Cross Sector Data Sharing
Statewide Workshop Series

Executive Brief
June 2022

Introduction

In response to growing awareness of the importance of the interactions between medical, behavioral, social and economic factors in maintaining and improving health, and the awareness by stakeholders about how people move between organizations as they receive care**,** MiHIN began planning to support enhanced collection of social care (SDoH) data and improved cross-sector data exchange in 2016 with its 'Coordinating the Coordinators' workshop series and subsequent White Paper. MiHIN continued this work by collaborating with Michigan Department of Health & Human Services (MDHHS) on a statewide SDOH workshop series and White Paper in early 2020. The primary goal of the 2020 workshop series was to inform development of a statewide SDOH Use Case that would enable social care screening data exchange between health care organizations, community social service organizations, and other key care providers for two purposes: (1) direct care coordination of individual patients/clients; and (2) population health reporting, assessment and improvement.

The importance of cross-sector care support has been made abundantly clear during the extended COVID-19 pandemic, which has exposed significant and growing disparities in access to health and social care. The State of Michigan is working to address these disparities by developing and implementing a comprehensive Health Equity strategy. One key aspect of this strategy is enhanced collection and exchange of information regarding social problems (needs), interventions, and outcomes of those interventions between health care providers, social care providers, public health officials, funders of health and social care, and local/state/national policy makers.

Social care data exchange is a highly complex data exchange problem to solve, as it requires extending current standards for content, informed consent, data security, and governance beyond existing health care-oriented regulations (ex: the Health Insurance Portability and Accountability Act, or HIPAA) into new sectors (social services, population health) in which corresponding standards have not yet been adopted. Reflecting existing power and funding disparities between health care and community/ social care, most work to date has focused on approaching this complex problem from the perspective of health care organizations. The State of Michigan is committed to engaging the community 'voice' to better address health equity needs in cross-sector data exchange, and MiHIN is committed to helping develop the technical solutions necessary to the success of this effort.

In its 2020 MDHHS White Paper, MiHIN made 6 recommendations for continued work in the cross-sector data sharing space: we have made progress toward each recommendation.

1. *Follow a Phased Approach for SDoH Use Case Design and Implementation.*

MiHIN recommended developing the SDoH Use Case in three distinct phases of data exchange design work: (1) SDoH screening; (2) social problem diagnosis; and (3) social problem treatments and interventions. **We have followed this approach.**

2. *Normalize Screening Results for Each SDoH Domain.*

MiHIN proposed to support multiple SDoH screening options by developing mapping tables to 'normalize' screening responses from different questionnaires. **This was implemented in MiHIN SDoH Use Case 3.0.**

3. *Normalize Priority SDoH Domains to Start.*

MiHIN recommended a first wave of work to standardize the SDoH domains most highly prioritized by stakeholders; Food, Housing, Transportation, Utility Assistance, Mental Health, Health Care Finances and Employment, followed closely by Education and Social Isolation. **We have followed this approach.**

4. *MDHHS Supports Development of a Statewide Social Health Consortium and Resource Center*

The development of local Community Information Exchanges (CIEs) will require that Community Based Organizations (CBOs) become more equal and effective partners to medical organizations. MiHIN supported development of a statewide Social Health Consortium and Resource Center to facilitate adoption of a common vision and operating model for cross-sector service delivery and data exchange. The Consortium would engage the community (CBOs and community leaders) and medical/ behavioral care (organizations and payors), as equal partners with MiHIN, MDHHS, and public health as committed participants. **Under MDHHS leadership, cross-sector working groups and a CIE Task Force are now being assembled.**

5. *Continue SDoH Stakeholder Engagement.*

The MiHIN SDoH team identified a high level of interest from payors and large CBOs in collaborative work to standardize methods for social diagnosis and intervention data collection and exchange, as well as a need to more actively engage important community collaborators. **MiHIN's SDoH team has continued to meet regularly with health care stakeholders, payors, the former SIM CHIRs, and individual CBOs to carry out this recommendation.**

6. *MDHHS Continues to Support SDoH Data Sharing Strategy Through Existing Federal Match Funds*

This work requires additional waves of multi-sector collaboration with local, state and, and national stakeholders. MiHIN requested MDHHS support of proposals that could harness Federal matching funds. **MDHHS Health Equity project funding now supports some aspects of this work.**

Despite exceptional strain on State of Michigan human services programs and resources during 2020-2021, in late 2021 MDHHS was able to convene a new SDoH program team, bringing dedicated technical and subject matter expertise to catalyze and guide work to enhance social care and reduce health disparities. A request was made to MiHIN to conduct another series of statewide SDoH workshops to better understand the current state of SDoH data capture and exchange within and across sectors and to prepare to address the full complexity of the work necessary to equitably manage cross sector data sharing. This new workshop series should be designed to capture the widest possible stakeholder feedback.

The stated goal of these workshops was an extension of the goal for the 2020 series: to **inform the continued evolution of the statewide SDoH Use Case that would enable social care data exchange to support two core purposes: (1) direct care coordination of individual patients/clients; and (2) population health assessment and improvement**. This series focused on achieving active engagement of three primary stakeholder 'sectors of care' (health care, social care, and government entities). Each session focused on a single sector to allow sufficient time for a deeper dive to better understand the perspectives of that sector.

Sponsored by many community organizations, MiHIN facilitated the 2022 SDoH Workshop Series in January 2022 with the following specific objectives and deliverables:

SDoH Workshop Series Objectives

1. Identify barriers to cross sector care and data exchange that impacts community-based organizations, and social care providers, healthcare organizations, and government entities.
2. Describe the goals, needs, and solutions to enable the collection and exchange of social care data at the point of care.
3. Give feedback towards a statewide social care data exchange strategy so that systems can effectively communicate regarding such data.

SDoH Workshop Series Deliverables

1. Development of an executive brief outlining workshop findings and recommendations

Progress Achieved

Partnerships and Sponsorship

The MiHIN SDoH team realized that it needed to engage a broader group of stakeholder participants than it could recruit on its own, and we were grateful for the assistance of our partners from the MDHHS SDoH Program Team in the recruitment process. We reached out to a number of statewide organizations, especially those representing community-based organizations, to sponsor and help publicize the workshops. We are deeply appreciative of the organizations that assisted us in finalizing agendas and formally sponsored the workshop series, including the Area Agency on Aging Association of Michigan (AAA), Community Economic Development Association of Michigan (CEDAM), Michigan Community Action, Michigan Multipayor Initiatives, the Michigan Association of United Ways, and United Way for Southeastern Michigan. Their sponsorship was invaluable in attracting many new CBO participants, in particular several organizations that had not previously participated in data exchange initiatives.

Attendees and Participation

MiHIN hosted three virtual workshops in January 2022. The first, on January 11, focused on exploring and reviewing SDoH and cross-sector data sharing from the perspective of Community-Based Organizations (CBOs). The second, on January 18, focused on exploring the same issues from health care providers' perspectives, and the final workshop on January 25 focused on orientation and activation of local, state, and selected federal government entities.

In all, members from 263 different organizations were in attendance for at least one workshop session, and the three sectors of care (health care, social care, and government entities) were well represented. Figure 1 depicts the average ratio of sectors represented in the three workshops. More information on attendees and their organizations can be found in Appendix A.

There were a total of 263 participants throughout all three workshops.

Some participants attended more than one workshop. They were counted as a participant for each of those that they attended.

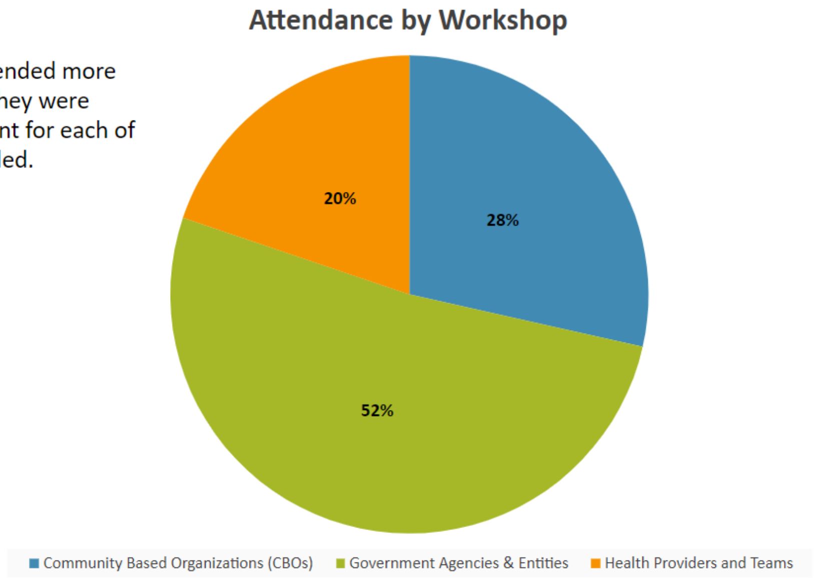


Figure 1. Attendance by Workshop

There were a total of 233 individuals that participated in at least one workshop.

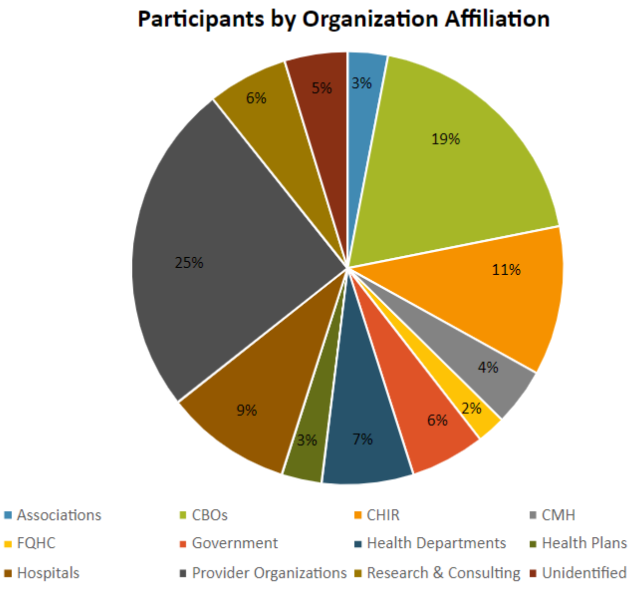


Figure 2. Participants by Organizational Affiliation

Participants in each session were encouraged to enter into conversations and/or provide direct feedback via online chat at any point during the workshop. Our intent was to assemble a broad range of personal and organizational perspectives on the core MiHIN content presented, as well as compile individual responses to several questions regarding current practices, successes, and facilitators and barriers to cross-sector care and data exchange.

Workshop agendas and content.

All workshops followed the same general format.

Each session began with a roughly 30-minute didactic session led by MiHIN SDoH team members, covering the overall MiHIN SDOH strategy, the proposed SDoH data model, and core data elements and their composition (see Appendix for slides used in each session). Content was tailored to each audience; for example, the initial workshop focused on describing the strategy, data model, and data elements from the perspective of a community-based organization. A short question and answer session at the end of this presentation allowed clarification of unclear content.

Small-group breakout sessions of roughly 45 minutes followed, facilitated by MiHIN staff working from a common set of potential questions/issues for group discussion (see Appendix B). A MiHIN staff member took notes on the discussion in each breakout session, chat entries were added to notes, and each session was audio recorded for later review.

Following breakout sessions, the full group reconvened to discuss, review and confirm reactions and responses to materials and issues presented.

Specific workshop topics were chosen to expose participants to the broad range of issues related to cross-sector data exchange and data interoperability. Realizing that some participants were highly experienced in health information exchange (HIE) while others had very limited knowledge, topics were carefully sequenced for each session.

The **first (CBO) workshop** introduced a range of topics, highlighting basic SDoH definitions, the concepts of Community Information Exchange (CIE) and Community Integrated Health Networks (CIHN), and SDoH program objectives. The opening session also presented the overall SDoH care model proposed by the Gravity Project and supported by MiHIN, tailored to focus on the specific role(s) of CBOs and the costs and benefits of their participation.

The **second (health care team) workshop** featured a more in-depth discussion of MiHIN's approach to support standardized SDoH data collection and exchange in alignment with the Gravity Project's framework and HL7 data exchange standards development. The potential role of CIE and CIHNs in organized systems of care was briefly described. Small group sessions highlighted the collective experience and expertise of several SIM CHIRs and CIHNs across the state in an exploration of current best practice in community-clinical linkages.

The **third (government entity) workshop** featured a broader description of the conceptual framework guiding CIHN development along with a general discussion about who participates in social care data collection and exchange. This workshop also addressed current 'big-picture' challenges in this area - establishing a shared vision, maintaining alignment, engaging and onboarding stakeholders, sustainability and funding, and ownership of SDoH data.

All workshop content was organized around the exploration of three key components of social care data exchange (see Figure 2 below):

1. ***Social care data capture***
2. ***Referrals and workflow***
3. ***Organizational Capacity***

Questions or issues related to each component (Figure 2) were compiled by the MiHIN SDoH team, tailored to match participants' needs for each session, and used to guide small group discussions.

For added detail on content and topic sequencing, please refer to the workshop slide decks, included in Appendix B.

CBO Workshop

- **Social care data capture:**
  - who collects/ doesn't
  - barriers to collection
  - differences in organizational approach
  - data format/ standards used
  - capacity to analyse/ aggregate data
  - Privacy and security policies
- **Referrals and workflow:**
  - how do the poeple you serve get to you/ who refers to you
  - how do you refer people to other services
  - how is organizational capacity known in the community
  - closing the loop
  - social care platform vendors
- **Organizational Capacity:**
  - use of data in organization
  - ability to meet demand
  - differences between want to do and organizational mission
  - Barriers to effective organizational capacity

Healthcare Workshop

- **Social care data capture:**
  - what is the value in social care data capture
  - how has social needs screening been implemented
  - z- code use / capture/ barriers
  - EMR / social care referral vendor
  - capacity to share/ exchange
- **Referrals and workflow:**
  - how are workflows impacted
  - screening everyone vs subset of the population
  - how do you refer and know that the referral is completed
  - how to know what orgs in community have capacity
- **Organizational Capacity:**
  - use of data in organization for improvement
  - what organizational capacity issues keep you form being more engaged in this work.

Government Workshop

Social care data capture:
- who collects/ doesn't
- is there value in this data capture
- is this information duplicated in your partners data
- who asks for this data

- **Referrals and workflow**:
  - how do the poeple you serve get to you/ who refers to you
  - what state level IT systems does this information get used in
  - what level of duplication exists in these systems
- **Organizational Capacity**:
  - do you have access to social care data that makes your job easier
  - what barriers exist to accessing this data
  - do you have access to this data; do you want access to this data

Figure 2. Workshop Discussion Topics

Post-workshop Data Analysis

After the workshop series ended, notes, chat entries, and recordings of small group sessions were used by MiHIN staff to carry out qualitative data analysis to identify key themes identified by participant stakeholders. These themes are reported as key takeaways in the next section.

In general, we believe that participants in all sessions were supportive of the key principles MiHIN presented at each workshop (see Appendix for slides), and we are confident that we have accurately summarized the key issues raised by stakeholders in each workshop session (see next section).

Seven Key Takeaways: Themes, Issues, and Recommendations

We identified seven key takeaways during review of plenary and small group session transcripts. In the following section we describe each takeaway point, the related themes and issues raised by participants, and make specific recommendations to address the issues raised.

Takeaway #1: Use of ICD-10-CM Z-Codes to capture and exchange information regarding active social problems.

Z-codes are a special group of codes provided in ICD-10-CM for the reporting of factors influencing health status and contact with health services, rather than describing a specific disease or health condition. They can be assigned by health care providers to document the presence of social problems in the problem list section of their Electronic Health Record (EHR). There are currently a small number of Z-codes, and their limited granularity has made them a poor fit for coding many social problems at the level necessary for social services organizations to document interventions or services. Consequently, this set of codes is essentially unused outside of the medical care setting and is not mapped to more detailed codesets describing community services such as the LA County/AIRS taxonomy. The Gravity Project has proposed extensions to Z-codes for several social domains, and many have been formally approved and released for general use in the past year.

Z-codes were mentioned in all workshops as part of the SDoH data model (see slides in Appendix) but were addressed in depth in workshop 2 (health care team session).

Themes from participants:

The use of Z-codes to document social problems for cross-sector care is highly appealing to health care providers and organizations. They are already in (limited and inconsistent) use in health care and payors are creating incentive programs to encourage increased coding by providers. Some payors and provider organizations (POs) have developed methods to map SDoH screening results to Z-codes to reduce workload; MiHIN has discouraged this practice, as data from the SIM demonstration has confirmed that a screening result is very different from a confirmed social problem. The lack of granularity in Z-codes is frustrating to health care providers, as codes for some common social problems are not yet available, and CBOs do not find these codes acceptable for their needs unless mapped to their preferred codes or terms for services provided. Health care providers are also reluctant to assign Z-codes in routine practice, even when they identify active social problems, as it requires added work: some EHRs do not have adequate lexicons or lookup functionality to easily assign codes at the point of care. In some systems, case managers or social workers are expected to code social problems to reduce provider workload, but data quality of this workaround is unclear. There is also concern regarding transmission of Z-codes in current medical claims processing algorithms: payor algorithms may automatically truncate diagnoses submitted with claims, and since Z-codes are often the last codes assigned they are more often truncated and lost even when present.

- *"One of our challenges is that our case managers are sometimes the folks identifying needs, however they are not able to enter z-codes due to EHR permissions" - PO staff member.*
- *"We use z-codes to identify when there is a need and to track the outcomes of the community support we have provided to the patient. It allows our social workers & care managers to easily identify a patient for follow-up" – PO staff member*
- *"As we talk about z-codes we need to talk about alignment. [Org X] mapped their screenings to z-codes to align with Medicaid. Issues with this were that z-codes would get dropped in billing claims" – CHIR member*

Summary: Z-codes are an important component of a future cross-sector data exchange strategy, as they are a best fit to current medical workflow. But they need expansion, more consistent use, and must be linked to terminologies and codesets used by CBO partners to capture service / intervention data needed for an interoperable closed-loop referral system. Linkage of Z-codes to CBO interventions could also provide a simple data source to support fee-for-service reimbursement to CBOs.

RECOMMENDATIONS:

1. Work closely with provider groups (ex: Michigan Multipayor Initiative and its SDoH work group) and payors (both commercial payors and Medicaid Health Plans) to encourage and incentivize use of Z-codes in routine medical practice.
2. Implement newly approved extensions to Z-codes across health care settings as they become available with updates of ICD-10-CM. Updates are generally released each October.
3. Work with payors and medical claims processors to minimize loss of assigned Z-codes by modifying algorithms used in claims processing.
4. Work with EHR vendors to create and implement a separate and interoperable 'social care problem list' in EHRs.
5. Work with social services taxonomy suppliers (ex: LA County/AIRS, Pathways Community Hub Institute) to construct and maintain standard mappings between Z-codes and reference social service taxonomies; make these mappings widely available to support future community information exchange development efforts.

Takeaway #2: The Importance of a Shared Comprehensive Social Care Resource Directory.

Cross-sector care coordination and inter-agency social care coordination have both traditionally depended on word of mouth, augmented by homegrown lists of key local community partners maintained by individual stakeholder organizations. These lists were by nature selective and incomplete, their maintenance was burdensome, and they were inconsistently used. In recent years, MDHHS has supported work by Michigan 211 to create and maintain a statewide social services resource directory that can serve as the reference database for the MI Bridges social services platform. This MI 211 resource directory also serves as the reference resource directory in at least one of the SIM CHIRs (Jackson County), and other communities and Community Referral Platforms have inquired about obtaining access to it. However, the 211 system is not seen as central to cross-sector care or social services referral in all regions of Michigan, and most current community initiatives have developed their own local resource directories tailored to the scope of their activities.

Themes from Participants:

All participant groups agreed that reliable resource directories were an essential component of a cross-sector care initiative, and necessary to support closed-loop referral functionality. All organizations confirmed that referrals from their own agency to other CBOs or health care organizations were necessary at times, and that a more efficient and effective way to make these connections would be highly desirable. Every CBO participant engaged in care coordination of any type confirmed that they were using a social services resource directory; most admitted that they were using and maintaining their own homegrown lists. Health care participants confirmed their interest in accessing or sharing these lists rather than developing and maintaining their own. Some participants are leveraging local 211 directories, others are working with IT vendors to develop a local directory to embed in EHRs or Community Referral Platforms, but for most the cost and complexity of developing and maintaining a comprehensive local resource directory is a barrier to progress. There was general acknowledgement that quality of current directories is inconsistent, and the presence of multiple homegrown directories in a community leads to inefficient and inconsistent cross-sector care coordination. Most participants agreed that all current resource directories were lacking one essential piece of information: the current capacity of listed service providers (Is this program accepting new clients right now?).

- *“Making sure our database is updated is important, and to make sure we have the right phone numbers and reflecting the right information is a huge process. A formal resource directory would be a huge help” - CBO lead*
- *“One huge challenge is not knowing services in the community or how to make the correct referral(s).” – PO staff member*
- *“An updated data base showing community resources that is always up to date and accessible would be extremely helpful.” – CBO lead*

Summary: Most CBOs are currently working with homegrown social service resource directories. While some health care organizations and IT vendors are working to develop local resource directories, the proliferation of local non-interoperable directories will not solve the problems identified by participants. Across all workshops, participants agreed that a reliable and comprehensive shared statewide resource directory would have tremendous value.

RECOMMENDATIONS:

1. Leverage the investment already made by MDHHS in the Michigan 211 statewide resource database by providing the resources needed to expand its listings, enhance its maintenance, and strengthen regional 211 systems so that they can actively participate in maintenance.
2. Work with Michigan 211 to develop a sustainable funding mechanism to support the statewide resource directory through tiered licensing or subscription fee arrangements.
3. Consider providing resources to enable Michigan 211 to add ‘current capacity’ information to service provider entries in the statewide resource database.
4. Provide incentives to (or set requirements for) local communities and CIE initiatives to adopt local instances of the statewide 211 directory as their core resource directory infrastructure: this will enable interoperability of referrals across regions or localities.
5. Provide incentives to (or set requirements for) local communities and CIE initiatives to commit to making local social care data conform to developing standards for content and exchange (for example, use of LA/211 taxonomy for services, standardized referral messages, and data exchange via API standard(s)).

Takeaway #3: Challenges in Achieving Data Interoperability.

Health care organizations are still struggling to improve data interoperability. Electronic Health Record (EHR) vendors have been slow to implement standards for format and exchange. The primary format used to move information between organizations (the HL7 Consolidated Clinical Document Architecture, or C-CDA), is difficult to implement. Identity verification, necessary to link data from multiple sources, has proven to be a major challenge. MiHIN has developed tools, including Admit/Discharge/Transfer (ADT) messages, Common Key service (CKS), Active Care Relationship Service (ACRS), and SDoH screening normalization, to overcome some of these limitations.

Social care data exchange is in its very early stages, and standards for content and interoperability are only now being developed. The Gravity Project has developed and proposed standard content for coding SDoH screening results, social problems, and some social care interventions in close coordination with HL7 and IT stakeholders. The HL7 SDoH workgroup has developed an implementation guide that seeks to standardize FHIR API-based data exchange between medical care organizations and a range of social care organizations. These developing standards have been tested in synthetic IT environments in a series of SDOH Connectathons, but real-world pilots are only now getting underway. MiHIN and its InterOperability Institute have been deeply engaged in Gravity Project work, including participation in Connectathons.

Themes from Participants:

Interoperability is still a problem for health care data exchange, so it is difficult for organizations to think about expanding to a new SDoH screening use case. At this point, a small number of health care organizations are submitting SDoH screening data to MiHIN, but most are not yet able to submit using HL7 v2.0 or FHIR; the majority of submissions are sent in CSV format. Exchange of SDoH screening data between organizations is still very limited due to lack of interoperability. Many health care organizations are working with a single Community Referral Platform vendor to develop local capacity to screen and refer, so interoperability is not an active concern for them. A major concern for CBOs is that in some communities, they are being asked to connect to several non-interoperable Community Referral Platforms by competing health care organizations, putting them in the extremely difficult position of having to learn multiple interfaces and develop multiple workflows with very limited resources. Most CBOs report that compliance with their funders' mandatory reporting policies requires them to manually enter the same information into multiple unconnected databases. Organizations that are actively engaged in cross-sector data exchange efforts uniformly agree on the necessity of broad, cross-platform interoperability to make bidirectional exchange of information feasible. Rural participants highlighted the limited IT capacity of many rural CBOs to express their concerns that urban-rural disparities could be made worse with widespread adoption of digital CIE initiatives.

- *"A top challenge for us is many databases and varied reporting obligations" – CBO staff member*
- *"Each payor [health system] has their own format or tool they want filled out for the outcome of their work" – CBO lead*
- *Disparate systems make it very difficult for reporting for those we need to…[we] spend a lot of time mashing information into spreadsheets and loading it into other mandated databases that don't connect to anything else." - CBO lead*
- *"If the systems are drawing information on [and from] CBOs by using the Web they will be increasing rural/underserved community disparities because our CBOs are not online." - CBO lead*

Summary: Data interoperability is highly desired by all stakeholders, but it has been difficult to achieve within the health care sector and faces additional barriers in its extension to cross-sector care. National efforts to develop consensus standards for capture and exchange of social care data are underway, and a combination of national standards and current MiHIN data exchange tools (for example, CKS, Health Directory, and ACRS) should be available to support cross-sector exchange in the near future. Implementation issues will be challenging to overcome, especially for community-based organizations.

RECOMMENDATIONS:

1. MiHIN will continue to accept multiple formats for submission and exchange of SDoH screening data, including CSV files, while stakeholders develop more advanced data exchange capabilities.
2. Work to align data capture and exchange priorities between health care and community stakeholders.

3. Development should proceed with a core requirement of supporting bidirectional data exchange between multiple stakeholders.
4. Employ current MiHIN solutions, services, and tools wherever possible to standardize bidirectional data exchange between health care and community stakeholders (ex: CKS, Direct Secure Messaging, ACRS)
5. Data capture and exchange standards should be designed to enable participation of ‘low tech’ and ‘no tech’ social care providers in CIE initiatives: this represents a fundamental health equity issue that must be addressed.
6. Work closely with the Gravity Project to synchronize development and implementation of standards with Gravity and HL7 release cycles.
7. Encourage and/or incentivize organizations and their IT vendors to support the FHIR SDoH standard as described in the HL7 SDoH Implementation Guide.
8. Approach commercial IT vendors to sign an Interoperability Pledge committing them to standards-based, interoperable data capture and exchange, and potentially make this a requirement for operations in the Michigan environment.

Takeaway #4: Misaligned Incentives are a Major Barrier to Participation.

Misaligned incentives impact both health care providers and CBOs participating in social care data collection and cross-sector data exchange, but they are clearly a major barrier to CBOs’ participation in community information exchange efforts. Simply put, most SDoH screening, assessment, and referral work is carried out by individuals (health care providers and CBO staff) who do not directly benefit from that work. Some Michigan health care payors have provided incentive payments to health care provider organizations for meeting targets for SDoH screening or Z-code diagnoses, but CBOs generally receive no additional reimbursement to cover the substantial additional work required to participate in local initiatives. Nationally, most cross-sector care initiatives have ‘stalled’ after partnering with 15 to 30 large CBOs; smaller, ‘low-tech’ CBOs have been very difficult to engage. Community stakeholders are increasingly expressing their reluctance to participate in cross-sector data exchange efforts that they believe are designed to support a health care-centric use case.

Themes from Participants:

Both health care providers and CBO staff report that SDoH screening, assessment and referral require substantial workflow changes and that this unfunded work has little direct value to them. Inconsistent reporting requirements and incentive program rules across multiple payors providers require additional work by POs and health care providers. Some CBOs report that staff need to do double or triple data entry work to participate in local initiatives, and that none of this extra work is reimbursable. At present, CBOs receive no added reimbursement for the extra work involved in connecting to local CIEs. Many CBOs need to do significant work to connect to community referral IT platforms, and in some cases need to connect to multiple incompatible platforms at their own expense. Participation leads to more referrals for many CBOs, straining limited capacity, and additional work to manage mis-routed referrals. While no CBO reported sustained success in achieving additional reimbursement for this work, leaders of regional initiatives employing the Pathways Community Hub model are optimistic that it can provide the framework for future outcome-based reimbursement to CBOs.

- *"More work (more referrals) is not a good thing." – CBO lead*
- *“It’s pretty time-consuming to capture all the data and there isn’t reimbursement for us” - PO administrator*
- *“A lot of the incentives that payers use to drive screening go to the POs not the practices doing the work. We need that money to support this staffing” – PO (medical) staff*
- *“Who’s funding my staff to participate?” – CBO lead*

Summary: Front-line health and social care providers report that SDoH screening, assessment, and referral require substantial additional work for which they are not reimbursed. Most CBOs see little benefit in participating in what they perceive as a health care-centric SDoH use case, and smaller low-tech CBOs have been difficult to engage in local initiatives. Work to realign incentives to support the front-line work necessary for cross-sector data exchange is urgently needed. The Pathways Community Hub model may provide a useful framework around which to align incentives and payment.

RECOMMENDATIONS:

1. Work to align SDoH and cross-sector care incentive programs across all health plans and payors. This could begin with Medicaid Health Plans and Medicare Advantage plans, which are most actively engaged in developing SDoH incentive programs at present.
2. MiHIN continue to meet with a CBO working group to learn CBO needs in this space and generate ideas for how to realign incentives, to be carried forward by a CIE Task Force (see 3 below).
3. MDHHS convene a CIE Task Force to review and recommend best options for better alignment of incentives to support community stakeholder participation in cross-sector data exchange.
4. Develop sustainable funding model to support work of CBOs in cross-sector care and data exchange, short-term FFS, longer term value-based care or shared savings. This may need to wait until reliable data on supply of and demand for services is available.

Takeaway #5: Work is Needed to Develop Privacy and Consent Standards to Support Cross-Sector Data Exchange

At present, collection and exchange of social care data by health care providers is guided by Health Insurance Portability and Accountability Act (HIPAA) regulations. SDoH screening and diagnosis data can be shared with health care providers who have active care relationships with a patient, and with payors to support treatment, payment, and operations (TPO) functionality. There are no equivalent regulations to guide sharing of social care data collected by social service providers.

This state of affairs has resulted in substantial confusion and inconsistency in local cross-sector care initiatives. In the SIM demonstration, some CHIRs designated a local Covered

Entity which could sign legal agreements with participating CBOs as business associates, this enabled consent and data sharing under HIPAA guidelines. However, the legal status of second-level data sharing with health care payors and MDHHS remained unclear for data initially collected by local CBOs. Each CHIR also developed its own policy on informed consent for social care data sharing, ranging from strict 'opt-in' to broad 'opt-out' and largely failing to address second-level data sharing.

The situation is complicated by wide variability in the sensitivity of social care data. For example, the problem of domestic violence and intervention of placement in a shelter requires a high level of security and an asymmetric approach to data sharing similar to those adopted for sensitive behavioral health data in 42 CFR Part 2.

MiHIN has developed an eConsent tool designed to conform to HIPAA and CFR 42 Part 2 requirements, but CBOs have found it burdensome to review and sign legal agreements that commit them to strict privacy and consent policies. In particular, small CBOs lack the resources to commission legal review of contracts or carry out conformance audits. Over the long term, MiHIN is working to reconcile health care, behavioral health, and social care consent and privacy requirements through a tiered consent and data sharing policy, but this cannot be completed until formal social care regulations are established. In the short to medium term, MiHIN proposes to follow HIPAA regulations and assist CBOs and other CIE participants in completing legal agreements with local covered entities.

Themes from Participants:
In general, participants expressed general awareness of the complexities of consent and security issues but had limited insight into best practices to share. Health care organizations were comfortable with the notion of following HIPAA regulations regarding consent, security, and data exchange. CBOs reported much confusion and some frustration in their attempts to develop common consent and security policies for local initiatives. Participants had many questions related to data governance and stewardship for MiHIN staff, including *'If consent is written for the purpose of coordination of care, does separate consent need to be given for secondary data use?, 'Who owns this data?'* and *'How can health care payors and vendors use SDoH data collected by CBOs without explicit permission or compensation?'*

Summary: Developing a standard approach to manage consent and data privacy for cross-sector data exchange is complicated by the presence of separate regulatory oversight of health care, behavioral health, and (soon) social care data. CBOs generally lack the resources needed to navigate the complex legal agreements needed to support local CIE initiatives. CBOs also raised many questions regarding data governance and stewardship.

RECOMMENDATIONS:
1. In the near term, base consent and data privacy policies on HIPAA regulations. More restrictive policies will need to be developed for highly sensitive social care data (ex: domestic violence, correctional system involvement).

2. In the near term, encourage or require local CIE initiatives to identify a formal Covered Entity to manage legal agreements with local participating organizations to meet HIPAA requirements.
3. For the long term, develop a comprehensive approach to support consent and data privacy across all sectors; one possible option would be a tiered approach to enable multiple levels of security and asymmetric data sharing.
4. MDHHS consider convening a multi-stakeholder working group to develop a common statewide model for data governance.

Takeaway #6: The Need for an Equitable and Sustainable Data Sharing Strategy

As described above (Takeaway #5), health care data exchange is governed by HIPAA regulations, clarified over many years and implemented largely through IT-enabled organizational pathways. CBOs have minimal experience in navigating HIPAA-compliant data-sharing agreements and minimal infrastructure in place to review or negotiate such agreements.

Most current work to build cross-sector data exchange capacity has been designed to serve a health care-centric use case: SDoH screening in medical practices linked to closed-loop referrals to community social service providers, with intervention and outcome data returning to the health care sector. The benefits of this approach largely accrue to health care organizations and payors (reduced health care expenses, improved health outcomes, social care data for population health risk adjustment), with the additional work to collect and share data largely borne by CBOs.

As mentioned above (Takeaway #2), some CBOs are being asked to connect to several non-interoperable Community Referral Platforms to send data back to competing health care systems. In most of these situations, the CBO has no capacity to retain control over its own data or use it for its own internal purposes: data sharing is primarily in one direction. In many settings data sharing is limited to vertical exchange between medical practice and single CBO (1:1), rather than a distributed system that shares data across all network partners engaged in caring for an individual patient/client. The net result is generally an inequitable system of care in which social care providers effectively subsidize health care organizations' efforts to collect social care data and address social care problems to reduce costs. The longstanding power differential between health care organizations and CBOs makes it difficult for CBOs to negotiate a more equitable solution.

Themes from Participants:

Several CBOs reported being asked to connect to non-interoperable Community Referral Platforms by competing local health care systems or a commercial payor. In general, front-line providers have limited knowledge of the data sharing capabilities of their networks. Training in use of technology is inconsistently provided and often minimal and data sharing arrangements are rarely discussed. Most CBO staff are trained simply to receive and return referrals. In a few cases, CBOs have participated in co-design of local networks that offer direct connection and data sharing between partner CBOs as well as with health care providers: where available, direct connection between CBOs is seen as highly valuable as it enables coordination across a 'community care team'. Most CBO participants had concerns about secondary use of social care data without express consent but were not aware of local network policy or the regulatory environment that governs data sharing. CBOs uniformly expressed frustration with lack of access to their own social care data as well as de-identified local data that could be used for community dashboards and local resource planning.

- *"If we could see who else is working with the client, it could be a huge source of helping the client." – CBO staff member*
- *"One thing that does concern me is the resources, both human and financial, that organizations need to make this happen. A lot of times things are created with a health system mind that CBOs and health provider groups don't necessarily have. How are we going to make it work for them [CBOs]?" – PO administrator*
- *"It is hard to start building capacity without working toward shared vision and commitment to shared measures." – CBO lead*

SUMMARY: Data sharing is in principle well-established in the health care sector but not in the social care sector. Current cross-sector care initiatives are built to support a health care-centric use case, resulting in inequitable data sharing arrangements that favor health care organizations and missed opportunities to use this data to address community needs.

RECOMMENDATIONS (also see Takeaway #3 and #5):

1. Identify and disseminate current 'best practices' in equitable data sharing from Michigan CIE initiatives (ex: community co-design prior to technology implementation)
2. Engage CBOs locally and at the State level to co-design and disseminate equitable data sharing and data use policies that can better meet community needs (ex: inter-agency data sharing, community dashboards, local resource planning). This process will likely require the guidance of an external subject matter expert.
3. After reconciling conflicting consent and data security regulations (see #5 above), MDHHS could consider convening a multi-stakeholder working group to develop a common statewide policy for data sharing covering primary and secondary use. This will help equalize the power differential between health care and community, build trust, and increase equity.
4. Encourage CIE initiatives to develop or select technology solutions that enable direct connections between all CBO participants as well as health care providers ('distributed networks'), rather than solutions that only enable direct 1:1 connection between a CBO and a referring health care provider.
5. Support development of local technical capacity to enable proper collection, analysis, and sharing of local social care data across all community stakeholders (ex: supply and demand for local services, community dashboards, population health statistics).

Takeaway #7: The Need to Work with Multiple Vendors

At present, there are at least nine commercial Community Referral Platform vendors actively operating in Michigan. Vendors are primarily focusing their effort on directly contracting with health systems but have also contracted with payors. A few vendors have reached agreements to connect their platforms to the largest EHRs. Some are now tailoring their existing platforms and marketing to large regional CBOs. In most Michigan regions, several vendors are actively recruiting CBOs, health systems, and provider organizations. In addition to commercial vendors, MDHHS (MI Bridges) and Michigan 211 have developed and implemented versions of Community Referral Platforms that are now in active use.

Single platform solutions have been tested in other states. In these settings, short-term 'wins' in rapid implementation and ease of data capture have been offset by longer-term 'losses' in scalability and limited engagement of smaller CBOs and other community stakeholders (Cartier & Gottlieb, 2020).

With several vendors now established in Michigan, MiHIN believes that a single platform solution is not a realistic option. We have adopted a vendor-agnostic approach that focuses on developing and implementing technical standards for content and data exchange that will achieve data interoperability across platforms. We expect that most local CIE initiatives across Michigan will require a multi-platform solution that connects several vendors' platforms. This can be accomplished through a community social care data hub, provided and supported by MiHIN in its role as the state's Health Data Utility (parallel to MiHIN's role in supporting health care data exchange).

Themes from Participants:

Participants from all sectors confirmed the overwhelming presence of commercial Community Referral Platform vendors in their communities. Some CBOs have been directly recruited by multiple vendors, by local health systems, and state associations. Some have been offered signing bonuses and financial incentives for recruiting other local organizations. CBOs uniformly acknowledge that they have minimal organizational knowledge or capacity to evaluate these opportunities, and little bandwidth to develop local coalitions or caucuses to collectively process options. Most participants report that details regarding data 'ownership' and stewardship (vendor data lakes, rights to local data use, secondary data sharing) are not explicitly discussed during the contracting process. In most current CIE initiatives, resource directories are homegrown or developed by a vendor and proprietary, making it extremely difficult to exchange referral messages with a different platform used by another local CBO.

SUMMARY: Several Community Referral Platform vendors are already active in Michigan, and aggressive marketing of non-interoperable platforms to multiple stakeholder groups has disrupted efforts to develop a comprehensive solution to support cross-sector data exchange. Adoption of a vendor-agnostic policy that requires vendors to meet interoperability standards will reduce disruption and enable cross-platform data exchange.

- *"If we are using different platforms, we need the systems to be able to talk to each other. Price is also an issue." – CBO lead*
- *"[Our organization] works with hospitals, health systems and other community partners. Often times we must check, interact with and double enter data into several*

different databases to receive a referral or work collaboratively in a cross-sectoral way." - large CBO lead

RECOMMENDATIONS:

1. [From Takeaway #5 and #6] MDHHS consider convening a multi-stakeholder working group to develop common statewide models and policies to guide data governance, stewardship, and data sharing.
2. [From Takeaway #3] Approach commercial IT vendors to sign an Interoperability Pledge committing them to standards-based, interoperable data capture and exchange, and potentially make this a requirement for operations in the Michigan environment.
3. [From Takeaway #2] Provide incentives to (or set requirements for) local communities and CIE initiatives to adopt local instances of the statewide 211 directory as their core resource directory infrastructure. Requiring all commercial vendors to include the statewide 211 resource directory in their platforms will support interoperability of referrals across regions or localities.
4. For short-term work, reach consensus on a core [minimum] set of data elements and/or messages essential for cross-sector social care coordination, then determine content, formatting, and data exchange standards for each element and message. The initial core set is TBD but might include: SDoH screenings, social problems, social care referrals, and outcome(s). This set becomes the core content that vendors must make interoperable.
5. Invite, incentivize, or require commercial vendors to engage in pilot projects testing data elements, messages, and cross-platform data exchange. This parallels the Gravity Project strategy of commissioning, coordinating and evaluating Tier I, Tier II, and Tier III pilot projects.

Conclusion

MiHIN's vision for the future of cross-sector care and population health improvement in Michigan is built upon the premise that local communities can self-organize and effectively partner with medical organizations to develop **Community Integrated Health Networks**, and that MiHIN can assist networks by creating a statewide **Community Information Exchange** technology infrastructure that will provide the scalable technical infrastructure necessary for their success.

We have made progress since the 2020 statewide workshop series while dealing with the exceptional strains placed on health and social care by the Covid-19 pandemic. Several local CIE/CIHN initiatives are currently in progress across Michigan, and health care organizations are rapidly moving to implement enhanced SDoH screening protocols and build local social care referral capacity.

This workshop series was created to prepare Michigan stakeholders for the next stage of work to align and scale work across regions and sectors. We hoped to engage the three primary stakeholder groups engaged in cross-sector data exchange in Michigan (health care, social care, and government entities) in deeper conversations about their perspectives regarding cross-sector care and how to manage the collection, exchange and use of social care data. During three sessions, over 270 stakeholders actively collaborated to share their knowledge, experience, and most importantly the context in which their organizations and staff carry out this work every day.

This brief summarizes what we learned from those conversations. **We identified seven key takeaway points.** They clearly overlap: this space is complicated and there are multiple cross-dependencies in addressing the issues highlighted in this report. **We listed 36 specific recommendations.** Some recommended actions will be useful in addressing more than one issue; some were intended to be carried out in sequence in a stream of work. Our intention was to create a comprehensive list, then to work with MDHHS and stakeholders to refine the list and set priorities for the next stage of work.

In general, we see three streams of work ahead. Most of the recommendations fit under one of these work streams.

1. **Adoption of core technical standards.**
   This stream primarily addresses Takeaways #1 (Z-codes) and #2 (statewide resource directory), and some of #3 (use of MiHIN standard tools wherever possible). Much of this work can be accomplished in the near term through MiHIN -MDHHS collaboration. Efforts are already underway to improve health care organizations' capture and exchange of Z-code data, MiHIN can extend the HIE tools used for health care data exchange to social care organizations, and conversations with Michigan 211 on resource directories have begun.

2. **Development and testing of data exchange standards.**
   This work stream addresses Takeaways #3 (interoperability) and #7 (working with multiple vendors), and some of #5 (consent and privacy). This is near to longer term work that can be aligned to match the pace of social care data standards development. MiHIN SDoH team members are already working closely with the Gravity Project, HL7, and the Direct Trust collaborative on pilot work and implementation strategy. All commercial Community Referral Platform vendors active in Michigan have agreed to sign MiHIN's Interoperability Pledge, signaling their commitment to following technical standards to achieve data interoperability and enable cross-platform data exchange. With this foundation in place, we believe that many of the recommendations can be carried out through a series of pilot projects involving local CIE initiatives, testing one or more aspects of the data exchange process. One current example can be seen in the joint Health Equity/CQI project involving CHRT, MiHIN, and BCBSM, where MiHIN is working with the project leadership to identify a basic social care data exchange protocol.

3. **Equitable Cross-sector Policy and Payment Alignment.**

This stream addresses Takeaways #4 (misaligned incentives), #5 (privacy and consent standards), and #6 (equitable and sustainable data sharing). Solving the complex issues embedded in this third steam will require a sociotechnical design approach, with many stakeholders coming together to co-develop equitable solutions for local data governance (consent, sharing, secondary use), incentives that can increase and engagement by community stakeholders, and policies that can balance the core interests of multiple sectors to maintain alignment. This work will take place over many conversations involving local communities (CHIRs and CIE initiatives), single-sector and multisector work groups, and the creation of a CIE Task Force that can take in all this content to develop recommendations for policymakers and the state HIT Commission. We trust that the recommendations listed under these Takeaways can help guide MDHHS, the HIT Commission, and other stakeholders in carrying out this longer-term work stream.

With the State's support and the continued involvement of key stakeholders, we feel strongly that our recommendations will advance the exchange of social care data across the state. We look forward to robust discussion about these recommendations - and to our continued collaboration to advance this work.

Appendix A - Workshop Attendance Report

January 11, 2022 – Community Based Organizations

First Name	Last Name	Company
Jodie	Baker	NEMCSA
Jennifer	Barangan	
Brad	Barron	MDHHS
Kerry	Baughman	Northwest Michigan Community Action Agency
Megan	Bentley	Area Agency on Aging
Greg	Bloom	Open Referral
Alicia	Brace	MDHHS
Bethany	Burge	Henry Ford Allegiance Health
Alexa R.	Burgei	Jackson Collaborative Network
Esperanza	Cantu	United Way for Southeastern Michigan
Brittney	Carnahan	Development Centers
Ernest	Cawvey	MCA
Derocha	Clemmons	Wayne Metro CAA
Rachel	Copeland	MDHHS-MCPD QIPD
Yvonne	Cudney	Housing Bureau for Seniors
Ebony	Curry	Washtenaw Health Plan
Lily	Doher	United Way for Southeastern Michigan
Cynthia	Edwards	Michigan Dept of Health and Human Services
Rachel	Egelhof	JFS Washtenaw County
Xavier	Endress	Greater Flint Health Coalition Inc.
Amy	Florea	Senior Resources of West Michigan
Lisa	Gdaniec	Jewish Family Services
Sara	Gold	
Annalise	Guitar	Cinnaire
Laurie	Gustafson	Henry Ford Allegiance Health

Heidi Gustine	Gustine	Area Agency on Aging of Northwest Michigan
Stephanie	Hall	Area Agency on Aging 1-B
Sheri	Harris	Area Agency on Aging of Western Michigan
Cierra	Hessbrook	Greater Flint Health Coalition
Tiffanie	Hilgendorf	
Danielle	Hilliker	Southeastern Michigan Health Association
Sarah	Hong	Jewish Family Services of Washtenaw
Greg	Hull	
Sarah	Jacobs	AAA 1-B
Sharon	Kim	CHRT
Jill	Kind	Jewish Family Services of Washtenaw
Krista	Kirkpatrick	Oakland Family Services
Maureen	Kirkwood	Health Net of West Michigan
Bob	Kreha	Bright street Group
Kirsten	Laing	Tri-County Office on Aging
Nancy	Lindman	Michigan Association of United Ways
Joseph	Longcor	MDHHS
Nicole	Luczak	United Way of Bay County
Kat	Mackrain	
Lee	Marana	Upper Peninsula Health Information Exchange
Cartyea	Mathies	
Gabe	Matteson	
Ewa	Matuszewski	MedNetOne
Ernestine	McRae	HAVEN
Nick	Miller	
Tim	Moriarty	Health Net of West Michigan
George Motakis	Motakis	Lakeshore Regional Entity
Megan	Murphy	Michigan Health Endowement Fund

Stefanie	Murphy	Region IV Area Agency on Aging
Jenifer	Murray	Northern Michigan Community Connections
Emily	O'Brien	The Salvation Army
Dawn	Opel	Food Bank Council of Michigan
Jacqueline	Raxter	Chaldean Community Foundation
Alyssa	Rietveld	COTS
Rhonda	Sanders-Adams	
Ninah	Sasy	MDHHS
Sherry L.	Silwanowicz	
Kirk	Smith	Greater Flint Health Coalition
Nichole	Smith-Anderson	
Ramaswamy	Srinivasan	AAANM
Elizabeth	Stanley	The Senior Alliance
Jeanine E.	Stanley	Henry Ford Allegiance Health
Jane	Sundmacher	Northwest Michigan CHIR
Janée	Tyus	Greater Flint Health Coalition
David	Underwood	Detroit Community Care Network
Marie	Verheyen	Oakland Livingston Human Service Agency
Mary Jo	Vortkamp	Detroit Public Library
James	Vulicevic	Region IV Area Agency on Aging
Joshua	Williams	Lifeways Community Mental Health
TJ	Youngquist	MDHHS

January 18, 2022 – Health Care

First Name	Last Name	Company
Ashley	Agnew	St. Mary's PHO
Chelsea	Arlington	St. Joe's
Kristina	Baas	Health West
Tricia	Baird	Spectrum Health
Yasir	Bakko	OPNS

Stacey	Bartell	Ascension Providence Medical Center South Lyon
Kristin	Batts	Cherry Health
Heather	Bermudez	TTI, Inc.
Michelle	Berry	Ascension Medical Group
Tanisha	Black	Development Centers
Mitchel	Blum-Alexander	Red Maple Resources, Inc.
Marcia	Brandt	Genesys PHO
Annaliese	Brindley	Oakland Southfield Physicians
Bethany	Burge	Henry Ford Allegiance Health
Jennifer	Burkett	Ascension
Ayse	Buyuktur	Center for Health & Research Transformation
Hannah	Cary	Development Centers
Michele	Causley	Genesys PHO
Ernest	Cawvey	MCA
Jaye	Clement	Henry Ford Health System
Derocha	Clemmons	Wayne Metro CAA
Rachel	Cotton	Genesys PHO
Carolyn	Custer	Authority Health
Susan	Dare	Molina Healthcare
Debra	Darling	MSU Institute for Health Policy
Beth	DeHart	SC Thrive
Mary Margaret	Dunneback	Sparrow Health System
Cynthia	Edwards	Michigan Dept of Health and Human Services
Xavier	Endress	Greater Flint Health Coalition Inc.
Jerome	Finkel	HFHS
Mary	Fisher	Michigan Medicine
Rebecca	Fleming	Packard Health
Jenna	Fletcher	HVPA
Alissa	Folger	Medical Advantage Group
Jane	Foote	Michigan Medicine
Sandy	Foster	Oakland Physician Network Services
Melissa	Gary	GLPO
Lisa	Geffros	Reliance PO of Michigan
Jane	Gietzen	Spectrum Health
Mike	Gleeson	United Physicians
Ashley	Goddard	Alcona Citizens for Health, Inc.

Brenda	Goldammer	Cadillac Family Physicians PC
Cindy	Golusin	Silver Pine Medical Group
Carol	Gray	MSHIELD
Pandora	Hall	Homewatch
Brian	Handspicker	National Interoperability Collaborative
Kathryn	Harmes	Michigan Medicine
Diane M.	Harper	University of Michigan
Dee	Hawley	East Jordan Family Health Center
Jacquelyne	Helgeson	McLaren Physician Partners
Robin	Hepfinger	MPHI
Andrew	Hickok	Michigan Medicine
Helen	Hill	SEMHIE
Hanna	Hillier	MyMichigan Collaborative Care Organization
Jess	Howell	Avalon Housing
Jennifer	Humphreys	Ascension Medical Group Genesys
Beth	Jabin	Spectrum Health
Sarah	Kajdasz	AmeriCorps MI- Southeastern Michigan Health Association
Kelly	Kamm	Michigan Technological University
Bruce	Kelly	GMP Network
Stephanie	Kendzierski	Henry Ford Health System
Jennifer	Kerns	NMHSI
Juhee	Kim	Hope Clinic
Sharon	Kim	CHRT
Suzie	Knoff	MyMichigan Health
Jessie	Korte	McLaren Physician Partners
Harriet	Kramer	Michigan Medicine
Sharon	Kraydich	The Physician Alliance
April	Kuehen	Integrated Health Partners
Lori	Kunkel	Greater Flint Health Coalition
Diane	Lambert	St Mary's PHO
Jeremy	Lapedis	Washtenaw Health Plan
Mark	Lazar	MedNetOne Health Solutions
Samantha	Lewis	Genesys PHO
Elizabeth	Lipscomb	Ascension Medical Group
Lindsey	Loepp	MSU
Joe	Longcor	MDHHS
Jeff	Lott	Michigan Medicine

Julie	Lowry	CHTN/HFHS
Alicia	Majcher	Michigan Medicine
William	Marella	HealthShare Exchange
Diane	Marriott	University of Michigan
Ewa	Matuszewski	MedNetOne
Janet	McElrath	Henry Ford Macomb Faith Community Nursing Network
Ashley	McKay	Cadillac Family Physicians
Cleamon	Moorer	American Advantage Home Care, Inc
Lacey	Morris	District Health Department #10
George	Motakis	Lakeshore Regional Entity
Stefanie	Murphy	Region IV Area Agency on Aging
Barbara	Murringer	UPHS Marquette
Dilhara	Muthukuda	MSHIELD
Eboni	Nichols	Aetna Better Health of MI
Beth	Oberhaus	Northern Michigan Care Partners
Ayo	Ogunsola	University of Michigan-Ann Arbor
Sarah	Oleniczak	District Health Department #10
Roseanne	Paglia	Partners in Care
Brittany	Pappa	Lakeland Care Network
Elisabeth	Paymal	University of Michigan Center for Health Research Transformation
Erica	Phillips	Munson Healthcare
Alex	Plum	Henry Ford Health System
Annette	Price	Silver Pine Medical Group
Carolyn	Rada	The Physician Alliance
Julianne	Ralph	Holland Home
Jake	Reiss	University of Michigan
Debra	Roberts	HVPA
Amy	Robertson	Spectrum Health Hospitals
Erica	Ross	Medical Network One
Melissa	Roy	Easterseals MI
Karly	Saez	Professional Medical Corporation
Lee	Schultheiss	Integrated Health Partners
Gina	Schutter	Holland PHO
Michelle	Seguin	Portage Health Foundation
Ruth	Shamraj	Michigan Medicine
Kelly	Shew	Olympia Medical
Ashley	Smith	Ascension

Deana	Smith	Center for Health and Research Transformation
Jordan	Smith	Alcona Health Center
Kirk	Smith	Greater Flint Health Coalition
Mark	Socks	Henry Ford Health System
Deborah	Spencer	Oakland Physician Network Services
Jessica	Steinhart	Ascension
Adam	Stevens	Montcalm Care Network
Kortnie	Strain	OPNS
Laura	Sutter	AAA3C
Faiyaz	Syed	Michigan Primary Care Association
Janée	Tyus	Greater Flint Health Coalition
Angela	Vanker	GMP Network
Christine	Vanlandingham	Region IV Area Agency on Aging
Haley	Walter	Oakland Southfield Physicians
Beverly	Walters	Oakland Physician Network Services
Natalie	Walther	HealthWest
Marie	Wendt	Great Lakes PO
Emily	Williams	UnitedHealthcare Community Plan
Daisy	Wright	Ascension Medical Group
TJ	Youngquist	Michigan Dept of Health and Human Services
Kathleen		

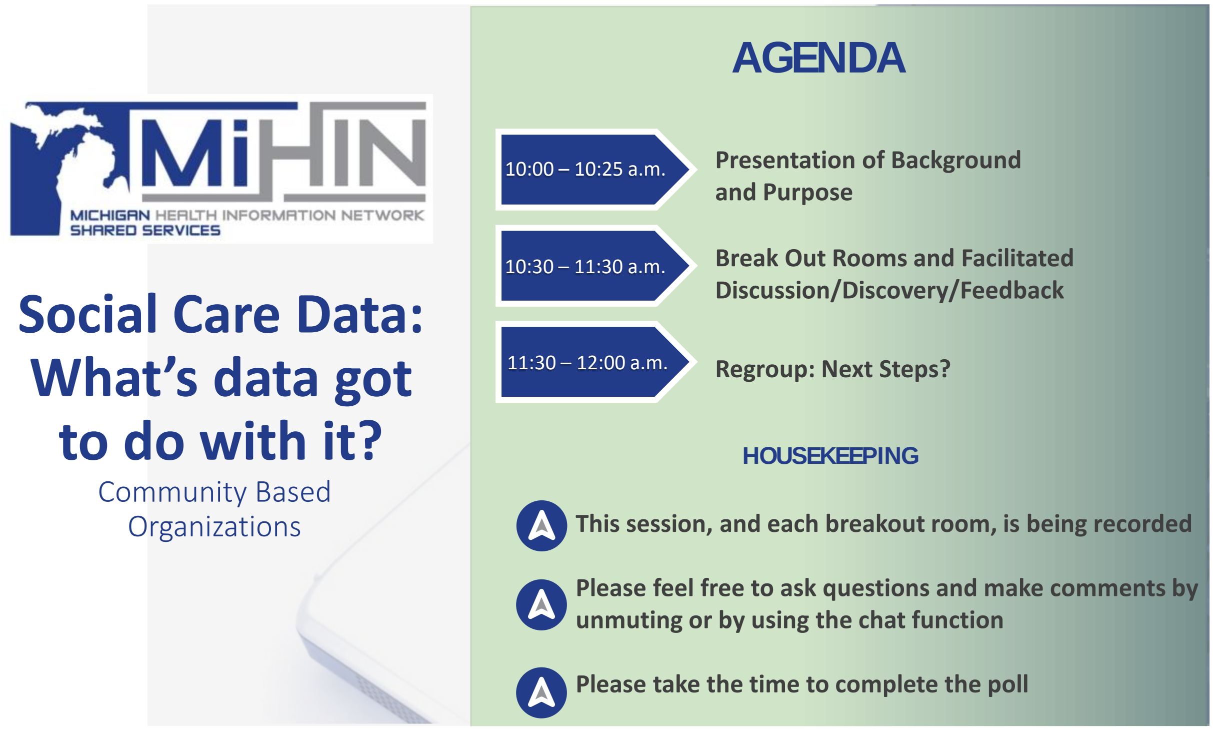
January 25, 2022 – Government Entity

Jan 25 2022		Government Entity Workshop
First Name	Last Name	Company
Angela	Arnott	Office of Senior Services
Kristina	Baas	HealthWest
Michelle	Barefoot	Benzie Area Chamber of Commerce
Brad	Barron	MDHHS
Mitchel	Blum-Alexander	Red Maple Resources, Inc.
Katie	Commey	Michigan Department of Health and Human Services
Michelle	Dardis	The Joint Commission
Donna	Davidson	HHS
David	Dieterich	The Virginia Northern Company
Cynthia	Edwards	Michigan Dept of Health and Human Services
Brion	Edwards	Disability Network
Moonson	Eninsche	Washtenaw County Office of Community & Economic Development

Audrey	Fleming	United Way - Montcalm Ionia
Mariah	Goos	EUP Regional Planning
Brian	Handspicker	National Interoperability Collaborative
Jeanine	Hatcher	GenesisHOPE
JaWanna	Henry	HHS
Robin	Hepfinger	MPHI
Danielle	Hilliker	Southeastern Michigan Health Association
Katie	Hoffman	Washtenaw County Office of Community and Economic Development
Jeri	Hunley	Single Family Living
Paula	Kaiser Van Dam	MDHHS
Sarah	Kajdasz	AmeriCorps MI- Southeastern Michigan Health Association
Laura	Kilfoyle	MDHHS
Sharon	Kim	CHRT
Amanda	Klein	United Way for Southeast MI
Nichole	Kleiner	City of Hart
David	LaLumia	Area Agencies on Aging Association of MI
Sue	Latour	Harvest Time Christina Fellowship
Erma	Leaphart	Sierra Club Michigan Chapter
Diane	Marriott	Michigan Multipayer Initiatives
Lisa	McKenzie	Western UP Planning & Development Region (WUPPDR)
Katie	Montoya	Berrien County
Lacey	Morris	District Health Department #10
George	Motakis	Lakeshore Regional Entity
Dilhara	Muthukuda	MSHIELD
Donna	Norkoli	District Health Department #10
Stephanie	Osterland	Habitat for Humanity Detroit
Jordan	Powell	District Health Department #10
Katherine	Ralston	Michigan State University Extension
Emily	Reyst	CEDAM
Gary	Ringer	Joy Southfield CDC
Melissa	Roy	Easterseals MI
Jessica	Serman	Upper Peninsula Health Plan
Kaitlyn	Sibai	Blue Cross Blue Shield of Michigan
Joseph	Sullivan	State of Michigan - DIFS
Laura	Sutter	AAA3C
Lindsay	TerHaar	Oakland County Health Division
Monica	Trevino	Michigan Public Health Institute

Janée	Tyus	Greater Flint Health Coalition
James	Vulicevic	Region IV Area Agency on Aging
Lisa	Williams	New Beginnings CDC

Appendix B - Workshop Slide Decks



Social Care Data: What's data got to do with it?

Community Based Organizations

AGENDA

10:00 – 10:25 a.m.	**Presentation of Background and Purpose**
10:30 – 11:30 a.m.	**Break Out Rooms and Facilitated Discussion/Discovery/Feedback**
11:30 – 12:00 a.m.	**Regroup: Next Steps?**

HOUSEKEEPING

- **This session, and each breakout room, is being recorded**
- **Please feel free to ask questions and make comments by unmuting or by using the chat function**
- **Please take the time to complete the poll**

SDOH: What's data got to do with it?

Health Care Provider Teams

AGENDA

10:00 – 10:25 a.m.	Presentation of Background and Purpose
10:30 – 11:30 a.m.	Break Out Rooms and Facilitated Discussion/Discovery/Feedback
11:30 – 12:00 a.m.	Regroup: Next Steps?

HOUSEKEEPING

- This session, and each breakout room, is being recorded
- Please feel free to ask questions and make comments by unmuting or by using the chat function
- Please take a moment to type into the chat the main reason you are attending today.

SDOH: What's data got to do with it?

Government Entities

AGENDA

10:00 – 10:25 a.m.	Presentation of Background and Purpose
10:30 – 11:30 a.m.	Break Out Rooms and Facilitated Discussion/Discovery/Feedback
11:30 – 12:00 a.m.	Regroup: Next Steps?

HOUSEKEEPING

- This session, and each breakout room, is being recorded
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- Please take a moment to type into the chat the main reason you are attending today.

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