture of a community and its care needs.

In this partnership, Generate Health explored four main approaches to using data for change:

- Storytelling for systems change
- Building (virtual) community data sessions
- Using evaluation for sustainable funding
- Building case studies

As part of their mentorship, Elevate Health offered an inside look at their own data strategy. This meant guiding Mentees through the process of creating a data approach that integrates community voice and translates better governance models into actual health equity.

Meaningful system-level change happens when the people experiencing health inequities are driving the key strategies and are holding decision makers accountable. The positive impact is well worth it, even if this approach requires extra support and creativity.

“We plan to use this new approach to data to provide better access to health care, bring racial disparities in health to zero, and recruit community leaders living in high-impact zip codes that have adverse birth outcomes,” Kennedy says.

FROM LEARNING TO ACTION

Systemic and structural racism plays a significant role in birth outcomes. That is why the staff at Generate Health understands the importance of having a trauma-aware and culturally sensitive healthcare system and workforce. On top of that, the potential for change increases significantly when the work is supported by data collection, analysis, and sharing across sectors.

Since finishing their mentorship, Generate Health developed a [Guide for Evaluation for Systems Change](#). The guide is a road map for implementing their knowledge within the community.

In the summer of 2021, they also hosted Virtual Data Sessions with community members. The goal was to build infographics and a story map. They also set out to build a data visualization dashboard that highlighted key priority areas to support peers and collaborators in their work with the St. Louis community. The tools developed from these sessions are in production and will be shared with the *All In* network when available.





Humility Homes and Services, Inc.

Greater Quad Cities area of Illinois and Iowa

THE CHALLENGE

“Why can’t they just get a job?” That’s the question you hear most often when people who aren’t familiar with the complexities of homelessness discuss the topic. Humility Homes and Services, Inc. knows that the issue is more nuanced than that.

“Getting a job” isn’t the best solution when someone is dealing with substance abuse, domestic violence, job loss, divorce, little or no family support, and more. Just a single setback can trigger a domino effect. Falling ill, for example, could mean missing work, which can rapidly upset someone’s overall financial stability and housing security.

This is the reason why the research-backed movement “Housing is Healthcare” is gaining traction among health and hospital systems. The movement looks at the big picture and promotes the health benefits of supportive housing.

In that spirit, Humility Homes and Services, Inc. and its community partners prioritize specific individuals with a higher need for supportive housing. They do this by matching data from diverse sources: the Homeless Management Information System (HMIS), healthcare utilization data, plus incarceration and arrest records.

THE EXPERIENCE

Humility Homes and Services, Inc. partnered with DASH Mentor Corporation for Supportive Housing (CSH). CSH was founded on the idea that people living on the streets deserve a safe home, surrounded by the care they need to thrive.

Community Snapshot

Organization: Humility Homes and Services, Inc.

Partners: Institute for Community Alliances (Homeless Management Information System managing entity)

Community: Greater Quad Cities area of Illinois and Iowa

Capacity Built / Progress Made in following DASH Framework Domains:

Trust and partnerships | Shared vision | Technology | Data governance | Standards | Human and organizational capacity

Mentor Round 2: Corporation for Supportive Housing

About the Mentee

Humility Homes and Services, Inc. is committed to ending homelessness by offering housing opportunities and supportive services in the greater Quad Cities area of Illinois and Iowa. They believe that everyone should have a future that isn’t dictated by their past, and they rely on the power of partnerships to work toward ending homelessness. Humility Homes and Services, Inc. provides Housing First programs that prioritize the need for quality and safe housing. To date, they have served more than 1,100 people, including 102 children under 17 and 227 veterans and their families.

“It is exciting to see what has worked in other communities to see what is possible. This mentorship helped **expand the vision** of some community members and **alleviated trial-and-error** work that will take time when we can utilize tools and experiences that have proven to work.”

Ryan Bobst, Strategic Initiatives and Grants Manager at Humility Homes and Services, Inc.

Together, Humility Homes and Services, Inc. and CSH worked to identify a subpopulation that was engaged in non-housing social service programs. They knew these people would benefit from targeted supportive housing.

“We were looking at people in the justice system or utilizing emergency rooms for their primary care or emergency shelter,” explains Ryan Bobst, Strategic Initiatives and Grants Manager at Humility Homes and Services, Inc.

CSH shared their expertise on how to best use COVID-19 relief funds to expand housing intervention. They also gave technical guidance on data integration. CSH provided this mentorship through webinars, office hours, peer-to-peer meetings, and one-on-one meetings.

DASH connected Humility Homes and Services, Inc. to attorneys from Network for Public Health Law as well. The attorneys offered insights on how to navigate the legalities of data sharing for public health and housing response.

“Our mentor (CSH) helped us strategize on engagement, especially with the healthcare system, since there were so many data privacy concerns. We started talking to other communities to be more data-driven before we started the housing,” Bobst notes.

It must be mentioned that managing COVID-19 drastically impacted the team’s ability to participate in the mentorship. This is largely due to Humility Homes and Services, Inc. being a direct-service provider that operates emergency shelters and other congregate housing.

Nonetheless, Humility Homes and Services, Inc. demonstrated true grit. They found staff capacity and resources to re-engage with the project and made tremendous strides.

Finally, CSH facilitated conversations between Humility Homes and Services, Inc. and the local entity that manages the Homeless Management Information System called Institute for Community Alliances.

This ultimately helped Humility Homes and Services, Inc. achieve their original goal of executing a data-sharing agreement.

FROM LEARNING TO ACTION

Humility Homes and Services, Inc. have begun their data-sharing work since finishing their mentorship. Better yet, they even redesigned their project to incorporate feedback from CSH and include COVID-19 and other racial and demographic variables in their datasets.

“We got ten people housed. People stopped going to jail, the hospital, the emergency shelter, which was really the point. We created a tool to prioritize people in all three systems. We flagged interconnections in a Venn diagram where the three systems overlapped to benefit chronically homeless individuals that connected to all three systems,” Bobst explains.

That’s the power of data. Indeed, DASH’s work with Humility Homes and Services, Inc. helped the organization build new and improved housing and service interventions in the community. They expanded their capacity to translate the value of data sharing to direct action—to changing real lives.





Advocate Aurora Health

Milwaukee County, Wisconsin

THE CHALLENGE

You'd be forgiven to think that the re-entry of formerly incarcerated individuals into the community is merely a matter of justice. The fact, however, is that re-entry is just as much a matter of health care. Case in point is how AAH cares for 80,000 justice-involved individuals in Milwaukee County alone.

But this connection hasn't always been clear. In fact, learning the true scale of the justice-involved population in AAH's care was a discovery that came out of a data-sharing effort between AAH's Center for Urban Population Health (CUPH) research team and various municipal and local justice institutions in Milwaukee County.

The collaborating parties matched ten years of individual data from Milwaukee County jails and Wisconsin prison facilities to the electronic medical records of AAH. What fell out was a subpopulation of 80,000 people. This is a staggering revelation: Tens of thousands of people would have remained "hidden" in plain sight had the datasets continued to sit in silos.

Going forward, AAH believes that collaboration and sharing data across multiple agencies will be foundational to the sustainability of their critical work. Sharing data is also essential to expanding their work beyond Milwaukee County.

However, in order for different agencies to come to the table, stakeholders must agree upon a shared vision and use cases. Therefore, AAH and their DASH Mentor, Center for Outcomes Research and Education (CORE), began the mentorship with a focus on articulating the purpose and desired outcomes generated through shared data.

Community Snapshot

Organization: Advocate Aurora Health

Partners: Wisconsin Department of Corrections, Progressive Community Health Center

Community: Milwaukee County, Wisconsin

Capacity Built / Progress Made in following DASH Framework Domains:

Trust and partnerships | Shared vision

Mentor Round 2: Center for Outcomes Research and Education (CORE)

About the Mentee

Advocate Aurora Health (AAH) is the 11th largest nonprofit integrated health system in the U.S. They are present across 500 sites of care in Illinois and Wisconsin. AAH is committed to leading the way within the rapidly changing healthcare industry, and this ambition is underscored by the 3 million people who have chosen AAH as their trusted healthcare partner. The experience of their consumers guides the vision of AAH, empowering the nonprofit health system to offer new possibilities in the diverse communities they serve.

THE EXPERIENCE

CORE comprises a team of scientists, researchers, and data experts. Collectively, they nurture a vision of a healthier, more equitable future. CORE’s work focuses on shaping systems, policies, community conditions, and on creating better health care for everyone.

During their mentorship, CORE shared invaluable knowledge about different aspects of data sharing. They showed how to communicate persuasively and articulate a clear vision and purpose. They proposed the best ways to find and use data and ask key questions of stakeholders. And they explained how best to avoid common data-sharing roadblocks.

Kurt Waldhuetter is vice president of research development and business services for the Advocate Aurora Research Institute. [In a press release](#), he recognized the partnership with DASH as essential to improving the health of underserved communities.

In his view, research can strengthen the flow of information between the health systems and critical community services in the Upper Midwest. This is important when data sharing between health systems is limited through the state health information exchange.

On the flipside, real lives can change for the better when multiple agencies have access to individual-level data. The simple reason for this is that working collaboratively across sectors can help agencies pinpoint stereotypical healthcare usage patterns in vast datasets.

In other words, agencies can reveal where and why community members cycle through multiple systems—and this knowledge is critical for designing effective interventions.

That is why AAH expanded their vision through their mentorship with CORE. They began integrating data on healthcare utilization, justice system contact, and housing instability. Their long-term ambition is to increase each entity’s capacity to provide more efficient care coordination across agencies.

By refining their use case, AAH partnered with a local Federally Qualified Health Center called Progressive Community Health Center (PCHC). The idea for AAH was to implement a specialized care model where they would integrate those who were recently released from incarceration into culturally competent primary care.

“Anything is possible when we apply our imaginations and knowledge toward our purpose of helping people live well.”

Kurt Waldhuetter, Vice President of Research Development and Business Services, Advocate Aurora Research Institute

To that end, AAH and the Wisconsin Department of Corrections (DOC) developed a data use agreement with a rolling three-month projection of DOC releases to determine any historical connections between AAH and patients nearing release.

A designated intermediary person initiated a screening of medical eligibility for the program. They also began a conversation with the patient prior to their release in order to learn if they were interested in enrolling.

PCHC joined this collaboration at a later date via a third-party agreement. This allowed AAH to expand the scheme to additional future releases who may be eligible.

The collaboration designed a database in REDCap, a software for designing databases that was developed by Vanderbilt University. The idea was to house cross-sector data on individuals who are enrolled in the program. The data includes social risk needs, justice utilization, and healthcare utilization, all of which helps with care management and quality improvement.

A work process of this importance and complexity has its own challenges. One such challenge is determining an appropriate comparison group—a “control group” if you will. Other challenges include the need for manual data entry and finding funds for analysis. The collaboration will also require the informed consent of participants before any information can be used.

Sarah Reimer is Nuclear Radiologist at Advocate Aurora Health. She says, “Success at the small local level will likely be necessary and foundational to larger work.” She credits the inclusion of community health workers with lived incarceration experience. Their inputs are invaluable as AAH screens for housing and other social determinant needs.

FROM LEARNING TO ACTION

Representatives from AAH, PCHC, and the largest local DOC facility continue to meet monthly. They provide a strong feedback loop to increase collaboration. They also discuss any issues that arise within their referral pathway that connects correctional health to community health at either AAH or PCHC, even if they are not historical patients.

Empowered by their work with DASH, AAH is now working on the following:

- Build trust and gain approval to access to the Housing Division’s HMIS database on shelter utilization and homelessness, and gain permission to link the data with justice utilization data;
- Integrate justice, homelessness, and electronic medical record (EMR) data for care management and evaluation, after having decided on an ultimate structure for the integrated data; and,
- Design and implement any consent processes necessary with other sectors to enable additional data sharing.





THE CHALLENGE

In Minnesota, health systems focus on providing patients with resources to help address their needs. The result is a complex landscape of services for healthcare and social service providers. In other words, Minnesota does not have a coordinated community-driven approach.

Greater Twin Cities United Way funds and manages United Way 2-1-1, a helpline where people can obtain free and confidential information on health and human services. As such, United Way 2-1-1 serves as a unified platform that pulls together relationships, data management, and technology resources.

Nearly 60 percent of 2-1-1 contacts are currently related to housing needs. This means GTCUW is in a unique position to become the trusted hub of resources and referral data for local healthcare and nonprofit organizations.

The 2-1-1 program has undergone significant transition and growth over the past two years. But going forward, they needed to establish equitable data-sharing policies and protocols that can be applied to partnerships across different sectors.

THE EXPERIENCE

DASH paired GTCUW with Mentors from United Way Worldwide (UWW). UWW advances the common good in communities around the globe by focusing on the building blocks for a good life: education, income, and health.

UWW coached with equity and sustainability in mind. They hosted deep-dive conversations on business models and on putting data sharing into use. Plus, they shared insights on minimizing pain points and earning the buy-in of stakeholders.

Community Snapshot

Organization: Greater Twin Cities United Way

Community: Twin Cities, Minnesota

Capacity Built / Progress Made in following DASH Framework Domains:

Trust and partnerships | Shared vision

Mentor Round 2: United Way Worldwide

About the Mentee

The mission of Greater Twin Cities United Way (GTCUW) is to unite as changemakers. They advocate for social good and develop solutions that address the challenges no one can solve alone. Equity is a critical part of this mission. But what distinguishes them is how user feedback informs their work as they give a seat at the table to those with lived experience.

It was immensely helpful to have a **group of experts** to consult with as we navigated real-time situations. We were new to some of these topics and having **candid conversations** with others who have done this work before was invaluable in helping us learn and feel more confident.

UWW also provided invaluable guidance on how they incorporate equity into every aspect of their work. They are a credible source in this regard, given how community voice is a critical foundation of their work.

GTCUW went into the mentorship program with a desire to develop a strategic perspective on data sharing. They were looking to learn more about formulating new relationships and engaging in data-sharing partnerships.

FROM LEARNING TO ACTION

GTCUW is grounded in community relationships. They have essential 2-1-1 resource data, which makes them a backbone community provider, and the mentorship program helped GTCUW further cement their position in the community.

The mentorship also allowed GTCUW to work with community partners and peer organizations on bridging the data gap between healthcare and housing programs.

In fact, many 2-1-1s have established community information exchanges (CIEs) and other similar data-sharing arrangements. For this reason, GTCUW had a series of discovery meetings with other 2-1-1s to learn about the best ways to structure the governance and financial aspects of their own work as they move forward.





United Way of Northern Shenandoah Valley

Shenandoah Valley region, Virginia

THE CHALLENGE

The Northern Shenandoah Valley is a rural Appalachian area that has very limited access to mental-health providers. Sadly, this problem pairs with an increased rate of drug overdoses and suicides.

The Valley Health System knows that access to care must be a priority issue under these circumstances. Patients, clients, service providers, and partners confirmed this during roundtable discussions. The case for change is clear-cut.

This is not to say that there aren't available safety-net organizations in the area. Various resources exist. However, organizations are siloed and struggle to communicate information to one another.

That's where United Way of Northern Shenandoah Valley (UWNSV) saw an opportunity. The organization could potentially function as a "dispatching" system: They could connect individuals and families with the services they need. To that effect, UWNSV launched the Connect NSV network in August 2019 in partnership with Valley Health System and George Mason University.

This network of partner agencies addresses equity through a coordinated care network. They link health and human service providers, and they integrate health and social care. The method is straightforward: Providers across sectors can send and receive secure referrals, track a person's total health journey, and report on the outcomes.

Community Snapshot

Organization: United Way of Northern Shenandoah Valley

Partners: Blue Ridge Habitat for Humanity, Faithworks, Blue Ridge Housing, Sinclair Health Clinic, Valley Health System, Winchester Public Schools, Frederick County Public Schools, and many more

Community: Shenandoah Valley region, Virginia

Capacity Built / Progress Made in following DASH Framework Domains: Trust and partnerships | Shared vision | Technology | Human and organizational capacity

Mentor Round 2: United Way Worldwide

About the Mentee

United Way of Northern Shenandoah Valley (UWNSV) works to increase the organized capacity of people to care for one another. UWNSV focuses on creating large-scale, population-level social change, while intentionally engaging community members to improve their quality of life. In that spirit, UWNSV launched the Valley Assistance Network (VAN) in 2017. VAN is a resource and referral program that connects individuals and families with the resources they need to move from crisis to financial stability.

Connect NSV is making considerable headway. However, they are experiencing growing pains. As they expand their work, they need to find better ways to increase engagement among network partners and collect data points.

THE EXPERIENCE

UWNSV paired with United Way Worldwide (UWW) under the DASH Mentorship Program. Together, they worked to increase the points of care within agencies. The ambition was to improve end-to-end care coordination within various care systems.

UWW advances the common good in communities around the globe by focusing on the building blocks for a good life: education, income, and health.

As with other Mentees, UWW coached UWNSV with a focus on equity and sustainability. They hosted dedicated discussions on business models and on putting data sharing to use. They shared insights on minimizing recurring problems and earning the trust of stakeholders.

In addition, UWW brought two local United Way organizations on board to serve as peer leaders to Mentees. The peer coaches joined one-on-one meetings and provided real-time technical assistance. This collaborative approach made practical experiences on data sharing available to UWNSV, which eliminated the need to develop redundant processes.

UWNSV started their mentorship with DASH with a three-fold goal:

1. Develop a work plan to increase partner-to-partner referrals by 150 percent;
2. Achieve the funding to expand the network and data-sharing platform; and
3. Learn how to enhance relationships and trust with network partners.

Impressively, UWNSV has quickly progressed on their primary goal of increasing partner engagement and collaboration during their mentorship.

“Our work with DASH validated our need for a **robust data-sharing** network and ended up being perfect timing for us to expand the **connections** within our network in order to provide disaster relief funding.”

Jennifer Hall, Senior Director of Community Investment, United Way of Northern Shenandoah Valley

FROM LEARNING TO ACTION

UWNSV set a goal to have 50 referrals across agencies by the end of 2020. They surpassed that goal by securing 198 referrals—and they resolved 458 cases in which clients who had been seeking resources received what they needed.

An additional and unintended outcome of the DASH Mentorship Program was the creation of UWNSV's COVID-19 Fund. Agencies looking to support housing, food, utilities, and more received the funding through the data-sharing platform.

UWNSV also developed a communications strategy during the pandemic by sending out a monthly newsletter that highlighted partner success stories and shared infographics explaining how the network can improve workflows.

By demonstrating the “art of the possible,” UWNSV earned the buy-in of its partners—and this success had a snowball effect. The agency's standing with local government improved, which led to a request for UWNSV to manage \$400,000 in CARES Act funding for housing support.

UWNSV is now ready to spread their data-sharing effort and grow their network throughout Virginia in coordination with United Way Worldwide.





Minneapolis Public Housing Authority

Minneapolis, Minnesota

THE CHALLENGE

Minneapolis Public Housing Authority (MPHA) serves more than 26,000 people. They coordinate initiatives on health, education, and employment for residents of public housing units. As such, they are an anchor institution within the community.

For years, MPHA worked with the Minneapolis Health Department to improve the health of residents. Namely, MPHA wanted to improve pedestrian safety and bring community health workers into high-rises. They also wanted to increase access to health and social services for the families and individuals they serve.

As part of these efforts, MPHA arranged to match datasets with the Hennepin County government. This project revealed that public housing residents were disproportionately more likely to go to the emergency room.

In fact, MPHA residents rely on emergency room services three times as often as other elderly and disabled people on Medicaid within the state of Minnesota.

There wasn't enough data available to shed light on all the factors that might drive this trend. However, even without nuanced data, it was clear to MPHA staff that residents were simply not getting the care they needed.

THE EXPERIENCE

MPHA partnered with the DASH Mentor organization the Center for Outcomes Research and Education (CORE). CORE is composed of scientists, researchers, and data experts who all work toward a healthier and more equitable future.

Community Snapshot

Organization: Minneapolis Public Housing Authority

Community: Minneapolis, Minnesota

Capacity Built / Progress Made in following DASH Framework Domains:

Shared power with community | Trust and partnerships | Human and organizational capacity

Mentor Round 1: Center for Outcomes Research and Education (CORE)

About the Mentee

The mission of the Minneapolis Public Housing Authority (MPHA) is to promote and deliver quality and well-managed homes to a diverse, low-income population. Working with partners, they strive to contribute to the well-being of individuals, families, and communities. MPHA works to assure the homes they provide are here for decades to come for those who need them the most.

The **broad range of knowledge** and experience within our CORE mentorship team was invaluable. They made really helpful suggestions to move our work forward in a variety of areas and connected us to **valuable resources in more areas than we expected.**

MPHA wanted to parlay their DASH mentorship to better understand the needs of their community. When the DASH mentorship started, there were already multiple agencies and nonprofits in the high-rises providing services to the residents.

The presence of multiple providers suited MPHA's goals, since the housing authority wanted to develop a strategic data-sharing plan that could help them build a more complete understanding of health. More sources of data would mean a more complete picture of health.

However, there was little to no coordination between all the nonprofits and agencies that were serving the residents. This is where CORE stepped in to provide guidance to MPHA on how to develop an effective approach, connect with the right partners, and make use of multi-sector data sharing.

FROM LEARNING TO ACTION

MPHA managed to grow their capacity for engaging with public health and health care. They achieved this through one-on-one coaching calls and peer consultancy opportunities. Ultimately, this helped MPHA partner with new sectors. For instance, they held a Health and Housing assembly, which led to further relationships with the health sector.

MPHA also secured a DASH Community Impact contract. This allows them to carry out further work on a data dashboard that can bridge the gap between different organizations and agencies. The dashboard will use a human-centered design process to serve residents.

Finally, MPHA launched the Highrise Health Alliance to foster the relationships established during their mentorship. The main priorities for the alliance are providing access for residents to primary care, medication management, and mental-health services.





2-1-1 Broward

Broward County, Florida

THE CHALLENGE

2-1-1 Broward serves as a gateway to more than 1,200 of Broward County's nonprofits. They connect residents to vetted programs that can respond to immediate needs. This is highly valuable, as it allows nonprofits to focus on service delivery instead of fielding phone calls.

2-1-1 Broward collects an enormous amount of data through their intake and referral process. Yet, there aren't proper systems in place for agencies to "talk" to one another about program capacities or waitlists. This leads to a community care system that's difficult to navigate.

Leadership at 2-1-1 Broward recognized that transitioning to an open and shared data platform would help agencies pinpoint gaps in services for specific populations. A new platform for sharing community-wide data could then translate to an increase in equity and community investments in targeted neighborhoods.

2-1-1 Broward began to encourage the buy-in and participation of nearly 1,000 organizations in their network. However, they needed guidance for a project of this scope.

Luckily, DASH Mentor 2-1-1 San Diego had already been doing similar work, and they were further along in advancing their own community information exchange (CIE). DASH provided an opportunity for Broward County to connect with 2-1-1 San Diego, which meant that 2-1-1 Broward could follow a successful template rather than "reinvent the wheel."

Community Snapshot

Organization: 2-1-1 Broward

Community: Broward County, Florida

Capacity Built / Progress Made in following DASH Framework Domains:

Shared power with community | Trust and partnerships | Shared vision | Standards

Mentor Round 2: 2-1-1 San Diego / Community Information Exchange

About the Mentee

2-1-1 Broward is a 24/7 comprehensive agency in Broward County, Florida. They provide individuals and families with all the necessary connections to health and human service agencies and programs in a single call. Over the past six years, 2-1-1 Broward's call volume has averaged 116,000 incoming calls a year. Almost 50 percent of those calls were for basic needs services including food, shelter, rent, utilities, and public assistance. Today, more calls than ever come from individuals who have never used 2-1-1 or who have never needed to access services.

“2-1-1 San Diego’s willingness to **share information, guidance, and their expertise** was invaluable. Their race-forward approach is unlike anything we’d seen. We were so inspired by their **powerful anti-racist framework** and were able to make progress on our goals to a great extent due to their support.”

William Spencer, Chief Social Enterprise Officer, 2-1-1 Broward

“Personally, I was just excited about this project,” says William Spencer, Chief Social Enterprise Officer at 2-1-1 Broward. “I did my Google research. I found CIE San Diego. They were doing amazing work! They were always committed to equity as an idea. Data as a means of achieving equity! So, they required equity outcomes.”

THE EXPERIENCE

When you factor in all the variables that might contribute to a person’s health, it becomes much easier to prescribe the right measures that shift behaviors, eliminate barriers to care, and save lives.

That was 2-1-1 Broward’s thinking as they approached their mentorship with 2-1-1 San Diego. In short, their goals were to:

1. Gain more insight into data sharing;
2. Build capacities within their local community; and
3. Create a user-friendly information exchange that collects, protects, and shares data with the necessary organizations and agencies.

Throughout the mentorship, 2-1-1 Broward partnered with community members with lived experiences of poverty, food and housing insecurity, and various other circumstances.

Ultimately, 2-1-1 Broward aimed to partner with the community to build a census and create community-first programming. In fact, the first time they brought together interested stakeholders was during the mentorship.

“We convened our first conference on the question of ‘what’s possible?’” Spencer explained. “We worried it would be one of those ‘what if you throw a party and no one came?’ It was standing room only. Our focus was to build community consensus for the CIE. We only planned on 108 to 110 attendees. We sold out! That was a success.”

Engaging community-based organizations is no easy task. Plus, you must think through sustainability models, understand data ownership, navigate technical discussions with technology vendors, and review the data you hold. The list goes on. To endeavor alone on a journey like this is daunting, to say the least.

Mentors, however, can help to eliminate much of the anxiety around these undertakings. 2-1-1 San Diego showed great leadership as they shared firsthand experiences and resources with 2-1-1 Broward. The mentorship helped 2-1-1 Broward develop key collaboration and infrastructure pieces that are necessary to advance a CIE.

FROM LEARNING TO ACTION

Since ending the mentorship program, 2-1-1 Broward has achieved several of their goals as they continue to build an effective CIE for their community. Moving forward, 2-1-1 Broward plans to explore the most important social determinants of health in systems-level change.

So far, they have done the following:

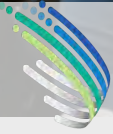
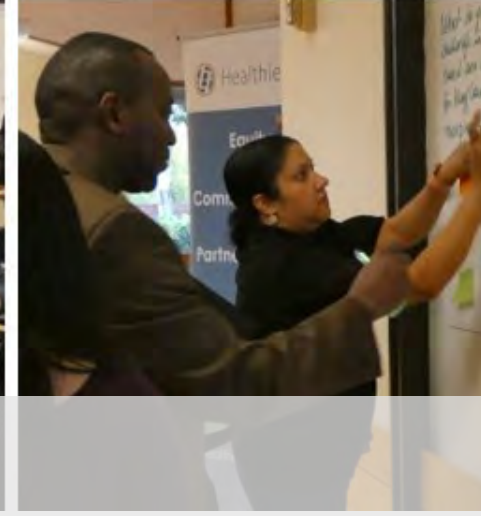
1. Convened a group of approximately 120 stakeholders for a one-day assembly that focused on creating a strong ethical framework;
2. Engaged people with lived experience and people whose data was already in the system, and added a racial equity lens to all activities;
3. Formed strategic partnerships with a significant foundation and local business leaders; and,
4. Planned a reconvening for January 2022 of their stakeholder steering committee with a goal to launch a pilot CIE project later in 2022.

Get Connected To

Housing • Food • Rent
 Health • Seniors • Disabilities
 Substance Use • Teen Concerns
 Questions About Child Development
 Mental Health • Suicide Prevention
 Utilities • Child Care • Employment
 Legal • Emotional Support
 COVID-19 Support • LGBTQ
 Financial Assistance

Dial 2-1-1
 24 Hours a Day
 Text Your ZIP Code to 898211

2-1-1
 Broward
 211-broward.org



HealthierHere

King County, Washington

THE CHALLENGE

HealthierHere is an Accountable Community of Health (ACH) organization in King County, the most populous county in Washington State. ACH organizations effectively function as a bridge between healthcare delivery systems and local communities.

As an ACH, HealthierHere has their work cut out for them. They mediate between the region’s healthcare and social service providers, which include hospital systems, Federally Qualified Health Centers (FQHCs), behavioral health agencies, tribal health providers, local jails, and community-based organizations.

The organization also leads the region’s Medicaid Transformation Project (MTP) efforts. The MTP is a five-year agreement where the federal government invests in the Medicaid delivery system of the state of Washington.

As part of this agreement, HealthierHere has a contract with the largest healthcare purchaser in the state, the Health Care Authority, to improve the health of more than 400,000 Medicaid participants.

The main challenges in HealthierHere’s work come from the lack of a unified data-sharing system. This creates barriers at both the population health level and at the point of care.

This was confirmed during HealthierHere’s stakeholder engagement process, where partners expressed an urgent need for a technical solution that would help with the exchange and integration of the various data that organizations collect.

Community Snapshot

Organization: HealthierHere (Washington State Accountable Community of Health—King County)

Partners: Crisis Connections (2-1-1)

Community: King County, Washington

Capacity Built / Progress Made in following DASH Framework Domains:

Trust and partnerships | Shared vision | Standards

Mentor Round 1: HealthInfoNet

About the Mentee

HealthierHere works to improve the health and well-being of people in King County. The organization aims to create a connected system of whole-person care that focuses on prevention, embraces recovery, and eliminates disparities. They believe the key is to bring together peer organizations to create a closed-loop referral and community information exchange (CIE) system. This balanced approach would inform decision-making for health care and lead to systems that support community-clinical partnerships.

“Much of our **decision-making was informed by available data**, but also through identified gaps in information. To strengthen partnerships and—most importantly—**build better care for our community**, we knew we needed to take our work to the next level.”

Alexis Desrosiers, Associate Director of Data Strategy, HealthierHere

THE EXPERIENCE

HealthierHere joined the DASH Mentorship Program to establish a system and infrastructure that meets information needs at all levels: at the point of care in clinical and community sectors, and at the community and population level.

DASH Mentor, HealthInfoNet, is an independent, nonprofit information services organization. They manage the statewide health information exchange (HIE) in Maine. The goal of the HIE is to pull together information from various sources and reconcile those into a single electronic health record.

Together with HealthInfoNet, HealthierHere set out to tackle the challenge of disparate health data in their community. “Maine was in a great position to tell us what had and what hadn’t worked in the past for them,” explains Alexis Desrosiers, Associate Director of Data Strategy at HealthierHere. “That was valuable for us.”

Indeed, the mentorship proved helpful. HealthInfoNet exposed HealthierHere to resources previously unfamiliar to them. Case in point is the [Washington State Medicaid Health Information Technology \(HIT\) plan](#), which helped demonstrate the potentials of intergovernmental, cross-agency data sharing to HealthierHere.

The DASH Mentorship Program provided opportunities for HealthierHere to connect with other organizations as well. HealthierHere received technical assistance from 2-1-1 San Diego, another DASH Mentor.

2-1-1 San Diego recommended initial steps and considerations for launching a community information exchange (CIE). 2-1-1 San Diego visited the King County region and provided in-person coaching for stakeholder engagement sessions. They even mentored Crisis Connections, one of HealthierHere’s partners.

“The complexity of the work surprised me,” Desrosiers admitted. “I had just underestimated what would be required. Having the guidance of HealthInfoNet and 2-1-1 San Diego was indispensable to managing that complexity. 2-1-1 San Diego even provided onsite support traveling to Seattle to offer advice firsthand.”

FROM LEARNING TO ACTION

Since finishing their mentorship program, HealthierHere has done the following:

- Launched an overarching governance group in early 2020 and established a request for proposal for a CIE vendor;
- Launched topic-specific work groups that recruited subject matter experts from participating organizations;
- Developed a [shared vision](#) for their CIE; and,
- Coordinated with other groups in the region who were considering similar CIE-type systems. This helped to ensure that HealthierHere weren't duplicating efforts.





Gulf Coast Community Design Studio

Biloxi, Mississippi

THE CHALLENGE

The region of the Mississippi Gulf Coast lacks public infrastructure that's necessary for people to lead more active lives. Safe walking, biking, and public transportation are scarce options.

Directly related to a lack of good infrastructure is the fact that obesity and chronic illness are key health issues in the region. Cardiovascular disease and diabetes lead the way.

Data from 2017 confirms these trends. It shows that Mississippi ranks 50th in the nation for cardiovascular deaths and premature deaths. ("Premature" is defined as death before the age of 75.) Mississippi also ranks 49th in the country for the prevalence of adult obesity and 48th for adult diabetes.

At first glance, the Gulf Coast Community Design Studio (GCCDS) may seem like an unusual organization to join the public health space. However, GCCDS works closely with municipalities and nonprofit organizations.

Their projects provide design and planning services to the community—especially to underserved populations. The work they do addresses systemic problems in the built and natural environment. In short, GCCDS is the missing link between public health and public infrastructure.

"We are a community-based design firm but always thought about health," explains Tracy Wyman, Landscape Architect at the Studio. "In 2015, we got grant money for the healthy initiative. We spent time learning the language. We learned how important it is to be talking across sectors."

Community Snapshot

Organization: Gulf Coast Community Design Studio

Community: Biloxi, Mississippi

Capacity Built / Progress Made in following DASH Framework Domains:

Shared power with community | Trust and partnerships | Shared vision | Standards | Human and organizational capacity

Mentor Round 1: The University of Pittsburgh Center for Social and Urban Research

About the Mentee

The Gulf Coast Community Design Studio (GCCDS) is a professional service and outreach program that's a part of Mississippi State University's College of Architecture, Art + Design. GCCDS was established in response to Hurricane Katrina to provide architectural design services, landscape and planning assistance, educational opportunities, and research to organizations and communities along the Mississippi Gulf Coast. The program helps local communities and organizations address housing, public space, and neighborhood development issues.

“The **resources and comprehensive group facilitation** provided by our mentor were not only relevant to our particular challenges but also provided many options from which to choose to **create a path** specific to our community and organization.”

Tracy Wyman, Landscape Architect,
Gulf Coast Community Design
Studio

Wyman reflected on what it was like to enter the public health space and bridge differences. “We began reaching out to former partners and putting together a steering committee from multiple sectors to do the planning: environment, hospitals, food systems, and so on. We didn’t speak one another’s language, so it was hard to recognize the value everyone brought to the table at first. We needed to speak ‘Social Determinants of Health!’”

THE EXPERIENCE

The design firm needed help to bring together the right players and ensure everyone was speaking the same language. GCCDS leaned heavily on their DASH Mentor, the Center for Social and Urban Research at the University of Pittsburgh.

“That was the greatest value add for us,” Wyman acknowledges. “Our mentor provided different resources and frameworks so that we could all be on the same page. It was pivotal in our understanding of where we have been and where we wanted to go.”

Their Mentor helped GCCDS conduct focus groups across sectors, solicit insights and receive feedback. According to Wyman, had it not been for the mentorship, they would not have known how to move forward.

FROM LEARNING TO ACTION

GCCDS gained knowledge on how to share data across multiple sectors, including housing, employment, food systems, economic development, health care, and hospital systems. This helped them prepare for scaling up their current work.

Since ending their mentorship, they have:

- Conducted three focus groups spanning multiple sectors to determine data-sharing needs and capacity;
- Developed a survey to go out to focus group invitees who were not in attendance at the focus groups to gain a full perspective from the community; and,
- Developed several new connections with municipal leaders, education, and economic development players around data sharing.

Peer interactions were also invaluable to the GCCDS team. For instance, they had the opportunity to learn from a New Jersey-based Accountable Community of Health organization. This partnership ultimately influenced their final report and the assessment of their data-sharing strategies as they began planning activities ahead of schedule.



Community Health Improvement Associates

Washington County, Ohio

THE CHALLENGE

People often do not see the complexities and the trauma that influences addictive behavior. In fact, many people see addiction as a matter of choice—and not as a matter of chance, influenced by myriad factors outside a person’s control.

Community Health Improvement Associates (CHIA) works to dispel these myths of individual responsibility around systemic, collective health problems. Their goal is to use data-sharing practices to save lives. CHIA is also a member of the Washington County Opiate Hub, which works to bring the community together to address stigma and find solutions in data.

CHIA, however, identified a gap: They had no local sources for data on overdoses and Naloxone administrations. This data is important for judging the increase and decrease of opiate use. In turn, sharing patient information on overdoses allows so-called recovery engagement teams to follow up faster, which is critical for better outcomes.

There is only a brief window after an overdose where recovery teams can successfully steer survivors into treatment and recovery. The more time that passes between an overdose and a follow-up, the higher the risk of relapse. In that sense, having and sharing the right data can save lives.

This data was available elsewhere in Ohio. Yet, CHIA did not have access to this type of information locally. That is where the DASH mentorship came in.

Community Snapshot

Organization: Community Health Improvement Associates

Community: Washington County, Ohio

Capacity Built / Progress Made in following DASH Framework Domains:

Shared power with community | Trust and partnerships | Shared vision | Technology | Standards | Human and organizational capacity

Mentor Round 2: The Civic Canopy

Mentor Round 3: Elevate Health

About the Mentee

Community Health Improvement Associates (CHIA) believes that working with peer organizations is foundational to solving poor health outcomes across the Appalachian environment. CHIA strives to change policies and systems to address health outcomes in a region that struggles with disparities as great as any racial minority population.

This mentorship gave us the **technical assistance** we needed to push through what felt like impossible barriers and **better serve our community** in a time when it's more important than ever to support folks experiencing the opioid crisis firsthand.

THE EXPERIENCE

CHIA served as a hub for partners across different sectors that had been working on substance abuse. These partners had a highly engaged set of other cross-sector connections. Despite having such an extensive network, CHIA was missing access to data from hospitals and law enforcement.

Without the participation of hospitals and law enforcement, the larger network would have missed critical data—data that would tell the full story of how individuals get picked up by the police and receive care at the hospital.

To help CHIA obtain that data, they were paired with the DASH Mentor and community-based nonprofit The Civic Canopy. This organization connects diverse groups, so communities can solve “society’s big, sticky issues” using a strength-in-numbers strategy.

Under the DASH mentorship, The Civic Canopy helped CHIA craft community engagement strategies that would earn the trust of these potential, new partners.

CHIA and The Civic Canopy tapped into the *All In* network for additional resources. The *All In* network provided tools to CHIA to build more accountability internally and to develop peer relationships that support their goals.

FROM LEARNING TO ACTION

CHIA produced a series of videos featuring individuals with substance abuse experience. This was meant to dispel the stigma around substance abuse, which had been a significant barrier to CHIA’s efforts.

The Civic Canopy also worked with CHIA to approach their relationships more strategically to ensure that they would be able to access key sources of lifesaving data. By the end of their mentorship, CHIA had accessed hospital data and had a pathway in mind for law enforcement data.

Calls with their Mentor helped CHIA troubleshoot their work and build momentum. Overall, CHIA’s mentorship experience provided the consistency they needed to act on the critical pieces of their community work.



Five Key Takeaways from the DASH Mentor Program

By: Susan Martinez, DASH Program Associate

Our Mentorship Program helped us gain a much better understanding of all the social determinants that can impact people's health. We've seen with clarity how structural racism maintains systems that disadvantage communities—and we know how building trusted partnerships across diverse sectors is essential to improving lives.

Below, we highlight five key takeaways from our program. These are learnings from our Mentors and Mentees that we've distilled into simple advice. Our hope is that other communities doing good work on the ground will find this guidance useful as they build multi-sector data-sharing partnerships in the service of health, well-being, and equity.

Please feel free to share findings with DASH and the *All In* network to help further this field of work.



1. Community projects should center the lived and learned experiences of people who carry the burden of historical and repeated trauma.

Local community engagement is vitally important, both at the start of a data-sharing process and throughout the work. Generate Health provides a great example of how to be trauma-aware and culturally sensitive during community engagement work (page 6).

Most importantly, centering lived experience can contribute to the work of organizations and to the well-being of community members throughout a data-sharing project. Take the community health workers at Advocate Aurora Health who have been essential to building trust with formerly incarcerated clients. Their work ensured the successful return of formerly incarcerated people to their local communities and highlighted the services that are necessary to facilitate that re-entry (page 12).

Data can help us answer hard-hitting, complicated questions. But we should never lose sight of the people and stories behind the data.



2. Collaborative projects that work on sharing data across sectors should be mindful of any changes that take place in the community.

2020 was an unprecedented year. COVID-19's impact on the health sector has been undeniable. Political movements in defense of Black lives and other marginalized communities brought systemic injustices to the fore. Some of these changes came quickly, without warning. Others sounded for years, but a lack of resources and political will have made it difficult to respond.

Humility Homes and Services, Inc. (page 9) is a vivid example of responding to COVID-19 effectively. Following guidance from their Mentors, they ensured that their supportive housing plan remained equitable, even as the pandemic impacted their rural community.

Likewise, Greater Twin Cities United Way (GTCUW) (page 15) availed themselves of their Mentor's help to continue work during the pandemic. Their efforts on housing coordination and on a regional community information exchange (CIE) carried on despite the challenges posed by COVID-19.



3. Getting local stakeholders to support data-sharing projects can be challenging. Securing funding, however, can effectively signal the potential of a project to your stakeholders.

Many of our Mentees report that the award has helped them make an internal case for pushing their project forward. The funds also helped with staff participation and other minor expenditures, including professional development.

In the last few years, DASH also revised its grantmaking process to reach under-resourced communities more effectively. These communities are often majority Black, Latinx, or rural populations.

Historically, they have been unable to benefit from philanthropy through conventional methods. That's why we hope that the shift in our funding structure will deliver much-needed resources to those who need them the most.



4. Engaging in national peer networks, like *All In: Data for Community Health*, can motivate others to join the work at the grassroots level.

The DASH Mentorship allows Mentees to connect with other organizations that do similar work. Former DASH grantees, practitioners, and community members within the broader *All In: Data for Community Health* network can share knowledge and solve problems together.

Our Mentees tell us that connecting with peers can feel validating. When they speak to peers who face similar issues, they feel “like [they’re] not alone.” Conversations with peers in the field have also led Mentees to think through different solutions.

Case in point is the Gulf Coast Community Design Studio (page 28) that conducted a call with the New Jersey-based Accountable Community of Health (ACH). As a result, the Studio applied ACH’s learnings into their own data-sharing strategies.

HealthierHere (page 25) was able to gain additional support from other DASH Mentors too, such as 2-1-1 San Diego. Plus, they connected with fellow Mentees in their Washington community.



5. Taking a step "back" can help your collaboration go further in the long run. It allows you to reflect, build trust, and listen to a variety of perspectives on data sharing.

There is often a sense of urgency to solve data-sharing challenges. This is partly due to the awareness that connecting across sectors could have immediate benefits to people’s lives.

But going too fast can cause unintended harm, so it’s important to take time to figure things out and build trust among participating organizations.

Mentees have reported how it can be helpful to take a step back and establish a use case as well as solidify their local relationships. This can generate momentum and establish trust among stakeholders—all of which can push the data-sharing project ahead.

Appendix I:

Meet the Mentors

Mentors: 2-1-1 San Diego / Community Information Exchange

The community information exchange (CIE) bridges collaboration between health and social services addressing health equity and creating comprehensive care. As a national leader for CIE, 2-1-1 San Diego believes in helping other communities address these issues within their local settings to spur innovation and improve equity for all. Through the mentorship, communities learn how to harness the value of cross-sector collaboration and data sharing to create a CIE that enables a network of health, human, and social service providers to deliver coordinated, person-centered care. Topics include CIE vision and governance, legal frameworks and considerations, selection of data systems and interoperable technology, establishing data workflows, and sustainability.

Featured in Mentee Spotlight on 2-1-1 Broward on page 22

Mentor: The Civic Canopy

The Civic Canopy is a community-based nonprofit focused on transforming how to solve society's big issues. The Canopy brings over a decade of experience convening and facilitating multi-sector partnerships positioned to bring shared visions to life. Through the mentorship, communities are exposed to the research-based Community Learning Model (CLM). The CLM puts results at the center to create meaningful, measurable change on social issues. Those results are achieved through a continuous learning process of including relevant and diverse stakeholders, engaging in thoughtful dialogue, developing action plans, and learning from efforts to achieve results—all within a culture of trust and collaboration.

Featured in Mentee Spotlight on Community Health Improvement Associates on page 30

Mentor: Center for Outcomes Research and Education (CORE)

The Center for Outcomes Research and Education (CORE) is an independent team of scientists, researchers, and data experts with a vision for a healthier, more equitable future. Research, evaluation, and analytics provide insights that help shape and sustain healthier systems, policies, and programs. CORE leverages its experience in collecting and analyzing multi-sector data to improve community health and change systems and policies. Through the mentorship, communities are supported in developing data-driven use cases, combining and analyzing data, designing data and reporting systems, and establishing priorities for using cross-sector data.

Featured in Mentee Spotlights on Advocate Aurora Health on page 12 and Minneapolis Public Housing Authority on page 20

Mentor: Corporation for Supportive Housing (CSH)

The Corporation for Supportive Housing (CSH) works to advance solutions using housing as a platform for services to improve the most vulnerable people's lives, maximize public resources, and build healthy communities. Through mentorship, CSH helps communities strengthen partnerships across sectors that serve a shared population and employ housing as an intervention to address health and other social needs. Mentees will explore integrating administrative datasets (e.g., incarceration, behavioral health, hospital/healthcare utilization) with their Homeless Management



Information System (HMIS). Opportunities for the use of integrated data include enhancing coordinated entry systems, prioritizing housing initiatives, and improving care coordination around vulnerable populations experiencing homelessness and housing instability.

Featured in Mentee Spotlight on Humility Homes and Services, Inc. on page 9

Mentor: Elevate Health

Elevate Health connects public funding and private investments to community resources for sustainable, transformative improvements across care delivery and health outcomes. From its origin as an Accountable Community of Health for Pierce County, Washington, it reaches far beyond those boundaries. With Elevate Health, partners and stakeholders from across the community are coming together to think and act strategically and collaboratively around shared community health goals. Through this mentorship, communities were provided a framework to bring together clinical and community organizations for whole-person health. Communities will learn how Elevate Health structures its accountable community of health model, develops care coordination programs, and structures its community resiliency fund.

Featured in Mentee Spotlight on Generate Health on page 6

Mentor: University of Pittsburgh Center for Social and Urban Research and the Urban Health Collaborative at Drexel University School of Public Health

The University of Pittsburgh Center for Social and Urban Research (UCSUR) is a hub for interdisciplinary research and collaboration focused on social, economic, and health issues most relevant to our society. UCSUR hosts the Western Pennsylvania Regional Data Center, which provides an inclusive community open data infrastructure and supports an ecosystem of civic data publishers and users. The Drexel University School of Public Health's Urban Health Collaborative (UHC) conducts research, disseminates evidence, and builds capacity by partnering and exchanging information with the community, decision makers, and other academic institutions. Through the DASH Mentorship Program, staff from the UCSUR and the UHC will draw on their experience supporting local collaborative data-sharing efforts and their participation in national networks of practice, including the National Neighborhood Indicators Partnership and the Promise Neighborhoods Initiative.

Featured in Mentee Spotlight on Gulf Coast Community Design Studio on page 28

Mentor: United Way Worldwide

Across the United States, United Way Worldwide (UWW) collaborates with local nonprofits, government agencies, and the private sector to identify the most pressing community needs and elevate solutions that improve health, financial stability, and education success. Data-sharing collaboratives enable partners to achieve greater impact at the individual and community level by coordinating services, increasing efficiency, and better understanding of individual clients. Through the mentorship, UWW supports leading data-sharing collaboratives that improve coordinated care and health outcomes. Topics focus on identifying and implementing data exchange and care



coordination models, increasing partnership and community engagement, navigating internal and external challenges to increase buy-in and align with the Modern United Way, and leveraging 2-1-1 infrastructures.

Featured in Mentee Spotlights on Greater Twin Cities United Way on page 15 and United Way of Northern Shenandoah Valley on page 17

Mentor: HealthInfoNet

HealthInfoNet is an independent, nonprofit organization using information technology to improve patient care quality and safety. The organization’s core service line is managing a statewide health information exchange (HIE) for Maine’s healthcare delivery systems, hospitals, and other providers to share important health information and improve patient care. In addition to the HIE, HealthInfoNet has experience assisting clients with value-added services such as population analytics, public health reporting, Accountable Care Organization data aggregation, and predictive modeling solutions. Through the mentorship, HealthInfoNet provided support investigating existing data capacity, end-user needs within workflows, user-interface designs for data use, and technical capacity across partners.

Featured in Mentee Spotlight on HealthierHere on page 25

Appendix II:

DASH Mentor and Mentee Partnerships Across Three Funding Cycles

Mentee Lead Organizations paired with 2-1-1 San Diego

Round 1	Location
Northwell Health	Long Island, NY
2-1-1 Broward County	Orland Park, FL
Crisis Connections	Seattle, WA
Franklin County Public Health	Columbus, OH
Atlanta Regional Collaborative for Health Improvement	Atlanta, GA
Human Services Coalition of Tompkins County	Ithaca, NY
Chatham County Safety Net Planning Council	Savannah, GA

Round 2	Location
2-1-1 Maryland	Baltimore, MD
Tampa Bay Cares	Tampa, FL
Better Health Partnership	Cleveland, OH
Colorado Health Institute	Denver, CO
Action Health Partners	Wenatchee, WA
North Central Accountable Community of Health	East Wenatchee, WA
Inland Empire United Way	Rancho Cucamonga, CA
United Way of the Mid-South	Memphis, TN
United Way of Southeastern Michigan	Detroit, MI
United Way of Summit County	Akron, OH

Round 3	Location
2-1-1 Orange County	Santa Ana, CA
Children's Health Alliance of Wisconsin	Milwaukee, WI
Cradle 2 Career	Rochester, MN
Maine Medical Association	Portland, ME
North Coast Health Improvement & Information Network	Eureka, CA
Public Health Solutions	Queens, NY
United Way of Salt Lake	Salt Lake City, UT
United Way of Southeastern Idaho	Boise, ID

Mentee Lead Organizations paired with CORE

Round 1	Location
United Way of Missoula County	Missoula, MT
Houston Food Bank	Houston, TX
Johnson County (KS) Dept. of Health and Environment	Olathe, KS
Minneapolis Public Housing Authority	Minneapolis, MN
Flathead City-County Health Department	Kalispell, MT

Round 2**Location**

Advocate Aurora Health	Milwaukee, WI
CHI Memorial Foundation	Chattanooga, TN
Colorado Health Institute	Denver, CO
Esperanza Community Housing	Los Angeles, CA
United Way of Greater Houston	Houston, TX
United Way of Northwest Vermont	South Burlington, VT

Round 3**Location**

Action Health Partners	Wenatchee, WA
Communities of Excellence 2026	Excelsior Springs, MO
Metropolitan Interdenominational Church First Response Center	Nashville, TN
United Way of San Diego	San Diego, CA

Mentee Lead Organizations paired with HealthInfoNet**Round 1****Location**

HealthierHere (King County Accountable Community of Health)	Seattle, WA
The Health Collaborative	Cincinnati, OH
D.C. Department of Health Care Finance	Washington, DC
Department of Finance and Administration, Division of TennCare	Nashville, TN
Healthcare Collaborative of Greater Columbus	Columbus, OH
Penquis Community Action Agency	Bangor, ME

Mentee Lead Organizations paired with Cooperation for Supportive Housing**Round 1****Location**

Texas Homeless Network	Austin, TX
Homeward Alliance	Fort Collins, CO
Medical Research Analytics and Information Alliance	Chicago, IL

Round 2**Location**

Community Health Partnership	Colorado Springs, CO
Humility Homes and Services, Inc.	Davenport, IA
San Antonio Housing Authority	San Antonio, TX
Southwest Washington Accountable Community of Health	Vancouver, WA
Yakima Health District	Yakima, WA

Round 3**Location**

ChristianaCare Value Institute	Wilmington, DE
Garden State Community Development Corporation	Jersey City, NJ

Mentee Lead Organizations paired with University of Pittsburgh and Drexel Urban Health Collaborative (joined in Round 3)

Round 1

Location

Berrien County Health Department	St. Joseph, MI
Reno County Health Department	Reno, NV
Gulf Coast Healthy Communities Collaborative	Biloxi, MS
Eau Claire City-County Health Department	Eau Claire, WI
Georgia Public Health, West Central Health District	Columbus, GA
Jersey City Department of Health and Human Services	Jersey City, NJ

Round 2

Location

UT Health School of Public Health	Dallas, TX
Town of Richmond	Richmond, VT
San Antonio Metro Health	San Antonio, TX
Oregon Health Equity Alliance	Portland, OR
Delaware General Health District	Delaware, OH

Round 3

Location

Alabama Department of Mental Health	Montgomery, AL
Atrium Health Foundation	Charlotte, NC
Center for Health Innovation	Chicago, IL
Lackawanna County Department of Human Services	Scranton, PA
Public Health Management Corporation	Philadelphia, PA
United Way of Yellowstone County	Billings, MT

Mentee Lead Organizations paired with Elevate Health

Round 2

Location

United Way of Treasure Valley	Boise, ID
United Way of Central Carolinas	Charlotte, NC
Jewish Community Services 2-1-1 Miami	Miami, FL
Generate Health	St. Louis, MO

Round 3

Location

VIA LINK	New Orleans, LA
Community Health Improvement Associates	Marietta, OH
Interfaith Health and Hope Coalition	Detroit, MI
Northern Michigan Health Consortium	Charlevoix, MI

Mentee Lead Organizations paired with United Way Worldwide

Round 2

Location

Greater Twin Cities United Way	Minneapolis, MN
United Way of Rhode Island	Providence, RI
Greater Kansas City United Way	Kansas City, MO
Metro United Way	Louisville, KY
United Way of Northern Shenandoah Valley	Winchester, VA
United Way of Wisconsin	Madison, WI

Round 3

Location

Maui United Way	Wailuku, HI
Brookings Area United Way	Brookings, SD
United Way of Greater Knoxville	Knoxville, TN
United Way of Southwest Georgia	Albany, GA
United Way of Pierce County	Tacoma, WA
United Way of Greater Cleveland	Cleveland, OH
United Way of Central Jersey	Milltown, NJ
United Way of Morgan County	Decatur, AL

Appendix III:

Recommended Resources



- [2-1-1 and the Social Determinants of Health White Paper](#) (United Way Worldwide)
- [A Toolkit for Centering Racial Equity Throughout Data Integration](#) (Actionable Intelligence for Social Policy)
- [Accountable Communities for Health Data-Sharing Toolkit](#) (CHOIR at UC Berkeley)
- [Building Connections for a Healthier North Carolina](#) (United Way Worldwide & NCCare360)
- [Civic Switchboard Guide: Understanding Your Ecosystem](#) (Civic Switchboard)
- [Collective Impact 3.0: An Evolving Framework for Community Change](#) (Collective Impact Forum)
- [Leveraging Community Informational Exchanges for Equitable and Inclusive Data: Community Information Exchange Data Equity Framework](#) (2-1-1 San Diego)
- [Community Information Exchange Toolkit](#) (2-1-1 San Diego)
- [Community Resource Referral Platforms: A Guide for Health Care Organizations](#) (SIREN)
- [Data Maturity Framework](#) (Data Science and Public Policy – Carnegie Mellon University)
- [Developing a Values Proposition Narrative Toolkit](#) (ReThink Health)
- [Elevate Health Brief](#) (Elevate Health)
- [Elevate Health Care Continuum Network Brief](#) (Elevate Health)
- [Equity Framework and Equity Toolkit](#) (United Way Worldwide)
- [Guide to Civic Technology and Data Ecosystem Mapping](#) (National Neighborhood Indicators Partnership)
- [Guide to Starting a Local Data Intermediary](#) (National Neighborhood Indicators Partnership)
- [HUD-issued guidance on using HMIS data to assess equity](#) (Department of Housing and Urban Development)
- [One Pierce Community Resiliency Fund Brief](#) (Elevate Health)
- [Racial Equity: Getting to Results](#) (Government Alliance on Race and Equity)
- [Turning the Curve Facilitator Guide](#) (Civic Canopy)

