Informing the Value Proposition

Metro Denver Partnership for Health
Social Health Information Exchange (S-HIE)
Focus Group and Key Informant Interview Summary

APRIL 2021

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Background and Introduction

The Metro Denver Partnership for Health (MDPH) Social Health Information Exchange (S-HIE) Steering Committee's User Group has been tasked to identify S-HIE user needs and address barriers to regional participation. The initial focus of this effort is on the unique business needs of community-based organizations in adopting and integrating into S-HIE now and in the future. The goal for the S-HIE User Group is to identify and document shared values and language and develop a value proposition for an interoperable regional S-HIE.

To accomplish this goal, the Colorado Health Institute (CHI), on behalf of MDPH, conducted four focus groups and three key informant interviews via Zoom in April 2021 to gather insights from community-based organizations, health systems, public health agencies, regional accountable entities (RAEs), and members of the community. The purpose was to gather feedback to inform the direction of the S-HIE User Group's work. CHI asked each focus group five to seven questions to gain a better understanding of current challenges and successes in coordinating care across health and community-based systems, and how participants think care coordination of services, particularly related to food insecurity, could be improved to better meet the social and health needs of individuals and families.

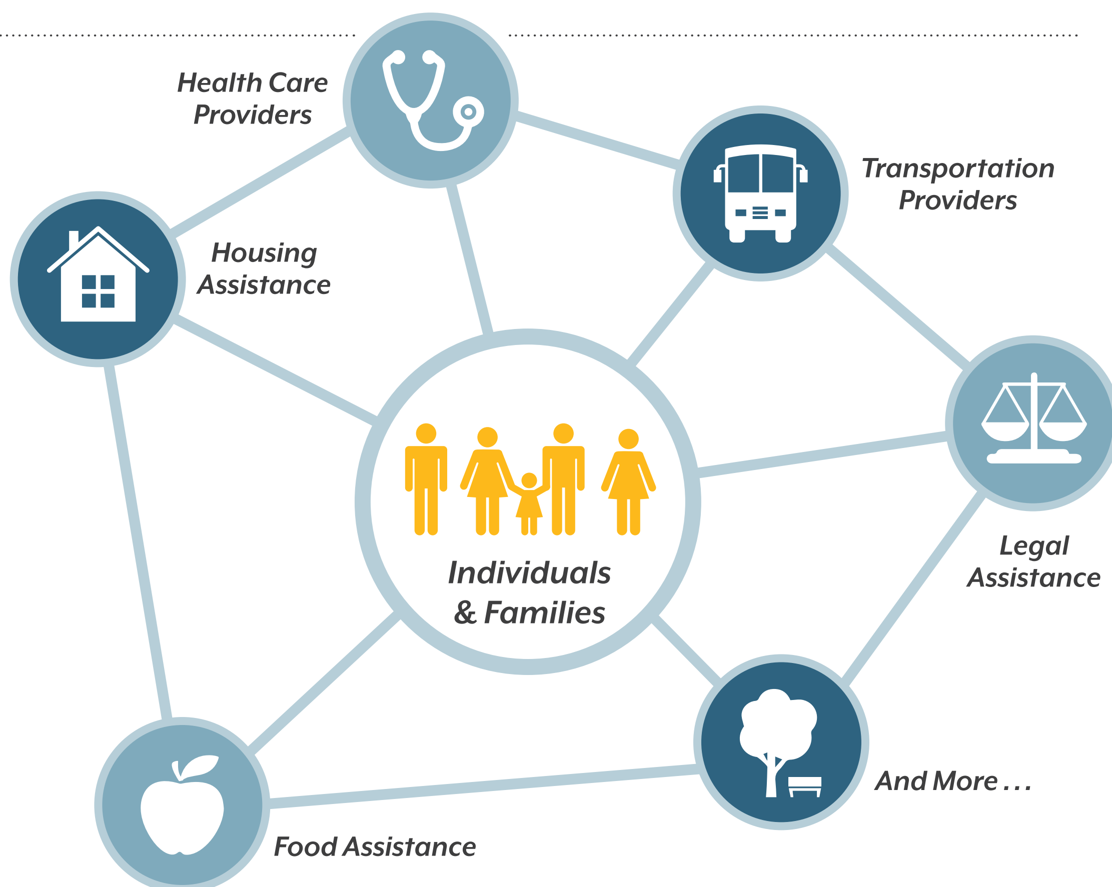
The following four groups, each with a different key focus, were assembled and interviewed:

1. **Health and Community (two groups):** Comprised of representatives from organizations working across all six core MDPH health-related social need domains (food security, housing, utilities, transportation, interpersonal violence, and behavioral health).
2. **Food Security Resources and Services (one group):** Comprised of representatives from food security organizations involved in screening, tracking, and referring people to food resources and services.
3. **Food Security Systems-level and Population Health (one group):** Comprised of representatives from food security organizations that track individuals and families across systems to better understand and inform population health planning needs.

(See Appendix for a full list of participating organizations)

S-HIE is about building a community of care around individuals and families.

S-HIE creates connections between and strengthens coordination among health, human, and community-based service providers to provide more holistic, customized care for people in need.



Definitions

S-HIE User: Any person or organization who will participate in S-HIE, which includes activities such as screening for health and social needs, seeking care and services, making referrals and coordinating care for individuals and families with other health and community service providers, and analyzing population-level data within the exchange to inform future public health priorities. In the future, S-HIE Users could include individuals and families, accessing their own information, resources, and referrals.

Interoperable: The ability of different information systems to connect, work together, and share information bidirectionally.

MDPH believes regional S-HIE efforts must be directed by the needs and priorities of the community. To represent community voice and include the perspectives of people with lived experiences, CHI interviewed three members of the community to understand their experiences with care coordination, what worked well, and what could have worked better.

This summary highlights key takeaways from each focus group and personal insights shared by community members.

Health and Community Focus Group

A total of 17 representatives from organizations that provide services across the six core MDPH health-related social need domains comprised the health and community focus groups. Questions posed to these groups centered on understanding the current challenges and successes of coordinating care within and across health and community-based systems, and how participants think health, human service, and community-based organizations could improve to better coordinate care and services for individuals and families.

Representatives included individuals working as care coordinators, case managers, resource navigators, patient advocates, and those in similar roles who screen and refer for social needs.

When asked about **what activities take up most of their time,** health and community focus group participants noted:

- **Responding to emails and phone calls.** Participants said a significant amount of time is spent attempting to connect individuals and families to resources. "Internal emails and/or emails with community partners and organizations take up a lot of time. Not with participants directly. With the community partners, it is a lot of emails around trying to get people connected to resources."
- **Educating people on resources.** Participants said they spend significant time making individuals and families aware of the services available to them. Care coordinators often spend a significant amount of their workday doing outreach, researching, and explaining resources to people they serve.

When asked about **what they would like to do less of,** health and community focus group participants cited:

- **Attending time-consuming meetings.** Participants said meetings that are called for information sharing compete with providing individuals and families with the help they need. These meetings include interactions with funders, strategy sessions among partner organizations, and team meetings within organizations.
- **Struggling to find adequate, tailored resources.** Focus group participants expressed frustration with trying to locate resources, which may be in short supply, to meet individual and family needs. They also noted they do repetitive follow-ups with individuals and families to ensure appropriate services are received, emphasizing a desire for cutting down encounters and getting people what they need quicker.

  "On one day, you get four to five people who need assistance with housing resources, and there is one in particular that I at least, don't have a solution for or resources that help. I have a list of resources, but I know deep down the resources I have are not going to get this person a house."

When asked about **what they would like to do more of,** health and community focus group participants noted:

- **Community-led innovative programs.** Participants suggested more collaboration with the community to create innovative, local responses to people's needs. "Let community members tell us what the programs need to look like so they can be the most supportive of members of our community versus us as professionals deciding what those look like. Community members are the experts."
- **Connecting individuals and families to services immediately.** Organizations prioritize getting services to people more efficiently. They want to emphasize service provision over less impactful tasks. "It's a problem having staff spend more time making sure data are entered correctly, versus more time making sure there is support for families and individuals."

When asked **how they would change the way health, human services, and community-based organizations coordinate care,** participants in the health and community focus group suggested:

- **Creating a coordinated system for communicating available resources.** Participants called for a streamlined system, statewide and locally, to promote communication among organizations, alerting them to what resources are available, and where, when, and how to connect people to them. "I would like to see that all community resources have more of a way to communicate easily. If we all had a way to communicate, we would be able to know what organizations were still around and what resources they were still providing."
- **Acknowledging community members as subject-matter experts.** Elevating the voices of community members can result in more tailored care coordination.

Food Security Resources and Services Focus Group

This group consisted of six representatives from food security organizations, who are involved in screening activities, referrals, provision of food and resources, and tracking outcomes for individuals and families. Questions posed to this group centered on current strengths, challenges, and a vision for better coordinating care to improve food security.

Participants represented food banks, community-based organizations, and local public health departments.

When asked about **what activities take up most of their time,** food security resources and services focus group participants noted:

- **Interactions with individuals and families, and resource provision.** This includes responding to calls and emails, helping people apply for assistance, and answering questions about resources. Focus group participants noted a significant amount of time is spent referring individuals and families to programs such as the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), food pantries, soup kitchens, and delivery services.
- **Coordination and communication with community partners.** This work includes holding meetings to coordinate workflows and distribution of resources, organizing delivery of food and resources, and communicating among partner organizations.

When asked about **what they would like to do less of,** food security resources and services focus group participants noted:

- **Being an in-between.** Focus group participants said their position is an intermediary role, connecting individuals and families in need with a provider or resource. "Being an in-between has increased with COVID. It involves speaking to a client who has a lot of concerns but can't get ahold of their provider. So, we have to call the provider through a patient line and tell the provider that they need to call their patient."
- **Spending time looking for resources and information for clients.** Participants said they are called upon to locate information and resources they believe should be readily available and easy to find. "We do a lot of research for clients on their cases that should be available to them. This includes things like finding updated food pantry information, rental assistance resources, and things like that."

When asked about **what they would like to do more of,** food security resources and services focus group participants suggested:

- **Leveraging program flexibilities allowed during the COVID-19 public health crisis.** Focus group participants said the COVID-19 pandemic highlighted a shift toward using technology more often to offer services. One participant said their organization benefited by "creating virtual healthy living courses with coaching, mentoring, and follow-up [which were previously in person]," making their processes more efficient to reach more people.
- **Connecting food security and human services partners.** Participants cited partnerships that connect organizations working in food security with those in human services to provide more whole-person care coordination so that the individual and family get everything they need. "I would really like to connect hunger relief partners with others in the area to provide wraparound services, not just food security resources, but also things like SNAP [Supplemental Nutrition Assistance Program] and other programs people could be involved in."

All focus group participants noted that on an average day, they are never able to serve everyone seeking help. Some said they get "thousands and thousands" of requests a week, with not enough capacity to address all needs.

When asked **how they would change the way health, human services, and community-based organizations coordinate care,** participants in the food security resources and services focus group suggested:

- **Promoting large-scale, co-located, wraparound services.** To address the growing need to provide multiple services, participants suggested a one-stop shop — where a person could call a phone number or go to one place to get connected to services. This would "enable folks to get whatever resources they need right away, so they do not have to be bounced around from organization to organization to get what they need."
- **Creating better data-sharing agreements.** Data sharing agreements between community-based organizations, health systems, and organizations that provide food services would promote more seamless information sharing and coordination of services.

Food Security Systems-Level and Population Health Focus Group

This focus group was comprised of five representatives from public health and food security initiatives and organizations that track individuals and families across systems to support care and/or population health data, planning, and advocacy. Questions posed to this group centered on tracking individuals and families across systems, highlighting current priorities and barriers in improving food security, and how more comprehensive and connected data collection through regional S-HIE could improve population health planning.

When asked about **their highest priority to improve food security in the metro Denver region,** food security systems-level and population health focus group participants noted:

- **Co-enrollment into services.** Participants cited enrolling individuals and families in multiple services, such as Medicaid, WIC, and SNAP, to get them the food security services they need. Some noted that the current enrollment system is time intensive, and that a significant priority is to make co-enrollment easier. They hope regional S-HIE can help their organizations do that.
- **Rapid response of food services to those most in need.** A priority shared by the group is to leverage funds and resources to get food services quickly to those most in need. One participant framed it as a "food now, food later" approach, where they address the most at-risk individuals and families immediately while also planning ways to leverage resources long-term to address community needs.
- **Scaling the work to the need.** Focus group participants noted a need to scale resources and services they provide to meet growing demand. "We need to focus on how we can continue to realize efficiencies to scale and bring our services to more folks, especially since we are expanding next year. We are looking at not reinventing the wheel but making sure everything is running smoothly."

When asked about **what barriers are getting in the way of cross-sector collaboration among systems to improve food security,** participants in the food security systems-level and population health focus group noted:

- **Barriers to data sharing.** Participants agreed that obstacles to data sharing were the most significant barrier to better cross-sector collaboration. "The barriers to data sharing in this human services space are just jaw dropping to me. At our hospital, we do primary care for 43,000 kids, and yet we can't achieve data sharing across the clinic from the family medicine doctor to the WIC office across the other side of the clinic." Participants suggested learning from approaches in health information exchanges (HIEs) to allow health and other systems to "succeed and allow them to share a large amount of data," with each other. "The bottom line is we have figured out data sharing before, so why can't we do it with S-HIE?" Participants suggested new policies at the state and federal level that could make data sharing and data governance more streamlined while respecting privacy guidelines.
- **Siloed funding streams.** A barrier, especially to co-enrollment into services that address food insecurity, are siloed funding streams — especially for programs like SNAP, WIC, and Medicaid, where funding is incentivized by enrolling people. One participant noted that "people can get SNAP dollars but only if they are enrolling someone in SNAP. If someone comes for help and is already enrolled, and has a ton of other social needs, it's like 'whoops, sorry, we don't get paid for that.'"

When asked **how more connected data collection and sharing through S-HIE could help population planning efforts,** participants in the food security systems-level and population health focus group noted:

- **S-HIE can foster closed-loop referrals.** Focus group participants agreed that having more connected data collection and sharing through regional S-HIE could foster better closed-loop referrals. This would help systems know when, where, and how services were delivered to families and individuals. Having that awareness creates the ability to "understand what your clients have already been referred to and being able to offer that continuum of care." Providing that awareness to individuals and their families and following up would encourage more people to access their referrals, getting them the resources and food, they need.
- **S-HIE can inform public health prioritization.** Having a regional S-HIE would create a system where identified needs, referrals, resource capacity, and outcomes could be tracked and evaluated, and used to prioritize time and investment where community needs are the greatest. "[S-HIE] can and should drive public health prioritization, right? [We can] focus our energy on what works and identifying the gaps."
- **S-HIEncan promote streamlined, automated enrollment into programs.** There is an opportunity to enroll people in an array of services by using S-HIE to efficiently screen and identify eligible individuals and families. This saves time, reduces administrative costs, and fosters greater impact with available resources. "If we know someone is on Medicaid, why are they not being automatically enrolled in WIC and sent an EBT card and told 'call this number to finalize your benefits?'"

Community Voice

CHI interviewed community members to get a better sense of their experiences navigating health, community-based, and human services systems, and their ideas of how these systems could be improved to better support individuals and families in meeting their health and social needs. Note: the terms care coordinator and navigator are used here, but these are used generally to describe positions that include but are not limited to health navigators, patient coordinators, social workers, community health workers, and others.

When asked **what was most helpful** in their experience being navigated to health, community-based, and human services, community members cited:

- **Thoughtful and knowledgeable care coordinators.** Community members credited their care coordinators with the positive experiences in getting the care and resources they needed. One community member noted that they particularly appreciated when their care coordinator took time to listen, identify their needs, and create a plan to address them together. Having face time with a

care navigator or care coordinator is important for the individual's and family's experiences.

- **A formalized screening assessment.** Community members said a structured screening with specific questions is helpful for them in determining their needs and highlighting how their care coordinators can help. One community member said the assessment they received helped them focus on their needs and work effectively with their care coordinator, but that some care coordinators screen more generally. "When care coordinators call and say, 'What can I help you with?' It's like – I don't know, what can you help me with?" Community members still want to voice their priorities and direct their care but noted how helpful structured screenings can be when they begin working with care coordinators.

One community member shared strong support and value in creating an interoperable S-HIE ecosystem. "I read the S-HIE White Paper — You have it down. We just need to make it happen. I can see it. It would save and transform lives."

When asked how navigating health, community-based, and human services **could be improved,** community members shared:

- **The importance of adequate training for care coordinators on social determinants of health.** Community members said it is important that care coordinators receive proper training in the specialized area they are working in—whether that is housing, food, mental health, or other social and health services — so they know how to ask the right questions.
- **Ensuring individuals and families know what tools they can use.** One community member said that "having the right resources at [their] disposal and the right tools," — like the right phone number, application, website, or other means — would help people know where, how, and when they can access resources to improve their health and well-being.
- **Devoting more money for services.** One community member highlighted the importance of sustainable funding for community resources and services. Social services and supports can only scale to meet the needs of communities if they are funded appropriately. Community members noted this as a priority for future care coordination efforts.

Informing the Value Proposition

The value of an interoperable S-HIE ecosystem depends on whether users find it helpful in addressing the unmet needs of individuals and families. If these needs are not met, there will be no improvement in health outcomes, health equity, and no return on the deep investment currently put into siloed S-HIE technologies. Takeaways from these focus groups and community member, key informant interviews will inform the larger value proposition that the S-HIE User Group will develop to guide the efforts towards an interoperable S-HIE ecosystem moving forward.

Appendix – Participating Organizations

The following organizations took part in a focus group or key informant interview from April 5 to April 20, 2021 via Zoom. Individuals representing these organizations included case managers, resource and eligibility specialists, social workers, navigators, dieticians and nutritionists, program coordinators, managers, directors, and administrators. The S-HIE Steering Committee sincerely thanks you for your participation.

- Atlantis Community, Inc.
- Brothers Development, Inc.
- Centura Health
- Children's Hospital Colorado
- Colorado Access
- Colorado Blueprint to End Hunger
- Colorado Department of Human Services, State Unit on Aging
- Denver Public Health
- Denver Regional Council of Governments, Area Agency on Aging
- Food Bank of the Rockies
- Hunger Free Colorado
- Jefferson County Public Health
- Mile High Connects
- Mile High United Way
- National Jewish Health
- One Colorado
- Project Angel Heart
- Salvation Army, an Energy Outreach Colorado partner agency
- Tri-County Health Department
- Sister Carmen Community Center
- UCHealth University of Colorado Hospital
- Volunteers of America

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