Data Sharing
RESOURCE GUIDE

NACCHO
National Association of County & City Health Officials

SCALE
STRATEGIC SOLUTIONS

D.E.E.P.
CONSULTANTS

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Table of Contents

This resource guide is organized in five chapters to outline how data sharing can be used to improve population health and health equity.

CHAPTER 1:

Purpose of Data Sharing

The Need for Local Data

While national datasets offer valuable insights into population health trends, local health departments (LHDs) require **granular, localized data** to effectively address community needs. This localized data allows LHDs to:

- **Measure risks and trends:** Identify emerging threats and track the course of health issues within their jurisdiction.
- **Evaluate program impact:** Assess the effectiveness of local programs, interventions, and laws implemented by the LHD.
- **Understand local needs:** Gain insights into the specific health challenges and social determinants of health (SDOH) affecting their communities.

Unlocking the Power of Data Sharing

Data sharing between LHDs and other local organizations presents a significant opportunity. Collaboration with schools, hospitals, police departments, judicial systems, and even community-based organizations can foster:

- **Public health research:** Access to a broader range of data allows for more comprehensive research studies relevant to local public health issues.
- **Knowledge generation and exchange:** Collaboration facilitates the sharing of best practices and expertise among different stakeholders.
- **Effective public health interventions:** By combining data sets, LHDs can develop more targeted and impactful interventions.

This document serves as a roadmap for LHDs to navigate data sharing with local partners. It provides a collection of tools and resources to help LHDs establish secure and collaborative data-sharing practices, ultimately enhancing their ability to improve public health outcomes within their communities.

1.1 Benefits of Data Sharing

Improved disease surveillance and outbreak detection: By integrating data on hospitalizations, symptoms, and lab results, public health officials can identify disease outbreaks faster and more efficiently. This allows for earlier intervention, containing outbreaks and minimizing their impact.

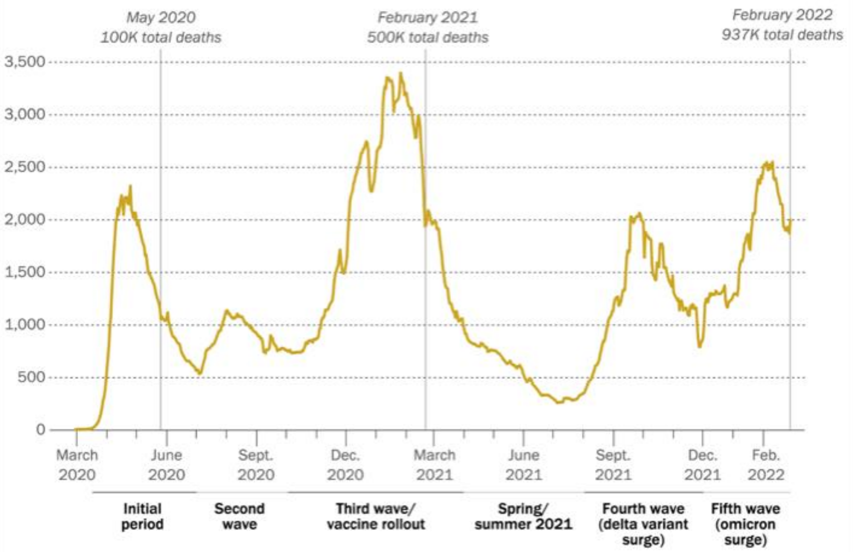
More effective program evaluation and resource allocation: By analyzing program data alongside community health information, public health professionals can assess the effectiveness of interventions and resource allocation strategies. This data-driven approach ensures resources are targeted towards the areas of greatest need within the community.

Enhanced research and development of public health interventions: Combining public health data with SDOH information allows researchers to identify factors contributing to health disparities and develop targeted interventions. This data can lead to more effective and equitable public health strategies.

Better understanding of SDOH: Public health data, when integrated with social and economic information, can reveal how factors like income, education, and access to healthcare influence health outcomes. This knowledge allows public health professionals to address the root causes of health disparities and create healthier communities for all.

Two years of coronavirus deaths in the United States

Average number of daily reported coronavirus deaths in the U.S.



Notes: Seven-day rolling average number of reported COVID-19 deaths. Excludes deaths in U.S. territories and those not assigned to a specific geographic location.
Source: Pew Research Center analysis of COVID-19 data collected by The New York Times as of Feb. 28, 2022. See methodology for details.

PEW RESEARCH CENTER

1.2 Data-Sharing Initiatives

Data sharing is already making a difference in public health. Real-world examples show how collaboration and data exchange are leading to earlier detection of outbreaks, better program design, and advancements in disease prevention and treatment.

The National Syndromic Surveillance Program is a collaboration among the Centers for Disease Control and Prevention (CDC), federal partners, local and state health departments, and academic and private sector partners, who have formed a community of practice. They collect, analyze, and share electronic patient encounter data received from various sources. This electronic health data is shared on the Biosense platform and then analyzed by the public health community.

For more information visit the website:
https://www.cdc.gov/nssp/index.html

CASE STUDY EXAMPLE:
Heat-Related Illness (HRI) Case Study

Challenge: Heat exposure is a major public health concern, causing illness and death across the United States. Vulnerable populations are at even greater risk.

Solution: The CDC addressed this issue by:

- **Prioritizing HRI surveillance:** Integrating data sources like emergency department (ED) visits to identify trends and high-risk groups.
- **Advancing the evidence base:** Establishing a collaborative workgroup and publishing reports (like the April 2024 MMWR) to highlight the problem's severity.
- **Empowering communities:** Utilizing tools like the CDC Heat & Health Tracker to provide accessible data and resources for local heat preparedness and response.

Outcomes:

- Improved understanding of HRI trends and risk factors.
- Increased collaboration among public health professionals.
- Empowered communities with data and resources to protect public health during heat events.

The CDC's HRI work is ongoing, with the workgroup continuing to share knowledge and develop solutions.

For additional information please check out the following website:
https://www.cdc.gov/nssp/index.html

Dallas County Public Health and Human Services (DCHHS) is the 2023 HIMSS (Healthcare Information and Management Systems Society) Davies Award winner for excellence in public health. DCHHS employed trusted enterprise-level software, including Salesforce, Informatica MDC, MuleSoft, Rhapsody, and Power BI. All these technologies were bought together to craft a seamless solution with streamlined user experience. These tools improved Dallas County's long-term preparedness to address future threats more readily. These systems allowed Dallas County to rapidly track cases and contacts in Dallas County, providing the ability to identify potential at-risk populations and deploy appropriate public health campaigns. The technology allowed officials to increase surveillance and rapidly contain public health emergencies.

For additional information please visit https://www.himss.org/sites/hde/files/media/file/2023/10/23/davies-2023-case-study-dchhs-public-health-final-august-29-2023.pdf

National Neighborhood Indicators Partnership (NNIP) is a national network of local organizations in over 30 cities. NNIP connects communities with data and helps them use that data to address local priorities. It focuses on working with underserved communities (low-income and communities of color). NNIP shares best practices and insights to accelerate innovation and advance equity nationwide.

Resources and Guides

NNIP has curated a variety of online guides, publications, and webinars on their website around data governance and security.

NNIP Lessons on Local Data Sharing online guide: This guide was developed in 2011 and updated in 2018 with the support of the Annie E. Casey Foundation. The guide has four sections: (1) Getting organized: steps to take before negotiating, (2) why data providers say no … and why they should say yes, (3) key elements of data sharing agreements, and (4) NNIP's collection of example data sharing agreements.

Resource Link:
https://www.neighborhoodindicators.org/library/guides/nnip-lessons-local-data-sharing

NNIP's Resource Guide to Data Governance and Security: This guide offers practical advice and resources to help organizations improve their data policies and practices. Drawing on the experience of the NNIP network and similar groups, the guide focuses on three key areas of a data governance program: (1) protecting privacy and human subjects, (2) ensuring data security, and (3) managing the data life cycle.

Resource Link:
https://www.neighborhoodindicators.org/library/catalog/nnips-resource-guide-data-governance-and-security

Lessons on Data Management Practices for Local Data Intermediaries: This brief helps organizations working as data intermediaries improve their Extract (collecting data), Transform (modifying it for analysis), and Load (storing it in usable format) process. The guide provides guidance and real-world examples (case studies) from successful NNIP organizations.

Resource Link:
https://www.neighborhoodindicators.org/library/catalog/lessons-data-management-practices-local-data-intermediaries

Principles for Advancing Equitable Data Practice: This 2020 brief introduces the Belmont Report's principles and provides selected principle-aligned practices and resources to help data experts at all levels integrate the principles into their work and move towards more equitable data practices.

Resource Link:
https://www.neighborhoodindicators.org/library/catalog/principles-advancing-equitable-data-practice

Data Across Sectors for Health (DASH): DASH offers a wealth of resources on using data effectively in cross-sector collaborations to improve health outcomes. It provides tools, case studies, and best practices for data sharing and collaborative analysis. It is valuable to public health officials because they are able to learn how to leverage data from various sectors (e.g., housing, education) to understand community health needs better and discover best practices for integrating data into policy development and advocacy efforts. DASH has a variety of resources related to data sharing.

One of their initiatives in collaboration with the Center for Health Care Strategies is the Learning and Action in Policy Partnerships (LAPP) funding program. This program helped community partners engaged in data-sharing projects to connect with state policymakers. The program ran in 2021–2022 with support from the Robert Wood Johnson Foundation.

Arizona Housing Coalition Example:

Addressing Homelessness in Arizona

- **Challenge:** High rates of homelessness significantly impact public health outcomes, including increased risk of infectious diseases and mental health issues.
- **Partnership:** The Arizona Housing Coalition (AHC) spearheaded a LAPP initiative, bringing together public health agencies, housing authorities, social service providers, and people with lived experience of homelessness.
- **LAPP Steps in Action:**
    - **Joint needs assessment:** AHC facilitated data sharing and collaboration to assess the scope and impact of homelessness in Arizona. This involved analyzing data on homeless populations, healthcare utilization, and resource availability.
    - **Policy development:** Based on the needs assessment, the partnership developed a comprehensive plan advocating for increased funding for affordable housing initiatives, expanded access to mental health and addiction treatment services, and improved coordination between sectors.
    - **Implementation and evaluation:** The AHC continues to work with partners to implement the plan, monitor progress, and refine strategies based on ongoing data collection and evaluation.
- **Outcomes:** The LAPP-driven partnership between public health and housing sectors has led to increased access to supportive housing and improved health outcomes for Arizonans experiencing homelessness.

More information about Arizona Housing Coalition can be found at https://www.chcs.org/media/LAPP-Case-Study-AZ_11.29.22.pdf

Utah: Combating Childhood Obesity

Challenge: Rising rates of childhood obesity pose a significant public health concern.

Partnership: The Utah Department of Health collaborated with schools, community organizations, and food retailers through a LAPP-driven initiative.

LAPP Steps in Action:

- **Joint needs assessment:** Partners analyzed data on childhood obesity rates, school lunch participation, and access to healthy food options across Utah communities.
- **Policy development:** Based on the assessment, the partnership advocated for policies promoting healthier school meals, increased availability of fresh produce in low-income neighborhoods, and physical education requirements.
- **Implementation and evaluation:** Ongoing monitoring tracks changes in childhood obesity rates and informs future policy refinements.

More information about Utah's project can be found at https://www.chcs.org/media/LAPP-Case-Study-UT-11.29.22.pdf

1.3 Advancing Health Equity

The U.S. continues to face significant health disparities, despite ongoing efforts to achieve health equity. To truly advance health equity, we need robust data collection and analysis strategies. This data plays a critical role in:

- **Identifying inequities:** By stratifying data, we can pinpoint areas where certain populations experience worse health outcomes.
- **Prioritizing action:** Data helps us identify the most pressing areas for intervention.
- **Driving improvement initiatives:** Data allows us to track progress and measure the effectiveness of implemented solutions.

Data is a powerful tool, but only if it's comprehensive and accurate. Moving beyond basic demographics like age, gender, and ethnicity is crucial. Integrating these with data on SDOH, like environmental factors and socioeconomic conditions, paints a more complete picture. This allows for a deeper understanding of the root causes of health disparities and the development of more targeted solutions.

CASE STUDY:
Puerto Rico Department of Health's (PRDOH) Health Equity Program

Challenge:

- **Addressing health inequities:** PRDOH recognized the need to tackle health disparities within Puerto Rico and sought to develop a data-driven approach to address these inequities.

Solution:

- **SDOH data dashboard:** PRDOH initiated the creation of an SDOH data dashboard to visualize and analyze health equity data.
- **Data integration and collaboration:** The project involved collaboration with various partners, including the U.S. Census Bureau and the Puerto Rico Comprehensive Cancer Center, to integrate diverse data sources reflecting SDOH themes.
- **Standard operating procedure (SOP):** PRDOH established an SOP for data collection, aggregation, and integration to ensure data quality and adherence to best practices.

Outcome:

- **Enhanced understanding of health inequities:** The SDOH dashboard is expected to provide valuable insights into health disparities in Puerto Rico, enabling PRDOH to make informed decisions and interventions to promote health equity.

Key Takeaways:

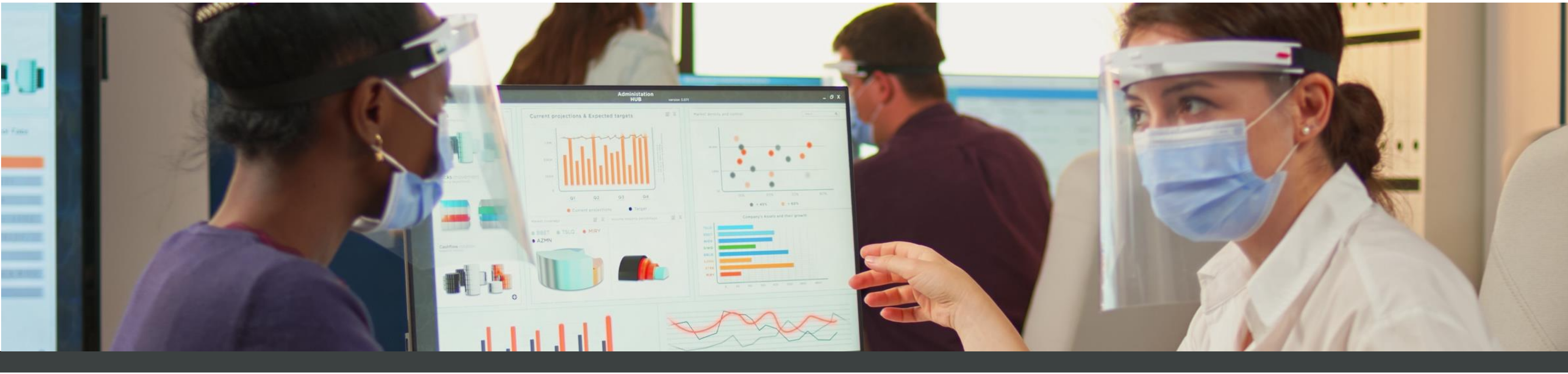
- **Data-driven approach to health equity:** The case study demonstrates the importance of utilizing data to understand and address health inequities.
- **Collaboration and data integration**: PRDOH's project highlights the significance of collaboration with various partners and integrating diverse data sources to create a comprehensive picture of health determinants.
- **Standardized processes:** The establishment of an SOP showcases the importance of implementing standardized processes to maintain data integrity and ensure the reliability of the SDOH dashboard.

Additional Considerations:

- **Data privacy and security:** It's crucial to ensure robust data privacy and security measures are in place when handling sensitive health information.
- **Community engagement:** Involving the community in the development and implementation of the SDOH dashboard can help ensure that the data reflect the needs and concerns of the population.
- **Sustainability:** Developing a plan for ongoing maintenance and updates of the SDOH dashboard is essential to ensure its long-term usefulness.

Overall, the PRDOH's Health Equity Program and the SDOH dashboard demonstrate a proactive approach to addressing health disparities in Puerto Rico through data-driven decision-making and collaboration.

More information about the PRDOH project can be found here: https://www.astho.org/globalassets/resources/developing-a-data-dashboard-to-address-health-equity-concerns_insights-from-puerto-rico.pdf



CASE STUDY: Roots of Health Inequity Course — Empowering Changemakers

Challenge: The complex issue of health inequity necessitates a deep understanding of its root causes, which extend far beyond the healthcare system. Traditional training often lacks the historical and structural context needed to effectively address these systemic issues.

Solution: The Roots of Health Inequity course, developed by experts and leaders in the field, presents a comprehensive and transformative learning experience. It delves into the historical and contemporary factors that shape health inequities, including racism, colonialism, and socioeconomic disparities.

Key Features:

- **Historical context:** The course explores the deep-rooted historical injustices that continue to influence health outcomes today, fostering a deeper understanding of the systemic nature of health inequity.
- **Structural analysis:** It examines the structural factors that perpetuate inequity, such as discriminatory policies, economic inequality, and unequal access to resources.
- **Interdisciplinary approach:** The course integrates perspectives from various disciplines, including public health, history, sociology, and economics, providing a holistic understanding of the complex issue.
- **Action-oriented learning:** It equips participants with practical tools and strategies to advocate for change and advance health equity in their communities.

Potential Impact: Participants can improve their understanding of health inequity and its root causes. The course can empower them to become more effective advocates for change, influencing policy decisions and community initiatives to promote health equity.

Conclusion: The Roots of Health Inequity course is free for all users and can be a powerful tool for individuals and organizations committed to advancing health equity. The course is available at https://www.rootsofhealthinequity.org/

Additional Considerations to Identify Your Data Requirements: The first step towards building a robust data infrastructure is to identify (1) the types of data your organization requires, (2) the specific individuals who need access to it internally and externally, and (3) how frequently it should be generated.

For more information please visit https://nap.nationalacademies.org/read/22261/chapter/4

CHAPTER 2:

Bridging the Data Divide: Investing in Technology to Improve Health Equity

In the wake of the COVID-19 pandemic, many lessons were learned. A review of our data responses indicates that there are areas for improvement. According to the U.S. Government Accountability Office, additional focus should be placed on tackling three major challenges as we modernize data collection, analysis, and sharing:

- **Common data standards:** Requirements for public health entities to collect certain data elements, such as client characteristics (e.g., name, sex, and race) and clinical information (e.g., diagnosis and test results) in a specific way.
- **Interoperability:** The ability of data collection systems to adopt consistent content and exchange electronic health information to simplify and expand data sharing; and
- **Public health IT infrastructure:** The computer software, hardware, networks, and policies that enable public health entities to report and retrieve data and information.

Resource: https://www.gao.gov/products/gao-22-106175

2.1 Common Data Standards:

To review, common data standards are requirements for public health entities to collect certain data elements, such as patient characteristics (e.g., name, sex, and race) and clinical information (e.g., diagnosis and test results) in a specific way. Data can be exchanged easily between organizations that adhere to the same health data standards. For example, a critical building block for the interoperability of electronic health information is the use of consistent formats such as vocabulary and code sets. The table shown below provides examples of vocabulary and terminology standards utilized by different healthcare systems.

Data sharing with organizations that do not closely adhere to recommended data standards can be challenging. Be sure to discuss data standards early in the process and jointly develop solutions when issues are identified.

Standard	Acronym	Description	Developer
Current Procedural Terminology	CPT®	Medical service and procedure codes commonly used in public and private health insurance plans and claims processing.	American Medical Association
International Classification of Diseases	ICD-10	International standard for classifying diseases and other health problems recorded on health and vital records. The ICD is also used to code and classify mortality data from death certificates in the United States.	World Health Organization
Systemized Nomenclature of Medicine	SNOMEDCT	Clinical healthcare terminology that maps clinical concepts with standard descriptive terms.	International Health Terminology Standards Development Organization
National Drug Code	NDC	Unique 3-segment number used as the universal identifier for human drugs.	U.S. Food and Drug Administration
RxNorm	RxNorm	Standardized nomenclature for clinical drugs. The name of a drug combines its ingredients, strengths, and/or form. Links to man of the drug vocabularies commonly used in pharmacy management and drug interaction software	National Library of Medicine
World Health Organization Drug Dictionary	WHODRUG	International drug dictionary	World Health Organization
Logical Observation Identifiers Names and Codes	LOINC®	Concept-based terminology for lab orders and results.	Regenstrief Institute for Health Care

Adapted from "Data Elements for Registries" in Registries for Evaluating Patient Outcomes: A User's Guide.

Patient-Driven Data Quality (PDDQ) Framework: Enhancing Patient Safety and Care Quality

Challenge:

- **Inaccurate and inconsistent patient data:** Healthcare organizations often struggle with fragmented and inaccurate patient information, leading to misidentification, medical errors, and compromised patient safety.
- **Data silos:** Patient data is often scattered across various systems and departments, making it difficult to access a complete and accurate patient record.
- **Lack of standardization:** The absence of standardized data formats and processes hinders interoperability and data exchange between different healthcare organizations.

Solution:

- **PDDQ Framework:** The PDDQ Framework provides a structured approach for healthcare organizations to improve the quality and consistency of patient data. It addresses key areas such as:
    - **Data governance:** Establishing clear policies and procedures for data management, including data ownership, access controls, and data quality assurance.
    - **Data quality:** Implementing processes for data cleaning, validation, and deduplication to ensure accuracy and completeness.
    - **Data operations:** Streamlining data collection, storage, and retrieval processes to improve efficiency and accessibility.
    - **Platform and standards:** Adopting industry-wide data standards (e.g., HL7®) to promote interoperability and facilitate data exchange.
    - **Supporting processes:** Integrating data quality into existing workflows and providing staff training to ensure sustainable improvement.

Benefits:

- **Improved patient safety:** Accurate and consistent patient data reduces the risk of medical errors and improves care coordination.
- **Enhanced care quality:** Complete patient information enables healthcare providers to make more informed decisions and provide personalized care.
- **Increased efficiency:** Streamlined data processes and interoperability reduce administrative burdens and improve operational efficiency.
- **Support for research and public health:** High-quality data enables valuable research and informs public health initiatives.

Case Study: Dallas County Public Health and Human Services (DCHHS)

Challenge: DCHHS faced data quality and integration challenges, hindering disease surveillance and response efforts.

Solution: DCHHS implemented the PDDQ Framework, leveraging technologies such as Salesforce, Informatica MDM, MuleSoft, Rhapsody, and Power BI to automate data ingestion, cleaning, and analysis.

Impact: The new system enabled DCHHS to rapidly track and contain public health emergencies, such as COVID-19 and Mpox outbreaks. It also streamlined workflows and reduced manual effort, allowing staff to focus on critical public health activities.

Conclusion: The PDDQ Framework is a valuable tool for healthcare organizations to address the challenges of patient data management and improve patient safety, care quality, and operational efficiency. By standardizing and integrating patient data, organizations can create a more seamless and effective healthcare system for all.

For more information visit the website: https://www.healthit.gov/playbook/pddq-framework/platform-and-standards/data-standards/

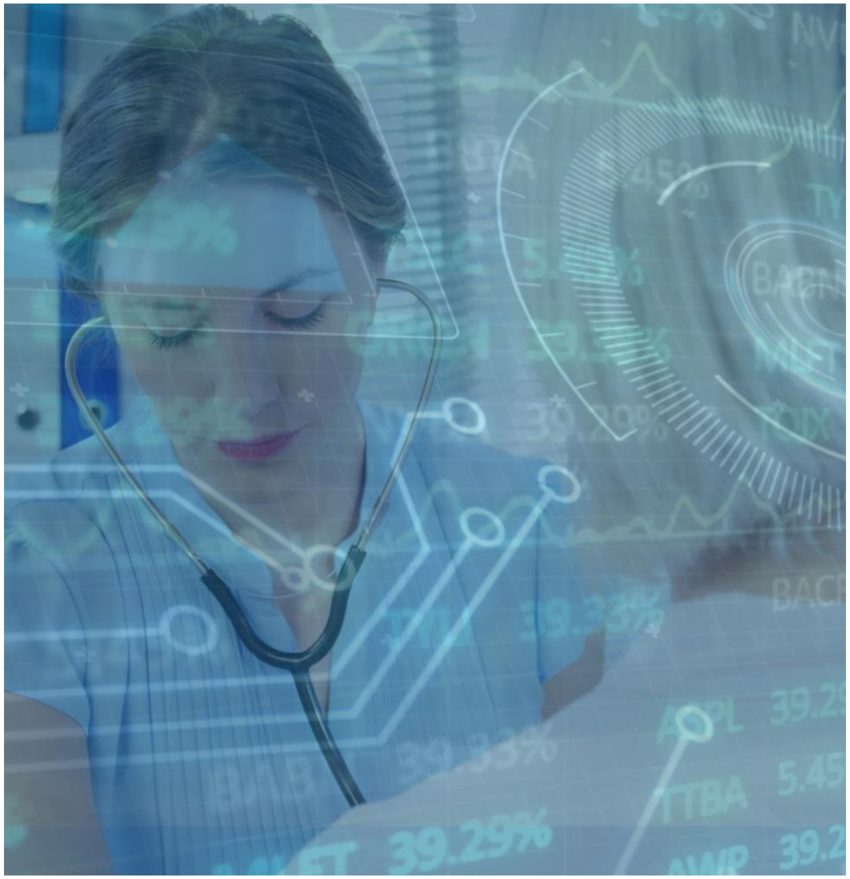
MMS Hub (Measure Management System Hub) of the Centers for Medicare & Medicaid Services provides information on the **Data Standards** used in specifying codes for quality measures.

- **Purpose:** Data standards are essential for ensuring consistency, interoperability, and meaningfulness of healthcare data across different systems. They define the format, structure, and vocabulary used to represent and exchange health information.
- **Importance in measure specification:** When specifying codes for quality measures, using established data standards ensures that data is collected and reported in a standardized way, allowing for accurate comparison and analysis.
- **Standards used:** The page lists several specific standards commonly used in measure specification, including:
  - **Code systems:** These are sets of codes used to represent medical concepts, diagnoses, procedures, etc. Examples include ICD-10-CM, CPT, HCPCS, LOINC, and SNOMED CT.
  - **Value sets:** These are collections of codes from one or more code systems that define the permissible values for a specific data element in a quality measure.
  - **Terminology services:** These provide tools and services for managing and accessing code systems and value sets.
  - **Data element definitions:** These provide clear and unambiguous definitions of the data elements used in quality measures.

Overall, the page emphasizes the critical role of data standards in ensuring the quality and comparability of healthcare data used for quality measurement and improvement. By using standardized formats and terminologies, healthcare organizations can effectively collect, report, and analyze data to improve patient care and population health. For more information, visit https://mmshub.cms.gov/measure-lifecycle/measure-specification/specify-code/data-standards

2.2 Interoperability

Interoperability is the ability of different information systems, devices and applications (systems) to access, exchange, integrate, and cooperatively use data in a coordinated manner, within and across organizational, regional, and national boundaries, to provide timely and seamless portability of information and optimize the health of individuals and populations**.**



2.3 Health Information Exchange

A Health Information Exchange (HIE) is one way to achieve interoperability. An HIE can be instrumental when sharing data across diverse organizations and can facilitate access to and retrieval of clinical data. An HIE provides the capability to electronically move clinical information among disparate healthcare information systems and maintain the meaning of the information being exchanged. The data will reside in a data cloud and the HIE will facilitate sharing, security, and in-depth queries of the collective data. When budgeting, local health departments should consider the direct and indirect cost of participating in an HIE.

More information about HIE can be found at: https://www.ama-assn.org/practice-management/digital/health-information-exchange-interoperability

There are several notable examples of local HIEs across the United States that are working to improve care coordination and population health:

- **Ventura County Information Exchange (VCCIE):** VCCIE is an integrated system that fosters collaboration across sectors to improve population health. By enabling real-time data sharing and care coordination, VCCIE supports individuals and families as they navigate the social service system towards improved well-being. Through shared language, outcome measures, and data analysis, VCCIE enhances collaboration among county health and social service providers, breaking down barriers and identifying resource gaps.

More information can be found at: https://venturacountycie.org/homepage/

Chicago Regionwide Community Information Exchange (CIE)

- **Focus on homelessness:** An initial pilot phase of the Chicago Regionwide CIE focuses specifically on improving the health of people experiencing homelessness. This targeted approach allows for focused development and testing of solutions before expanding to the broader population.
- **Mental health support:** The CIE aims to contribute to building a more robust mental health support system. By facilitating the exchange of relevant patient information, the CIE can help providers identify individuals in need of mental health services and connect them to appropriate resources.
- **Cross-sector collaboration:** The CIE brings together community members, healthcare providers, and social service organizations to streamline the delivery of health and social services and improve public health outcomes in marginalized communities.

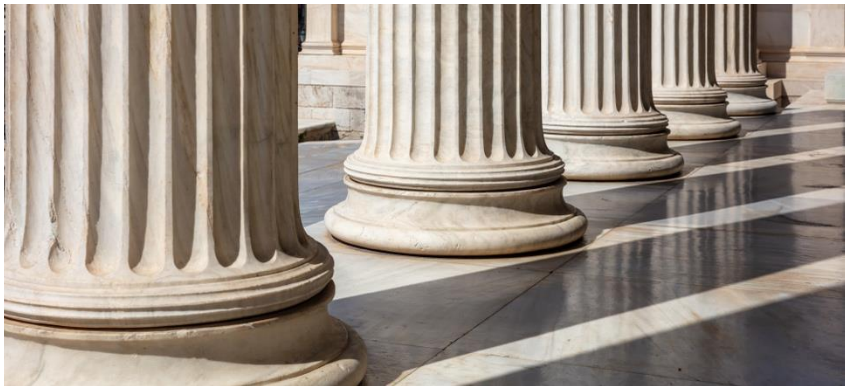
More information can be found at Chicago Regionwide CIE

San Diego CIE

- **Proactive care coordination:** The CIE enables a proactive system of care where multidisciplinary partners can collaborate on a single care plan, identify system interactions, and anticipate individual needs.
- **Real-time notifications:** When a significant event occurs, such as an ambulance call, care team members are notified so they can proactively address the individual's needs and make referrals to appropriate services.
- **Data equity framework:** CIE San Diego prioritizes equity and anti-racism in its approach to data sharing, ensuring that the CIE is used to address structural barriers to health and improve the lives of all people and populations.

These examples highlight the diverse ways that local HIEs can be tailored to the specific needs of their communities. By facilitating data sharing and collaboration, these CIEs play a crucial role in improving care coordination, addressing SDOH, and advancing population health.

More information can be found at Toolkit — CIE San Diego



2.4 Legislative Examples Expanding HIEs

Recent legislative examples highlight this expanding role:

- **Nevada (AB 7):** This bill establishes regulations for electronic health information exchange and protects providers who use HIEs for patient care.
- **Maryland (SB 914 & HB 811 "Josh Siems Act"):** This act requires fentanyl screening and reporting via the state HIE, improving public health surveillance.
- **Maryland (SB 584):** This bill leverages the HIE to share Parkinson's disease information, potentially paving the way for a future registry.

These examples showcase how HIEs are becoming a vital tool for not only patient care coordination but also public health initiatives.

More information can be found at:
https://www.astho.org/globalassets/pdf/legislative-prospectus-series/2024-data-modernization.pdf

2.5: Trusted Exchange Framework and Common Agreement (TEFCA)

Assistant Secretary for Technology and Policy and Office of the National Coordinator for Health Information Technology (ASTP/ONC) released a framework for Trusted Exchange Framework and Common Agreement (Common Agreement). The Trusted Exchange Framework and Common Agreement (TEFCA) aims to revolutionize nationwide health data exchange. It focuses on three key goals:

- **Standardization:** TEFCA establishes a set of common rules and technical requirements for secure health information exchange across different networks. This creates a "universal floor" for interoperability, ensuring seamless communication between healthcare providers.
- **Simplified connectivity:** TEFCA simplifies the process for organizations to connect and share health data securely. This fosters collaboration, improves patient care coordination, and ultimately leads to better health outcomes.
- **Patient empowerment:** TEFCA empowers individuals to access their own health information more easily. This fosters patient engagement and allows them to participate more actively in their healthcare decisions.

By achieving these goals, TEFCA has the potential to significantly improve patient care, population health, and the overall value of the healthcare system.

More information can be found at:
https://www.healthit.gov/topic/interoperability/policy/trusted-exchange-framework-and-common-agreement-tefca

Case Study Example: California's Data Sharing Agreement

In July 2021, California governor Gavin Newsom signed Assembly Bill 133 (AB 133), the Health Omnibus Trailer Bill. AB 133 mandated data sharing for healthcare providers in California and required the California Department of Health and Human Services to develop a Data Exchange Framework. The Data Exchange Framework is a single data-sharing agreement that certain organizations and providers in California are required to sign and comply with.

More information about this case study can be found at: https://www.chhs.ca.gov/wp-content/uploads/2022/07/1.-CHHS_DSA_Final_v1_7.1.22.pdf

2.6 CDC Data Modernization Initiative

The CDC's Data Modernization Initiative (DMI) is a multi-year, multi-billion-dollar endeavor aimed at revolutionizing the way public health data is collected, shared, and utilized across the United States. Launched in 2019 and further accelerated by the COVID-19 pandemic, the DMI seeks to address critical gaps and inefficiencies in the nation's public health data infrastructure, empowering decision-makers at all levels with timely, actionable insights to protect and promote the health of the population.

Key priorities of the DMI include:

- **Strengthening data collection and sharing:** Modernizing data collection systems and establishing interoperable platforms to facilitate seamless data exchange between federal, state, local, and Tribal health agencies.
- **Enhancing data quality and accessibility:** Improving data standardization, validation, and governance to ensure high-quality data that is readily accessible to public health professionals and researchers.
- **Expanding workforce capabilities:** Investing in training and development programs to equip public health professionals with the skills and knowledge to leverage modern data tools and technologies.
- **Promoting innovation and collaboration:** Fostering a culture of innovation and collaboration across the public health landscape to drive the development and adoption of cutting-edge data solutions.
- **Advancing health equity:** Utilizing data to identify and address health disparities and inequities, ensuring that all communities have the opportunity to achieve optimal health.

Through these efforts, the DMI aims to transform the public health data landscape, enabling faster and more effective responses to emerging health threats, improving disease surveillance and prevention, and ultimately creating a healthier and more equitable society for all.

More information can be found at https://www.cdc.gov/surveillance/data-modernization/index.html

CHAPTER 3:

Key Considerations for Data Stewardship, Data Security, and Privacy

Public health is undergoing a digital transformation, generating a vast amount of valuable data. However, public health agencies must balance harnessing this data's potential with ensuring the utmost privacy and security for sensitive patient and clinical information.

The key lies in establishing optimal data-sharing practices. These practices need to:

- **Promote accessibility:** Allow public health professionals to leverage data effectively for analysis and public health interventions.
- **Guarantee data confidentiality:** Employ robust safeguards to protect sensitive information and comply with patient privacy laws and regulations.

Finding the right balance between data sharing and privacy is paramount. By prioritizing both, public health agencies can unlock the power of digital data to improve population health outcomes.

3.1 Health Data Stewardship

Health data stewardship is the ethical management of personal health information. It involves a set of principles and practices that ensure this data is used responsibly throughout its life cycle. This includes collection, storage, access, sharing, analysis, and disposal. **Accountability** is a core principle. A designated data steward is responsible for overseeing the appropriate use of the data and bears the consequences of any misuse. **The goal of health data stewardship** is to strike a balance. It aims to unlock the potential of personal health information for improving healthcare and scientific understanding, while simultaneously safeguarding individual privacy and confidentiality.

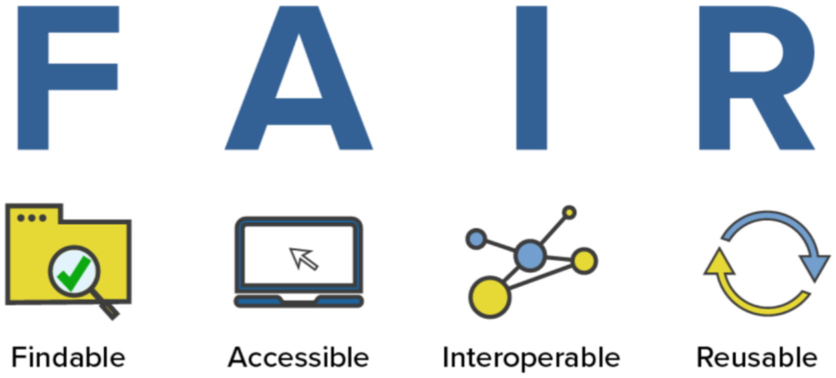
The National Institutes of Health Strategic Plan for Data Science has a guiding principle that all research data should adhere to FAIR Data Principles. Studies have shown that findable, accessible, interoperable, and reusable (FAIR) data leads to improved data sharing.

Findable data and metadata are assigned a globally unique and persistent identifier so that computers and people can easily find them. Data should be indexed as a searchable resource.

Accessible data can be retrieved via a standardized protocol that is universally implementable.

Interoperable data refers to accessible, shared, and broadly applicable language for knowledge representation, which allows for data integration with other data sources without ambiguity.

Reusable data is such that it can be further used or repurposed by using rich descriptions of data attributes.



More information about data stewardship in the context of health care can be found at: https://www.ncvhs.hhs.gov/wp-content/uploads/2014/05/090930lt.pdf

More information about FAIR data principles can be found at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10189186/

3.2 Barriers for Data Sharing

A systematic review of barriers to data sharing in public health was conducted in 2014. In the 10 years since, some of these barriers have continued to exist. The systematic review identified 20 potential barriers, classified in six categories: technical, motivational, economical, political, legal, and ethical. The first three categories are deeply rooted in well-known challenges of health information systems for which structural solutions have yet to be found; the last three have solutions that are more intangible and need dialogue aimed at generating consensus on policies and instruments for data sharing.

Link to the article:
https://link.springer.com/article/10.1186/1471-2458-14-1144

In reality, many times these barriers overlap with each other and the solutions to those challenges should also be multi-disciplinary. A recent study looks at three different examples of data sharing that sought to improve housing and health outcomes, ultimately improving the lives of vulnerable groups. Data strategies should first consider proving out the benefit in consultation with diverse stakeholders, mitigating legal risks from the beginning, and starting with a minimal data prototype.

Link to the article:
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7660439/

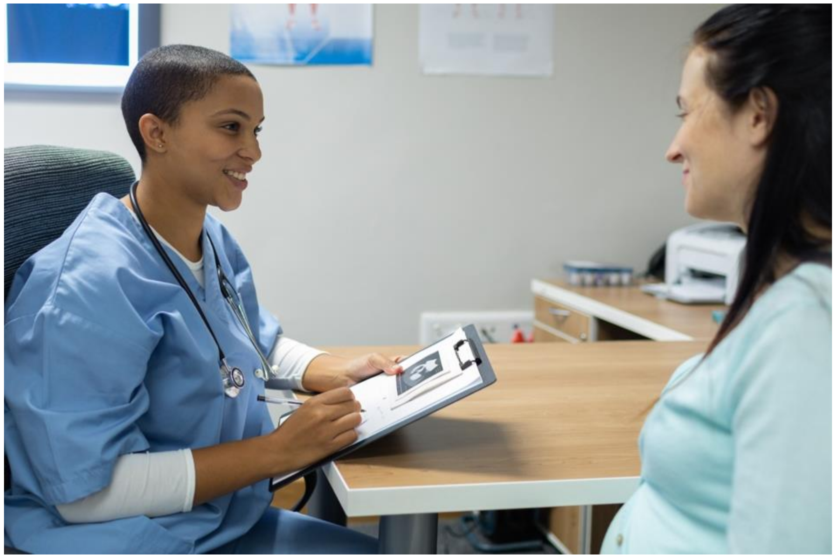
Category	Barrier
Technical	• Data not collected • Data not preserved • Data not found • Language barrier • Restrictive data format • Technical solutions not available • Lack of metadata and standards
Motivational	• No incentives • Opportunity cost • Possible criticism • Disagreement on data use
Economic	• Possible economic damage • Lack of resources
Political	• Lack of trust • Restrictive policies • Lack of guidelines
Legal	• Ownership and copyright • Protection of privacy
Ethical	• Lack of proportionality • Lack of reciprocity

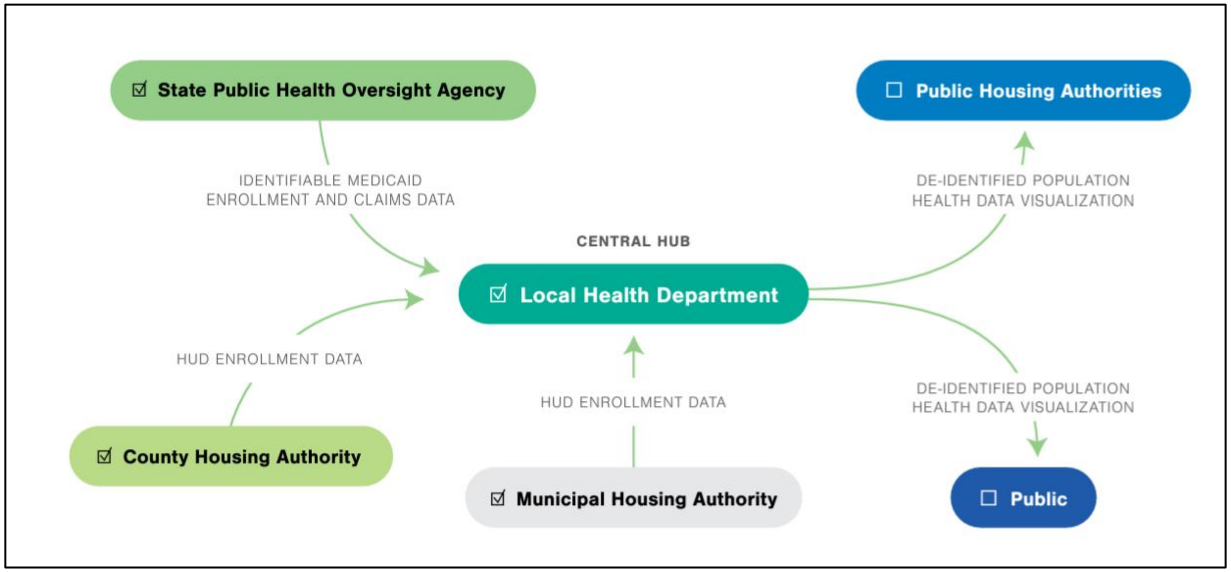
Legal Barriers to Data Sharing

There are multiple laws that regulate data sharing. Data is often subject to federal, state, and local laws. Generally, federal law overrules state law when their regulations overlap, in other words, federal law can trump state law when they cover the same ground. This concept is called preemption. There's an exception, though: floor preemption. Here, federal law sets a baseline but allows states to enact stricter regulations.

In data sharing, a prime example of floor preemption is HIPAA (Health Insurance Portability and Accountability Act). It establishes minimum data privacy and security standards, but states can add their own, more rigorous requirements.

Whenever data cross state lines, legal complexities arise. To navigate these complexities, particularly when multiple organizations are involved, consulting with an attorney is crucial. They'll help determine which state and federal laws apply to your specific situation.





Common Types of Data Laws	
Health Information	Identity Theft Protection
Public Health Reporting	Patient Rights
Medical Records	Professional Licensing
Data Practices	Facility Certification
Privacy	Insurance Law
Security	Consumer Protection
Breach Notification	Health Information Exchange
Sunshine Law	Social Security Number Protection

More information about legal barriers and how to overcome is available in this document: https://www.networkforphl.org/wp-content/uploads/2022/10/DASH_NPHL-Pathways_to_Yes-FINAL-PDF.pdf

Data Flow Map

Once the legal analysis is done, the data-sharing partners should map the data-sharing process. The Pathways to Yes document linked above has a chapter about data flow maps (see following page). These maps are helpful for legal analysis since they identify every point where people and systems interact and where data is transported. That's why devising a data flow map is a crucial step in developing your data sharing system.

Overcoming Technical Challenges:

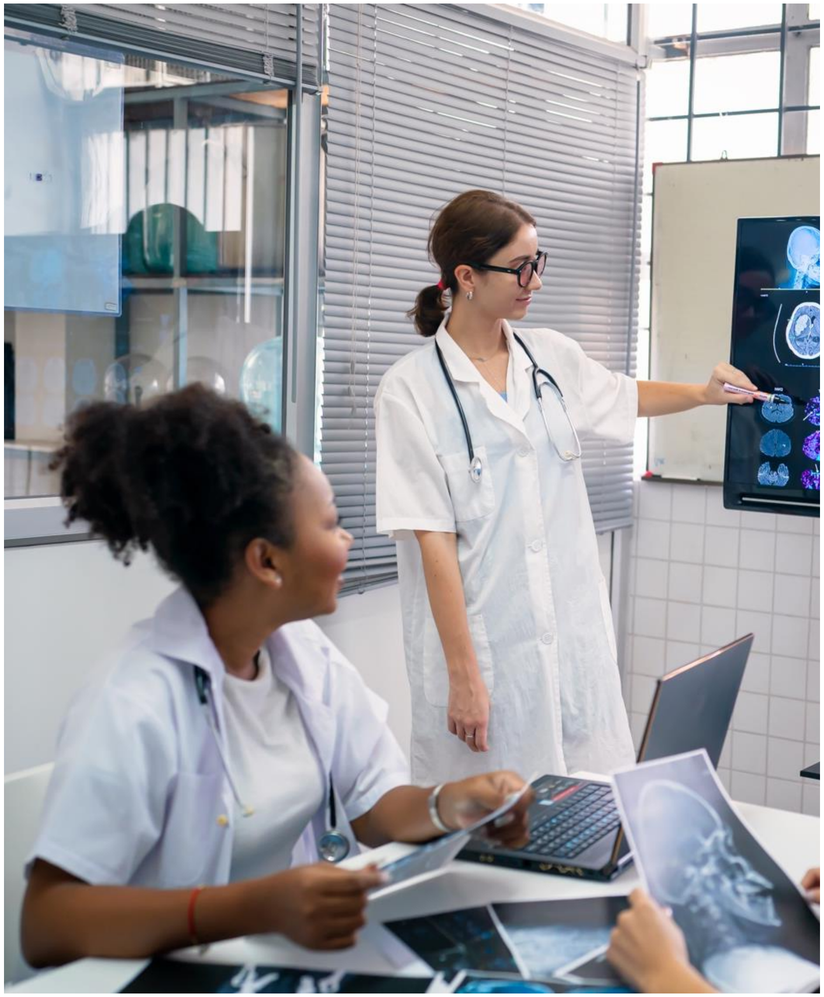
Data sharing is getting a boost thanks to innovative technology. Here are some ways it's happening:

- **APIs (application programming interfaces):** These act as messengers between computer systems, allowing them to share specific data securely. Imagine one agency asking another, “Is this person a patient in your program?” An API can send a yes/no answer based on predefined criteria, without revealing entire datasets.
- **Neutral third-party brokers:** Sharing data across organizations with different regulations can be tricky. A neutral third party can act as a go-between, running data matches and sharing only the limited, relevant information needed for analysis. This protects sensitive data while enabling collaboration.
- **One-way data sharing:** Organizations may have varying data-sharing restrictions. In such cases, a more restrictive agency can receive data from another, run the analysis internally, and send back only the results. This allows collaboration while respecting stricter regulations.

More information about these and other advancements can be found at https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Inside-MDHHS/Policy-and-Planning/Social-Determinants-of-Health-Strategy/CIE/Resources/Data-Sharing-to-Build-Effective-and-Efficient-Benefits-Systems.pdf

CHAPTER 4:

Bridging the Data Gap: Rural and Tribal Considerations



Closing the health gap in rural and Tribal areas hinges on access to accurate and reliable data. However, many communities face significant hurdles in obtaining data specific to their needs. These limited data hinder the development and effectiveness of crucial health programs.

Data Access Challenges:

- Researchers, health organizations, and Tribal leaders struggle with limited data availability, quality issues, and a lack of staff with the expertise and resources to analyze it effectively.

Solutions for a More Complete Picture:

- **Data skills training:** Increasing training on data informatics tools can empower communities to access and analyze data more effectively.
- **Exploring alternative data sources:** Look beyond traditional sources to gain a more comprehensive understanding of the rural community.
- **Collaborative data sharing:** Partner with organizations that possess additional data and expertise. These partnerships can benefit all parties involved.

By addressing these challenges and implementing these solutions, rural and Tribal communities can leverage the power of data to improve health outcomes for their residents.

4.1 Resources That Can Be Leveraged to Improve the Health of Rural Populations

Rural Health Information Hub (RHI): Funded by the federal Office of Health Policy, RHI is a national clearinghouse on rural health issues committed to supporting healthcare and population health in rural communities. https://www.ruralhealthinfo.org/success

County Health Rankings & Roadmaps (CHR&R): A program of the University of Wisconsin Population Health Institute that aims to create resources and provide tools that support evidence-informed solutions. The CHR&R provides a data snapshot for nearly every county in the nation. https://www.countyhealthrankings.org/health-data/how-to-use-your-county-health-snapshot

The National Rural Health Association is a national nonprofit membership organization that provides leadership on rural health issues through advocacy, communications, education, and research. https://www.ruralhealth.us/about-us/about-rural-health-care

National Organization of State Offices of Rural Health (NOSORH) Institutes are topical, virtual learning opportunities offered to state Offices of Rural Health and other rural health stakeholders throughout the year. NOSORH offers a variety of institutes, including the Independent Rural Primary Care Institute, Purpose-Driven Leadership Institute, Rural Health Grant Writing Institute, Rural Health Clinic (RHC) Mock Survey Masterclass, RHC Institute, Community Development Institute, NOSORH Leadership Institute, and Rural Health Data Institute. https://nosorh.org/educational-resources/nosorh-institutes/

The RHI Hub Rural Data Explorer provides data on a variety of topics related to rural health. The website is supported by the Health Resources and Services Administration. Users can view data by state, year, and metropolitan area. https://www.ruralhealthinfo.org/data-explorer

Case Study: Improving Care Coordination for Rural Elders in San Juan County, Utah

Challenge:

- **Fragmented care:** Rural elders often face challenges accessing healthcare and social services due to geographic isolation, limited transportation options, and a lack of coordinated care.
- **Communication gaps:** Healthcare providers and social service agencies often operate in silos, leading to communication breakdowns and missed opportunities to provide holistic care.
- **Data silos:** Lack of data sharing across organizations results in a fragmented understanding of individual needs and hinders efficient care coordination.

Solution:

Local Area Population Planning (LAPP) Data-Sharing Program:

- **Centralized data platform:** Established a secure and HIPAA-compliant platform for collecting and sharing relevant client information between healthcare and social service providers.
- **Collaborative care teams:** Fostered interdisciplinary collaboration among various stakeholders, including hospitals, home health agencies, and social service organizations.
- **Targeted interventions:** Utilized data insights to identify individuals at high risk and implement targeted interventions to improve health outcomes and reduce unnecessary hospitalizations.

Outcomes:

- **Improved discharge planning:** Enhanced communication and data sharing enabled seamless transitions of care for elders discharged from hospitals.
- **Identification of hidden issues:** Data analysis revealed a previously unrecognized problem of verbal abuse among elders, leading to targeted interventions.
- **Increased efficiency:** The program streamlined processes, reduced duplication of efforts, and optimized resource allocation.

Lessons Learned:

- **Importance of collaboration:** Building strong relationships and trust among diverse stakeholders is essential for successful care coordination.
- **Value of data sharing:** Breaking down data silos and facilitating information exchange enables a more comprehensive understanding of individual needs and informs effective interventions.
- **Scalability:** The program’s success in San Juan County demonstrates its potential for replication in other rural communities facing similar challenges.

This case study illustrates the positive impact of data-driven collaboration in improving care coordination for rural elders. By overcoming communication barriers and leveraging shared information, healthcare providers and social service agencies can work together to deliver more holistic and effective care to vulnerable populations.
More information about this case study can be found at https://www.chcs.org/media/LAPP-Case-Study-UT-11.29.22.pdf

4.2 Tribal Data Access and Sovereignty

Limited data exist to demonstrate an accurate representation of American Indian and Alaska Native (AI/AN) health status. The Indian Health Service has limited data as they track data only for individuals residing on American Indian Health Reservations, and Tribal nations have a right to maintain their own data. The Office of Minority Health reports that “87 percent of those who identify as American Indian/Native American live outside of Tribal land.” Data collection and sharing initiatives are needed to improve population health programming.

Building Trust: A Data Approach Rooted in Respect

For AI/AN communities, historical trauma from forced relocation, past injustices, and broken treaties has fostered a deep distrust of data collection and its potential misuse. However, accurate and comprehensive data is essential for designing effective health programs. Moving forward, we need data practices that respect these historical realities and rebuild trust.

A core principle is respecting AI/AN data sovereignty. The National Indian Health Board defines it as “the right of a nation to govern the collection, ownership, and application of its own data.” In essence, it’s about self-determination regarding data.

Local health departments working with Tribal communities should prioritize respect and educate staff on the historical context. Data collection methods must be designed collaboratively, reflecting the specific history, values, and sovereignty of each Tribal nation.

Open communication is key. Ownership, storage, and utilization of data should be mutually agreed upon with Tribal partners early in the project. This collaborative approach can build trust and pave the way for data-driven solutions that truly address the needs of AI/AN communities.

Resources:

- **Area Indian Health Board:** Guided by multiple Tribal Nations, they typically operate in several states and provide advice on program design, health policy and planning. https://www.nihb.org/about_us/area_health_boards.php
- **International Association for Indigenous Aging:** The International Association for Indigenous Aging, a 501(c)3 nonprofit educational association, works to ensure the provision of appropriate and quality services and resources for indigenous elders. https://iasquared.org
- **National Council on Urban Indian Health:** NCUIH is a national 501(c)(3) organization devoted to the support and development of quality, accessible, and culturally competent health services for American Indians and Alaska Natives living in urban settings. https://ncuih.org/about/
- **Office of Urban Indian Health Programs (OUIHO):** Within the U.S. Department of Health and Human Services, the OUIHO offers public health services and support to the United States’ urban American Indian and Alaska Native population. https://www.ihs.gov/urban/
- **Center for Indigenous Innovation and Health Equity (CIIHE):** Within the Office of Minority Health for the U.S. Department of Health and Human Services, CIIHE supports solutions to address health disparities for AI/AN and Native Hawaiian and Pacific Islander populations. https://minorityhealth.hhs.gov/center-indigenous-innovation-and-health-equity

CDC Office of Tribal Affairs and Strategic Alliance

The CDC Office of Tribal Affairs and Strategic Alliances (OTASA) is a crucial division within the CDC dedicated to improving the health and well-being of AI/AN communities. OTASA's overarching mission is to improve the health of AI/AN communities by fostering collaboration, empowering Tribal nations, and ensuring equitable access to public health resources and services. Through its work, OTASA helps to address health disparities and promote health equity in these communities.

Core Functions:

- **Government-to-government relationships:** OTASA upholds and strengthens the unique relationship between the federal government and Tribal nations, respecting their sovereignty and self-determination in public health matters.
- **Connecting Tribes to resources:** The office serves as a primary point of contact, linking Tribes and Tribal organizations to CDC programs, funding opportunities, and technical assistance.
- **Capacity building:** OTASA helps Tribes build and enhance their public health infrastructure through training, consultation, and resource development.
- **Data and information sharing:** The office facilitates the exchange of health data and information between Tribes and the CDC, promoting informed decision-making and effective public health interventions.
- **Advocacy and policy:** OTASA provides guidance and support on Tribal health policies and initiatives, ensuring that Tribal perspectives are represented in the development and implementation of public health programs.
- **Data sovereignty:** It is the 574 federally recognized Tribes that are sovereign nations and data (collection, analysis, reporting, etc.) on their people is owned by that Tribe. https://nativedata.npaihb.org/wp-content/uploads/2021/09/Handout-4-Tribal-Data-Sovereignty.pdf
- **Tribal Epidemiology Centers (TECs):** TECs are a vital component of the public health infrastructure serving AI/AN communities. These 12 centers, located throughout the United States, offer epidemiological and public health support to Tribes, Tribal organizations, and Urban Indian organizations. TECs play a crucial role in promoting data sovereignty by assisting Tribes in managing their own health information systems, conducting disease surveillance and investigations, implementing prevention programs, and responding to public health emergencies. You can learn more about TECs and their services on their website: https://tribalepicenters.org/

Challenge: Upholding Data Sovereignty and Improving Tribal Health

Data sovereignty: Tribal nations have the inherent right to govern their own data, including health information. However, historical practices and power imbalances often led to external entities controlling and misusing Tribal data.

Health disparities: AI/AN communities experience significant health disparities compared to the general population. Addressing these disparities necessitates effective data collection, analysis, and management at the Tribal level.

Capacity building: Many Tribal communities face resource constraints and limited access to public health expertise, hindering their ability to establish and sustain robust data management systems.

Solution: Empowering Tribes Through Tribal Epidemiology Centers (TECs)

Data control and governance: TECs help Tribes build capacity to collect, manage, and analyze their own health data, promoting self-determination and informed decision-making.

Culturally relevant public health: TECs provide technical assistance and training tailored to the unique cultural contexts and needs of Tribal communities.

Comprehensive support: TECs offer a wide range of services, including disease surveillance, outbreak response, health promotion, and program evaluation, all geared towards improving Tribal health outcomes.

Case Study: The Great Plains Tribal Epidemiology Center's Impact

- **Challenge:** The Great Plains region faces high rates of chronic diseases and health disparities among its Tribal communities. Data collection and management were often fragmented, hindering effective public health interventions.
- **Solution:** The Great Plains TEC partnered with Tribes to develop culturally relevant data collection tools, train Tribal health workers in data management, and conduct community-based health assessments.
- **Impact:** Enhanced data collection and analysis enabled Tribes to identify priority health issues, develop targeted interventions, and track progress. This led to improved disease surveillance, increased access to preventive care, and, ultimately, better health outcomes for Tribal members.

4.3 CARE Principles

For AI/AN communities, a focus on unrestricted data sharing can conflict with their rightful assertion of control over their data and knowledge. This control includes using AI/AN data to create value within their own worldviews and participate in the knowledge economy on their own terms.

The CARE Principles for Indigenous (AI/AN) Data Governance, developed by the Global Indigenous Data Alliance (GIDA), address this gap. People-centered and purpose-driven, these principles emphasize data's role in fostering Indigenous innovation and self-determination. They complement existing FAIR principles by urging open data movements to consider both the human aspect and the intended use of data.

GIDA, a network of Indigenous researchers, data experts, and policy advocates, champions Indigenous data sovereignty on a national and international stage. They welcome collaboration with anyone who shares their vision, including Indigenous data users, community groups, and policymakers.

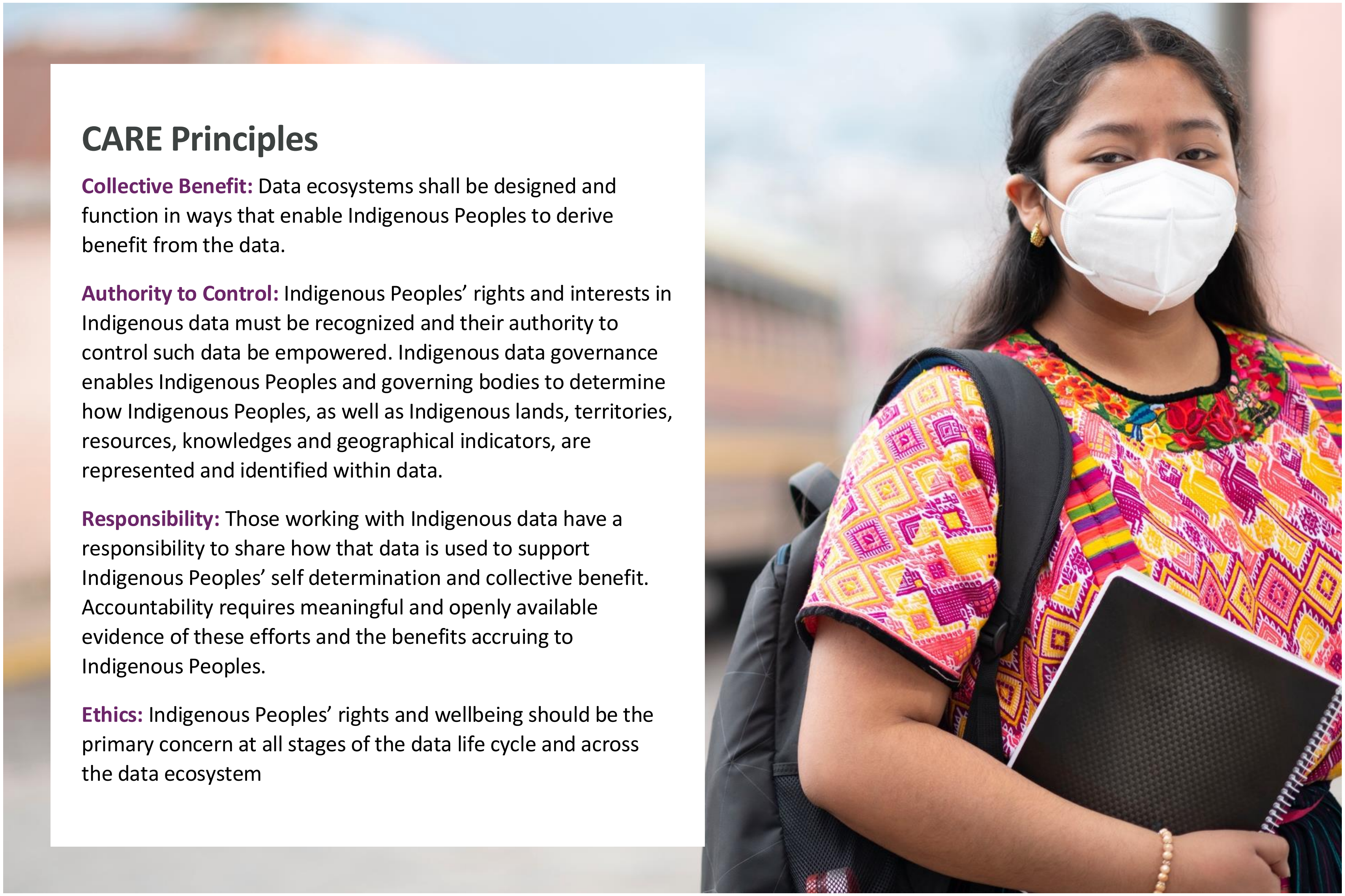
GIDA's core objectives include:

- **Promoting Indigenous data sovereignty and governance:** Empowering Indigenous Peoples to control their own data.
- **Asserting Indigenous rights and interests in data:** Recognizing the unique ownership and management rights Indigenous communities hold over their data.
- **Utilizing data for self-determined well-being:** Leveraging data for programs and initiatives that benefit Indigenous communities on their own terms.
- **Decision-making rooted in Indigenous values:** Upholding Indigenous rights to participate in data-related decisions in accordance with their own values and collective interests.

By incorporating these principles, the open data and open science movements can become more inclusive and respectful of Indigenous rights. This collaboration can lead to a future where data empowers Indigenous communities and fosters a more equitable knowledge landscape.

Resources:

More information can be found at GIDA's website. This site also has links to webinars, publications, and other resources. https://www.gida-global.org/care



CARE Principles

Collective Benefit: Data ecosystems shall be designed and function in ways that enable Indigenous Peoples to derive benefit from the data.

Authority to Control: Indigenous Peoples' rights and interests in Indigenous data must be recognized and their authority to control such data be empowered. Indigenous data governance enables Indigenous Peoples and governing bodies to determine how Indigenous Peoples, as well as Indigenous lands, territories, resources, knowledges and geographical indicators, are represented and identified within data.

Responsibility: Those working with Indigenous data have a responsibility to share how that data is used to support Indigenous Peoples' self determination and collective benefit. Accountability requires meaningful and openly available evidence of these efforts and the benefits accruing to Indigenous Peoples.

Ethics: Indigenous Peoples' rights and wellbeing should be the primary concern at all stages of the data life cycle and across the data ecosystem

4.4 Leveraging Medicaid-Medicare Data

State and local health departments play a crucial role in tracking population health data. Combining this data with Medicaid information offers valuable insights into health disparities across different communities. This is especially important for rural and Tribal communities, where dual Medicaid-Medicare eligibility is prevalent due to higher rates of poverty and disability, making integrated data analysis crucial for effective health planning and resource allocation.

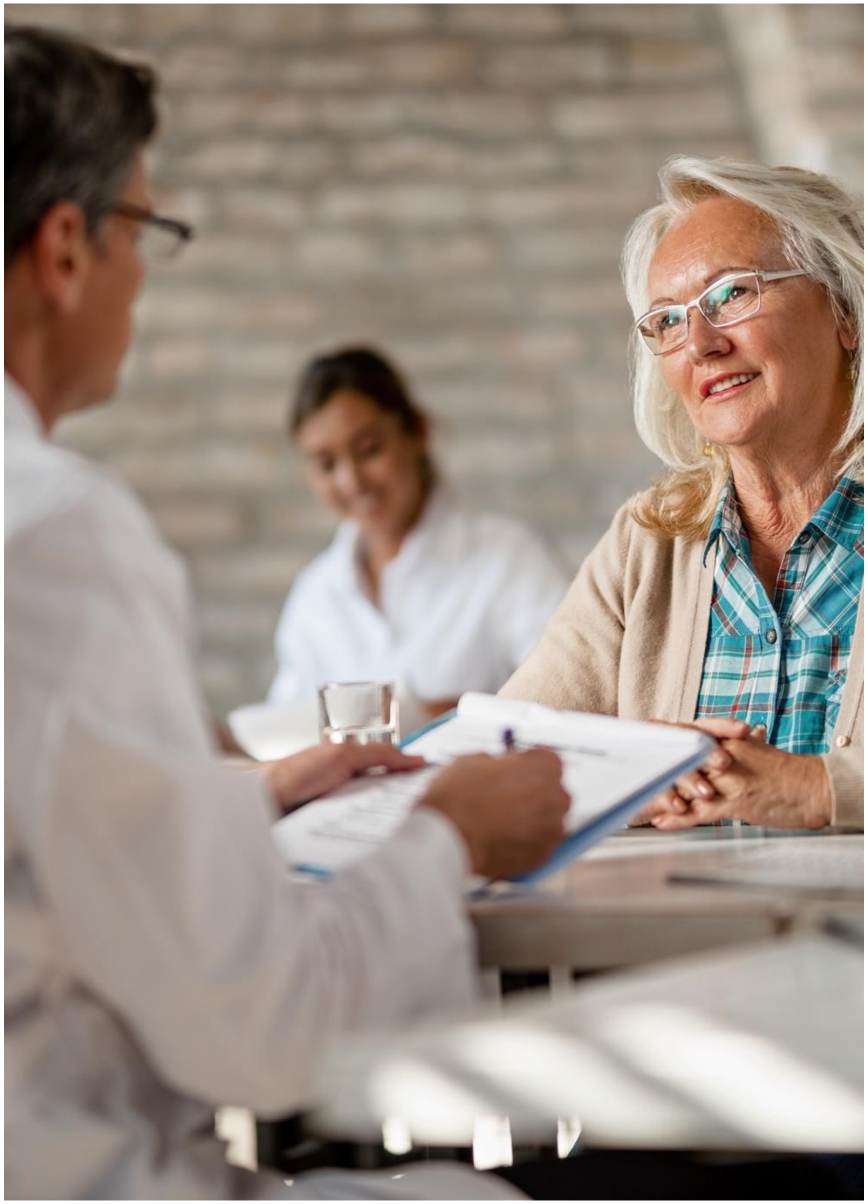
Recognizing this potential, the Centers for Disease Control and Prevention (CDC) launched the 6|18 Initiative. This initiative aims to provide state and local health departments with useful Medicare data specifically for dually eligible populations. These are individuals who qualify for both Medicare and Medicaid.

By integrating these datasets, the 6|18 Initiative empowers health departments to:

- **Gain a clearer understanding** of health disparities within dually eligible populations.
- **Develop more targeted interventions** to address these disparities.
- **Track the effectiveness** of these interventions and measure their impact on health outcomes.

This collaborative approach using the 6|18 Initiative holds the potential to significantly improve health equity for dually eligible beneficiaries.

Resources:
https://www.cdc.gov/sixeighteen/index.html



CHAPTER 5:

Emerging Topics

5.1 Protecting Choice: State Laws Shield Reproductive Health Data

A growing number of states are taking action to safeguard reproductive health data. At least 11 states and D.C. have passed laws specifically aimed at keeping this sensitive information out of the hands of those who might use it to penalize patients or providers involved in lawful reproductive healthcare. These are six of those limitations on data sharing.

1. Limitations on disclosure of reproductive rights
2. Limitations on mobile apps and websites collecting reproductive health information
3. Prohibitions on cooperating with out-of-state investigators, prosecutors, and agencies averse to abortion
4. Limiting use of state courts to assist out-of-state investigators
5. Segregating reproductive healthcare data from electronic health records (EHRs)
6. Barring utilization of Geofence (to locate individuals in a virtual boundary)

Resources:
https://www.networkforphl.org/resources/common-themes-and-creative-solutions-to-protect-privacy-of-reproductive-health-data/

5.2 Sharing Data With Police Departments to Prevent and Respond to Opioid Overdose

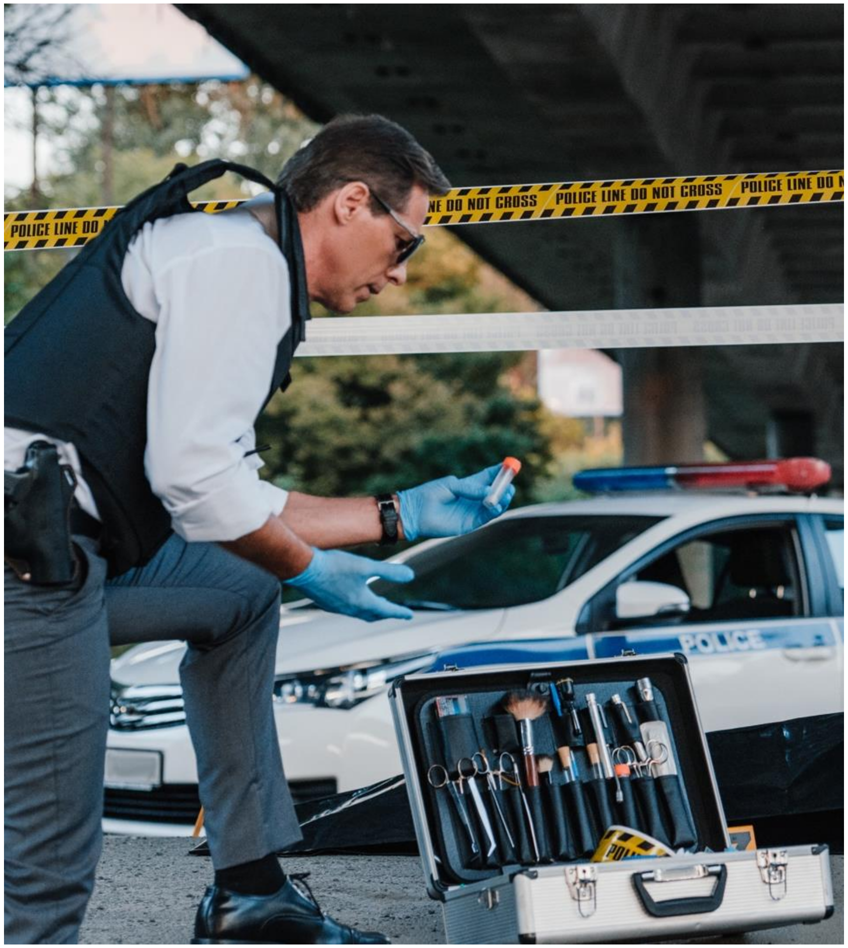
Michigan's Families Against Narcotics (FAN) program offers a lifeline to those struggling with opioid addiction. A key part of this program is the Comeback Quick Response Team (QRT).

This collaborative effort brings together police departments, substance use treatment providers, recovery services, peer support specialists, and community support organizations.

The QRT's mission is twofold:

- **Preventing opioid overdoses:** By working with the community, the team aims to raise awareness of overdose risks and prevention strategies.
- **Responding to overdoses:** Following a reported overdose, the QRT dispatches a team to the scene within 72 hours. This team includes a police officer, a peer recovery coach, and a family recovery coach. Their goal is to:
    - Offer support and resources to the person who overdosed.
    - Connect them with treatment and recovery programs.
    - Provide support and guidance to their family members.

The FAN Comeback QRT program exemplifies a community-wide approach to tackling the opioid crisis. By working together, these dedicated professionals offer hope and support to those in need.



Resources:
https://www.networkforphl.org/resources/legal-requirements-and-tools-for-sharing-data-with-police-departments-to-prevent-and-respond-to-opioid-overdoses/

CONCLUSION:

Unleashing the Power of Data for Public Health

This five-chapter toolkit has equipped you, as a local public health official, with the knowledge and resources to navigate the world of data sharing. We've explored the following key areas:

Chapter 1: Purpose of Data Sharing: We delved into the compelling benefits of data sharing, examining successful initiatives and their role in advancing health equity.

Chapter 2: Bridging the Data Divide: Investing in Technology to Improve Health Equity: We explored how technology can bridge the gap in data access and utilization, promoting more equitable health outcomes.

Chapter 3: Key Considerations for Data Stewardship, Data Security, and Privacy: We emphasized the importance of responsible data stewardship, ensuring data security and privacy remain paramount throughout the sharing process.

Chapter 4: Bridging the Data Gap: Rural and Tribal Considerations: We addressed the unique challenges faced by rural communities and explored ethical considerations for data sharing.

Chapter 5: Emerging Topics: We provided insights into new and evolving challenges in the data sharing landscape, equipping you to stay ahead of the curve.

By leveraging this toolkit and fostering a collaborative environment, you can unlock the potential of data to:

- **Identify emerging health threats** and take swift action to mitigate them.
- **Target interventions** to the populations most in need.
- **Measure the effectiveness** of public health programs and refine them for greater impact.
- **Promote health equity** by ensuring all residents have access to the resources they need to thrive.

Remember, successful data sharing requires ongoing commitment. Stay informed about evolving legal and ethical considerations and prioritize building trust with partners and the community. By working together, we can transform data into a powerful force for good, creating a healthier future for all.