

but as clinicians we found that the articles failed to present a roadmap for describing how providers can break down barriers to intersectoral collaboration from within the health care setting to build COSs that address social determinants of health. We identify 3 major challenges to creating such a roadmap: (1) rigorous research and evaluation; (2) concrete strategies for dissemination and implementation of COSs; and (3) recommendations for sustainable funding.

There is a concerning lack of research about the most effective ways for health care institutions to address social determinants of health. Linkage programs such as those described by Ferrer et al<sup>2</sup> and Garney et al<sup>3</sup> have for the most part failed to be accompanied by rigorous evaluation to demonstrate health status or utilization outcomes. There is also a lack of evidence about how to build effective COSs across sectoral boundaries and a paucity of data about related population-level outcomes.

Furthermore, how can practitioners work to develop models that can be implemented, scaled, and disseminated? The health resource centers described by Garney et al<sup>3</sup> link the delivery of health care and social services. This intervention reaches individual patients, geographic clinical catchment areas, and public health networks, but it offers insight into only one regional example rather than providing a tool kit that can be used by other regions. Garney et al conclude that solutions built and sustained within a COS are most effective. We would emphasize instead that interventions designed in external settings are not inauthentic but rather allow each community to base their efforts on an established framework. In fact, we believe that there *should* be networks in place to bridge learning and improve efficiency across different COSs, although there remain questions about what kinds of networks can be used and how recruitment, training, and data platforms can be shared across settings.

Finally, funding for innovative COS approaches that address social determinants of health in clinical settings is at best insufficient, although new demonstrations of payment reform are being explored in some state Medicaid programs. While there are studies suggesting that models for service linkage decrease ultimate health care costs, costs of implementation and concerns about ensuring subsequent reimbursement are major barriers.

These barriers are great, but so are the potential benefits of helping providers participate in COSs. Novel approaches to intersectoral collaboration are currently underway in programs around the country, some of which are described in the May/June issue of the *Journal*. Electronic health records and regional information networks provide additional opportunities to facilitate linkages across health and nonhealth settings. Important next steps include proving that these approaches make a difference in health outcomes for individuals and populations, articulating dissemination plans, and creating sustainable funding strategies. Such an approach will help to scale evidence-based COS models to regional and national forums.

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## Response: Re: *Journal of the American Board of Family Medicine Issue on Communities of Solution*

We appreciate the thoughtful comments of Burns and Gottlieb<sup>1</sup> and agree with many of their points. Throughout our work examining the Folsom Report,<sup>2</sup> we have noted many of the same pitfalls regarding current fledgling communities of solution (COSs): the lack of rigorous research, outcomes data, and nationwide or regional networks. Burns and Gottlieb's cogent suggestions to further the rigor of COSs and assess outcomes are critical next steps.

Health care providers are crucial members in a COS. While some barriers to provider inclusion do exist, providers often choose not to participate because of other pressing work or lack of payment for community-focused work. Alternatively, providers do not necessarily have to lead a COS but can join instead as partners. Groups may more willingly add providers to their invite lists if the providers are merely one of the stakeholders.

The concept of any particular local COS is not always scalable; it may not provide evidence for the same solution in another COS. However, there is a need for a lattice that can connect COSs for ideas, support, funding, research.

Health insurers and hospitals also play an important role in concordance with their mandates for community benefits. Funding agencies and foundations could consider supporting a national research network to inform the coalition of public health and primary care across

jurisdictions. Hopefully future work will feature COS outcomes on population health.

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