Metro Denver Connected Community of Care

Accountability Plan

SUMMER 2023

METRO DENVER
PARTNERSHIP FOR HEALTH

Contents

Acknowledgements

The Metro Denver Partnership for Health Accountability Workgroup developed this plan, incorporating feedback and suggestions provided by Implementation Workgroup and Community Board members.

Thank you to our Accountability Workgroup members:

- Arapahoe County Public Health
- Aurora Mental Health Center
- Boulder County Department of Housing and Human Services
- Colorado Department of Public Health & Environment
- Colorado Access
- Colorado Community Health Alliance
- Douglas County Mental Health Initiative
- Family Resource Center Association
- Healthy Jeffco Alliance | Jefferson County Public Health
- Kraushold Consulting
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Welcome

The Metro Denver Partnership for Health (MDPH) is a collaboration of local public health agencies, health systems, and Regional Accountable Entities working alongside leaders in health alliances, community-based organizations, behavioral health, and human service agencies. MDPH's work impacts roughly 3 million Coloradans who live in the seven metro counties of Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, and Jefferson.

MDPH is working to create a **connected community of care** in the region. The goal is to build connections and strengthen coordination among physical, mental, and behavioral health, human service, and community-based service providers to offer more holistic care for individuals and families. Through these efforts, MDPH aims to promote health equity by:

- Increasing trust and partnerships across sectors and with the community to support whole-person and whole-family care.
- Improving access to resources and services.
- Enhancing intentional investments to address resource gaps and capacity.

Background

What Is a Connected Community of Care?

A **connected community of care** is a network of partners who coordinate care and services for individuals and families, and who make collaborative resource investments to promote health equity and resiliency. A connected community of care:

- Is made up of **cross-sector partnerships** among health systems, clinics, public health and human service agencies, Regional Accountable Entities, community-based organizations, and mental health and behavioral health providers.
- Uses **interoperable technology**, such as social-health information exchange (S-HIE), as a tool to share information appropriately and securely, coordinate care, and determine how to make informed community health investments.

How Can a Connected Community of Care Serve Individuals and Families?

Within a connected community of care, health and social service providers will be able to fulfill five core functions:

- **Coordinate screening and assessment activities** to identify individual and family health and social goals using person-centered and culturally and linguistically responsive practices.
- **Share an integrated community resource inventory** that is comprehensive and up to date so people can choose the services that best meet their needs and preferences.
- **Coordinate referrals** so that individuals and families don't have to unnecessarily repeat their stories.

- **Facilitate whole-person and whole-family care coordination** so that providers are on the same page, and individuals and families can get the right care when and where they need it.
- **Compile community health analytics** to make intentional and informed investments to improve availability and access to services, and advance health equity.

The Metro Denver Connected Community of Care will require strong, lasting relationships between partners, formal partnership agreements, and technology to coordinate care and resources. This can be highly technical work, but at its heart, it is a human endeavor that will succeed or fail based on the efforts, relationships, and trust among its partners.

Measuring Value

The **value** of the Metro Denver Connected Community of Care will be measured in multifaceted ways, including those that are qualitative, quantitative, process-focused, and community-informed. Creation and implementation of the connected community of care is a long-term investment, taking years to yield meaningful social, health, and community changes. The theory of change (see Figure 2) illustrates the process for achieving the desired impact over time, with greater detail on how these steps will be achieved through the MDPH integrative governance process. Successful implementation and expansion of the connected community of care must include ways to measure value brought by the overall collective partnership through unconventional means to capture the incremental benefits of a healthier community.

Purpose of This Plan

The purpose of this Accountability Plan is to provide a road map for MDPH partners on how to monitor and evaluate the implementation of the **connected community of care** over the next 10 years through short-term, intermediate, and long-term evaluation planning, with an eye toward continuous process refinement and learning.

This plan captures the resources, activities, outputs, outcomes, and impact (see Figure 2) to determine the ultimate value of a **connected community of care** for its partners, users, and the individuals and families involved.

This plan is meant to foster **shared accountability** among MDPH partners. That is, MDPH partners agree to participate in, contribute to, and even lead components of the evaluation process, supported by MDPH's trusted convener, currently the Colorado Health Institute.

This plan is a living document that will evolve as the **connected community of care** is being built and sustained. MDPH partners will review the plan annually to determine progress, assess available resources, and determine ongoing work to complete.

Definitions

- **Business Case:** A project planning document that explains how the benefits of a project outweigh its costs and why it should be executed. Business cases are prepared during the project initiation phase, and they include the project's objectives, costs, and benefits to convince stakeholders of its value.
- **Community Leadership (Partners)**:
    - People who contribute as individuals to advocate for and raise the priorities of their own neighborhoods and communities, and
    - Community-based organizations, groups, or collectives who advocate for and provide services and resources for certain communities or populations.
- **Interoperability:** The ability of different information systems to connect, work together, and share information.
- **Lead Care Coordination Entity:** An organization responsible for serving as the primary point of contact for an individual or family and for coordinating with other MDPH partners that are also serving the individual or family. For example, a person may have several care coordinators, based on their insurance status, current housing situation, and mental health care needs. The person's lead care coordination entity would be responsible for communicating with all partners, ensuring that the person's information, referrals, care, and services are shared and coordinated (via appropriate permissions), so the person does not need to repeat their information or follow up with each of their care coordinators separately.
- **Metadata:** A set of data that describes and gives basic information about other data.
- **MDPH Partners (or Network):** All people and partner organizations participating in the Metro Denver Connected Community of Care initiative, including public health agencies, health systems and hospitals, Regional Accountable Entities, health alliances, community-based organizations, community members, and a trusted convener.
- **Shared Social-Health Information Exchange (S-HIE) infrastructure:** A technical solution that allows health care and social service providers to share individual and aggregate level data across their separate S-HIE systems or electronic health records. Shared S-HIE infrastructure allows health care and social service providers to work as a team to screen, assess, and refer people to resources and services, provide care coordination when appropriate, and evaluate overall impacts on health and well-being. Shared S-HIE infrastructure is a tool for a network of providers to coordinate services for individuals and families, identify resource or capacity gaps, and determine opportunities for collective investments in community health promotion and improvements.
- **Social-Health Information Exchange (S-HIE) system:** A technology tool or platform that allows health care and social service providers to screen, assess, and refer people to resources and services to address their social needs. S-HIE systems include individual and aggregate level data. Commercial examples may include Epic, findhelp, MEDITECH, Salesforce, Unite Us, and others. A local example is Boulder County Connect.

- **S-HIE Users:** Any person or institution that will directly participate in any component of the connected community of care, which includes activities such as screening for social needs, making a referral to a partner, accessing a patient/client record, coordinating care and services, and analyzing population-level data.
    - **Primary Users:** Care coordinators, case managers, community-based organizations, health care organizations, health navigators, etc.
    - **Secondary Users:** Data analysts, individuals and families, policymakers, public health experts, researchers, etc.
- **Social Needs:** Also referred to as health-related social needs. Social needs include food security, housing security and quality, utility assistance, transportation, and interpersonal safety.
- **Use Case:** A real-world scenario that illustrates how a connected community of care could be used to address a specific need (e.g., stable housing).

How This Plan Was Developed

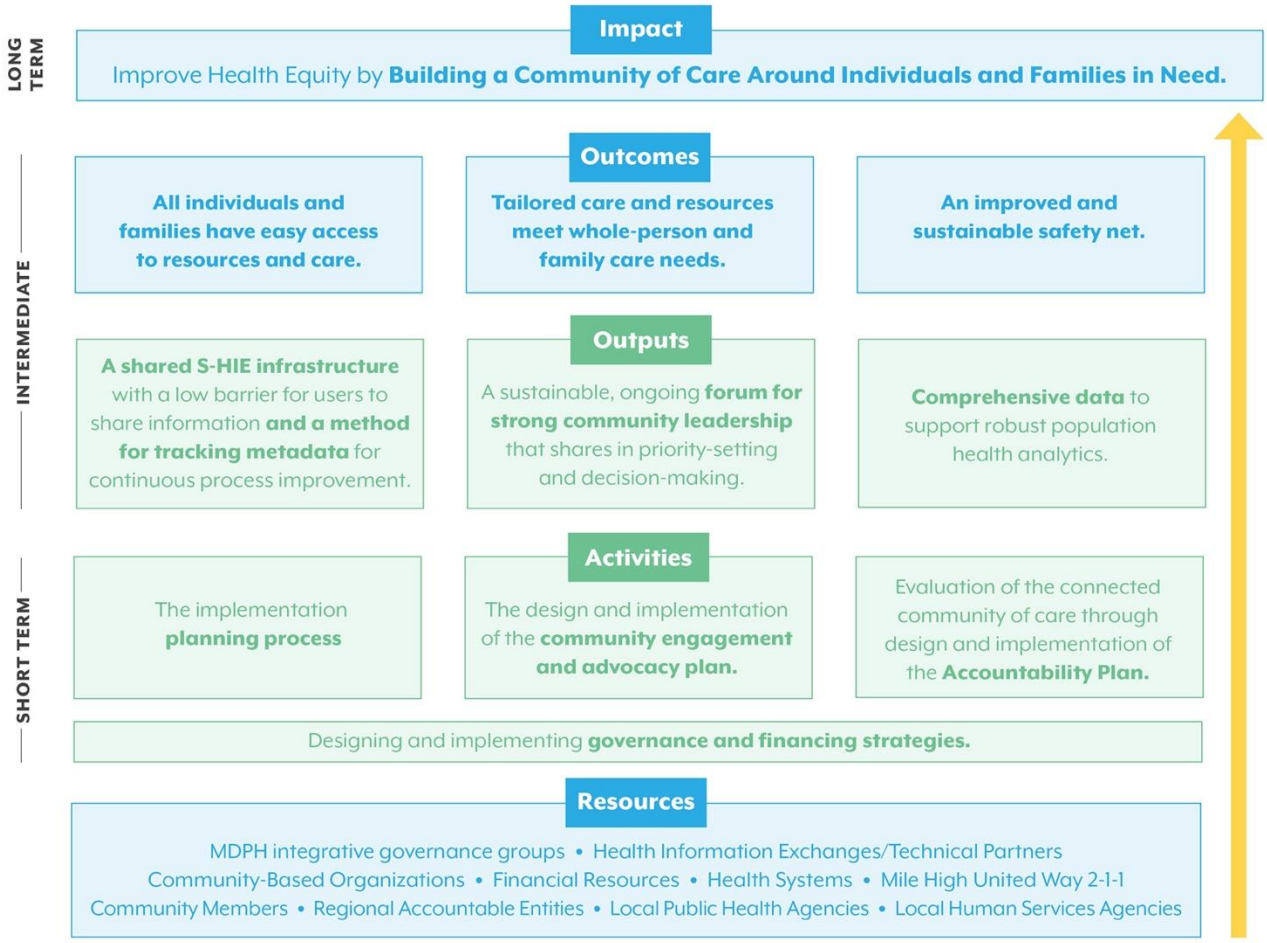
This plan is grounded in a theory of change (see Figure 2) developed by the MDPH Accountability Workgroup and was informed, advised, and contributed to by the MDPH Implementation Workgroup and Community Board.

The MDPH Accountability Workgroup developed key recommendations for evaluation goals and activities included in this plan. MDPH partners, supported by a trusted convener, will monitor and track evaluation goals and activities in the Progress Tracker, which will be updated throughout implementation of the connected community of care.

Understanding the Theory of Change

A theory of change is a tool that offers a comprehensive description and illustration of how and why a desired change is expected to happen. This tool frames the evaluation and monitoring efforts needed to understand and achieve the connected community of care's ultimate impact.

Figure 2. The Metro Denver Connected Community of Care Theory of Change



The **Metro Denver Connected Community of Care Theory of Change** includes:

- **Impact.** The ultimate impact of a connected community of care is to improve health equity of individuals and families being served.

- **Outcomes.** The main outcomes in the theory of change are based on three value propositions that were developed by community organizations and community members. They are the essential goals for a connected community of care that leverages shared social-health information (S-HIE) infrastructure, where:
    - All individuals and families have easy access to resources and care.
    - Tailored care and resources meet whole-person and family care needs.
    - An improved and sustainable safety net is built.

- **Outputs.** The outputs in the theory of change are the tangible results expected from the three main activities. The following outputs are needed to generate outcomes:

1. **Shared S-HIE infrastructure** with a low barrier for users to share information and have a **method for tracking metadata** for continuous process improvement in the connected community of care.
2. A sustainable, ongoing **forum for strong community leadership** that shares in priority-setting and decision-making in the connected community of care.
3. **Comprehensive data** collected to support robust community health analytics.

- **Activities.** The activities are the core actions MDPH partners are leading to implement the connected community of care and will be used to create the previously described outputs. The evaluation and monitoring of these activities and how they can be continuously refined are central to this accountability plan. Three activities to be evaluated are:
    1. **The implementation planning process.**
    2. **The community engagement planning process.**
    3. **Evaluation of the connected community of care through design and implementation of the accountability plan.**
    4. The fourth activity that undergirds this work is the design and implementation of **governance and financing strategies** to make this work sustainable. Evaluation of governance, financing, and sustainability are not explicitly covered within this plan. CHI will solicit ongoing collaboration on how to better resource and sustain this work as the funding and policy environment continues to evolve. See the MDPH Connected Community of Care Sustainability Plan for more details.
- **Resources and Inputs.** The resources and inputs are the organizations, resources, funding sources, technologies, infrastructure, and technical partners necessary to create a connected community of care.

The resources and inputs, activities, outputs, outcomes, and impact can evolve, change, and grow over the lifespan of the connected community of care.

How This Plan Is Organized

This plan is divided into **three co-occurring evaluations** that were agreed upon by MDPH partners. These aim to monitor and evaluate:

1. **The implementation planning process.** This evaluation aims to assess what worked well and what could have been improved in the creation of an interoperability strategy and implementation plan for the initial use cases.
2. **The community engagement planning process.** This evaluation aims to better understand best practices and implementation for community engagement activities.
3. **The effectiveness of the connected community of care.** This plan focuses on evaluating the implementation of cross-sector linkages and assessing whether the core functions of a connected community of care are achieving the impact that MDPH partners intended.

Each of the three evaluations is rooted in logic models that were developed with guidance from the MDPH Accountability Workgroup. A logic model is a tool to illustrate a sequential relationship between a program's resources, activities, and its intended effects and is used to determine where to focus an evaluation (see Figure 3).

As each of the three evaluations begins, documentation of processes, data collected, and summaries will each be decided by a neutral evaluator and collated into a cumulative evaluation report. The timing of the report is conditional on when implementation of use cases begins.

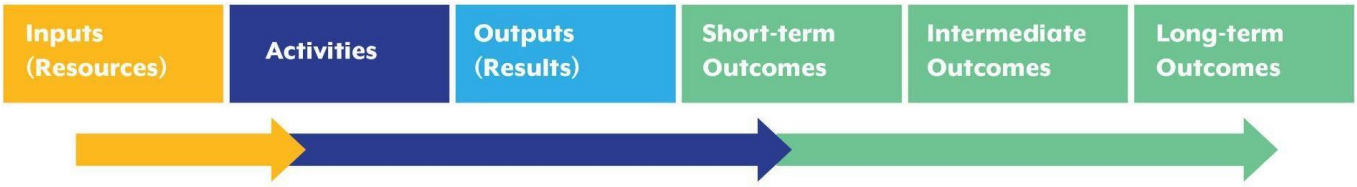
What to expect from this plan:

- An overview of the activities, outputs, and outcomes of MDPH partners.
- Short-term and intermediate plans to monitor and evaluate whether the connected community of care is working as intended.

What <u>not</u> to expect from this plan:

- Specific MDPH partners that will be administering and conducting the evaluation assessments and processes.
- Long-term plans to monitor and evaluate whether the connected community of care has improved health outcomes. Long-term plans will be developed as the short and intermediate goals are achieved and evaluated.
- A step-by-step guide on how to implement each core function of a connected community of care. Implementation guidance is outlined in the MDPH Connected Community of Care Implementation Plan.

Figure 3. The Logic Model Framework



MDPH partners provided input and guidance on the process metrics and milestones that will be evaluated over time. MDPH partners will follow this guidance in the short, intermediate, and long term:

- **Short-term** evaluation goals and activities will occur in 2023.
- **Intermediate-term** evaluation goals and activities will occur over a five-year period, 2024-2028.
- **Long-term** evaluation goals and activities will occur in 2028 and beyond. These goals and activities are not included in this initial accountability plan, because they will be based on the evolution of the connected community of care in the coming years.

Evaluation Plan 1. Evaluation of the Implementation Planning Process

About This Plan

The purpose of the MDPH Connected Community of Care Implementation Plan is to document commitments and activities among participating partners to implement and advance the core functions of a **connected community of care** through shared responsibilities and equity-driven practices and to formalize approval of those commitments.

This plan was developed based on MDPH's three initial health priorities, or use cases, for a **connected community of care**. However, this plan is meant to provide a framework that can be used across partners and as the community elevates different health priorities over time. Initial health priorities include:

- **Chronic Disease Screening and Referral**, in support of the prevention and management of diabetes, cardiovascular disease, and associated risk factors (e.g., high blood pressure, high cholesterol, and food insecurity).
- **Postpartum Care and Community Connections**, in support of Family Connects Colorado.
- **Social Need Screening and Referral**, focused on food insecurity, housing security/quality, transportation, utility assistance, and interpersonal safety, and in support of the Hospital Transformation Program.

The goal of this evaluation plan is to **evaluate the development of the interoperability strategy and implementation plan — which is informed by the use cases — with an eye toward improving planning in the future.**

The value of this evaluation plan is to guide MDPH partners on best practices for implementing an equitable and coordinated connected community of care.

Evaluation

The following five sections highlight the activities, outputs, and outcomes to evaluate how the implementation plan was developed.

Activity 1	Build a business case for each use case.
Output	Approved or rejected business case(s).
Short-term evaluation (2023)	A trusted convener conducts an after-action review for MDPH partners and community leadership partners to assess whether decisions were made equitably and efficiently. Questions should include: • What was expected to happen? • What actually occurred? • What went well and why? • What can be improved upon and how?

Intermediate evaluation (2024-2028)	A trusted convener identifies a process for evaluating how and when use/business cases are created. This process will capture how and when use/business cases enter the system by answering the following questions: • How can the process and timeline for selecting use/business cases be both equitable and relevant to community needs? • From which source(s) are the new use/business cases coming? • How has community need and input influenced the identification and creation of use cases? • Which stakeholders are included or missing from the conversation? Where are there gaps in outreach?

Activity 2	Create the necessary business and technical documents for each new use case: • Business requirements • Technical requirements • Solution design (including architecture and security approaches) • Cost estimates
Output	Necessary business and technical documents for each use case: • Business requirements • Functionality and interoperability requirements • Solution design • Cost estimates

Short-term evaluation (2023)	A trusted convener conducts an after-action review of the technical partners to assess whether documents were created with the appropriate level of communication and efficiency. The review will include the following questions:
	• What was expected to happen?
	  ○ If the process took longer than six months, what can be improved for greater efficiency in the future?
	  ○ What were the milestones/checkpoints to ensure the documents would be aligned?
	  ○ Was the order of operations correct? Which documents should have been created in parallel vs. iteratively?
	• What actually occurred?
	• What went well and why?
	• What can be improved upon and how?

Intermediate evaluation (2024-2028)	A trusted convener verifies that a process for creating all implementation plan documents (business requirements, functionality and interoperability requirements, solution design, and cost estimates) has been established. Process is evaluated annually to account for changes to the connected community of care and/or shared S-HIE infrastructure used by partners. Evaluation questions include: • To what extent has a process been established for creating all implementation plan documents? • How frequently will the process be updated to account for changes to the connected community of care and/or shared S-HIE infrastructure used by partners?

Activity 3	Key stakeholders review the implementation plan to provide feedback from the perspective of their unique organizations/settings before it is presented to larger groups.
Output	A reviewed implementation plan that is updated with stakeholder feedback
Short-term evaluation (2023)	A trusted convener conducts an after-action review to assess key stakeholder feedback on the implementation plan process. Questions include: • What information is missing? What requires expansion or greater definition/clarity? Does the plan effectively set up partners to roll the system out? • How were disconnects resolved before larger groups reviewed these documents? Were there common disconnects about certain sections/ documents? • Who was invited to review the plan compared with who actually reviewed the plan? Who did not/could not and why? What perspectives are missing?
Intermediate evaluation (2024-2028)	A trusted convener verifies a process for soliciting feedback from key stakeholders has been established. The types of key stakeholders involved in this initial review process are updated annually and tailored to the types of use cases that are developed. Questions to evaluate the review process include: • How are key stakeholders being identified? How can the process be modified to ensure equity in the selection process? • How can the process for collecting feedback from key stakeholders be modified? How does feedback from key stakeholders become incorporated into the plan?

Activity 4	Create and present a draft implementation plan to MPDH partners and community leadership partners.
Output	An approved implementation plan.

Short-term evaluation (2023)	A trusted convener conducts an after-action review to assess the development, drafting, and feedback processes. Questions include:
	• What did we expect to happen?
	  ○ Did these documents successfully set up partners to roll out the system?
	• What actually occurred?
	  ○ What were the system flaws or unaccounted for legal issues that needed to be addressed?
	• What went well and why?
	• What could have been improved upon and how?
	  ○ Were there any common barriers experienced across organizations?
	  ○ What information was missing? What could have been expanded?
	  ○ Were there any feedback discrepancies between organizations whose primary role is to receive referrals and those whose primary role is to send referrals?

Intermediate evaluation (2024-2028)	A trusted convener establishes a feedback process that incorporates input from all partners and external reviewers. The review process is updated annually to account for changes made to the connected community of care and/or shared S-HIE infrastructure used by partners or stakeholders. Evaluation questions to update the review process should include: • How can the feedback process be modified to ensure that all partners have an adequate opportunity to review and offer feedback? • How can the process for collecting feedback be modified? How does feedback from different stakeholders get incorporated into the plan?

Activity 5	MDPH partners finalize an implementation plan.
Output	A plan for establishing a connected community of care with low barriers for users to connect, send, and receive social and health information for the agreed-upon use cases.
Short-term evaluation (2023)	The trusted convener secures signatures of commitment/support from MDPH partners. These letters are an organization's commitment to implement the plan and support it through their organization's capacity. The convener will collect and assess the following: • What percentage of MDPH partners committed to the plan? • Are there varying levels of commitment among different types of partners?
Intermediate evaluation (2024-2028)	A trusted convener ensures that a routine process refinement is done every two years to ensure the implementation planning process is creating the best possible plan.

Evaluation Plan 2. Evaluation of the Community Engagement Planning Process

About This Plan

The purpose of the MDPH Connected Community of Care Community Engagement Plan is to outline commitments and activities for partners to engage with community members and share decision-making power with community leadership to ensure the Metro Denver Connected Community of Care is equity centered.

MDPH Community Board members, a trusted community engagement consultant, and the Metro Area Health Alliances contributed to the development of the plan. The board members' and consultant's perspectives, deep expertise, and lived experiences were invaluable to the community engagement planning process.

Community Board members served as leaders of and advocates for communities across the Denver region including Black/African American, Latino, Southeast Asian, and Indigenous communities, the LGBTQ+ community, people with disabilities, people with

experience in the criminal justice system, people experiencing homelessness, families of children with special care needs, and people from various faith traditions.

Equity-centered initiatives and efforts intentionally include, collaborate with, and co-design solutions with people and the communities who are disproportionately impacted by health disparities and inequities.

The community engagement plan is a living document. MDPH partners will review the plan annually with community leadership partners to determine progress, assess available resources, and determine ongoing work to complete.

The goal of this evaluation plan is to **assess the extent to which the process of developing and implementing a community engagement plan is successful as intended**.

This evaluation will measure the processes for creating and engaging the community board in developing a community engagement plan.

The short and intermediate assessments will capture whether the processes are working as MDPH partners intended by assessing the equitable opportunities for sharing leadership and decision-making, offering input on the use cases, and providing feedback and guidance on the community plan's development.

The value of this evaluation plan is to guide the implementation of equitable community outreach and engagement.

Evaluation

The following five sections highlight the activities, outputs, and outcomes to achieve and evaluate the development of the community engagement plan.

Activity 1	Establish a community board and identify MAHA partners to co-facilitate the board, and co-design the development of a community engagement plan.
Output	A shared leadership team to support membership and operations of the community board and a compensated community board with authority to make recommendations and share in decision-making processes with other MDPH partners.
Short-term evaluation (2023)	A trusted convener conducts an after-action review with community board members and MAHA partners. Questions include: • What worked well in the decision-making process? What could have been improved? • Did board members feel their voices were heard? Was the meeting facilitation structure a facilitator or a barrier to this? What have been other supporters and barriers to engagement? • Did facilitators offer nontraditional meeting formats, various locations, and time options, and did they integrate measures to address language and culture barriers? • Were the right people at the table? Which voices were missing?

	A trusted convener designs and administers short surveys and/or feedback sessions with community board members and MAHA leaders to collect feedback on how meetings are being conducted. Survey questions will address leadership, decision-making, and benefits and drawbacks of participation from the Partnership Self-Assessment Tool. Questions include: • How often do board members and leaders support the decisions made by the community board, MAHA leaders, and/or the chairs?
Intermediate evaluation (2024-2028)	A trusted convener identifies a process to establish and maintain MAHA partners and community board members as shared leaders in community engagement planning and operations. Questions to evaluate the process include: • Is the process for identifying and selecting board members and MAHA leaders equitable? • To what extent does the timeline for selecting/updating MAHA leadership and community board membership align with the creation of new use cases? To what extent do leaders and members need to have expertise or experiences with the use cases?

Activity 2	The community board examines the use cases through a community-centered lens during a discussion facilitated by CHI.
Output	CHI incorporates recommendations about key community perspectives, strategic partnerships, and implementation activities into the plan.
Short-term evaluation (2023)	A trusted convener conducts an after-action review for the community board on the use cases discussion. Questions include: • Did the board have clear communication to allow members to share leadership and provide feedback in decision-making? • What has worked well in the decision-making process? What could have been improved? • Did the meeting structure allow for people's voices to be heard? • Did the board have enough guidance on how to examine the use cases? A trusted convener administers short surveys and/or feedback sessions to collect information on how meetings are being conducted. Survey questions will address leadership, decision-making, and benefits and drawbacks of participation from the Partnership Self-Assessment Tool.
Intermediate evaluation (2024-2028)	A trusted convener identifies a process for introducing and soliciting feedback on use cases. Questions to evaluate this process include: • What are the main attributes/features of the process established for introducing and soliciting feedback on use cases? How could the process be improved?

Activity 3	The community board will provide feedback on CHI's research related to core principles for community engagement and identify what additional key perspectives are needed to inform long-term community engagement planning.
Outputs	• The community board approves the core principles, shared guidance, and best practices for meaningful community engagement in the plan. • CHI and the community board identify methods and priorities for additional community engagement as appropriate.
Short-term evaluation (2023)	A trusted convener conducts an after-action review to identify what worked well and what needs improvement in identifying best practices. Questions include: • Were the outlined community engagement activities effective to garner the additional input needed to inform the community board's long-term community engagement planning? • Were the right community members at the table to lead and inform community engagement activities? • How were community board members involved in the development of the questions and interview guides for community outreach? • What were the successes and challenges in CHI's process in identifying equity-driven community engagement strategies? • What additional research is needed? • Did the research review and feedback process allow for all community board members to offer input? • Did the community board have enough opportunities to share feedback and provide insight on the research methods proposed by CHI?
Intermediate evaluation (2024-2028)	A trusted convener identifies a process to successfully include various key community perspectives in the community engagement planning process. Questions to evaluate this process include: • To what extent are the approaches and strategies reaching key community representatives? • To what extent are community engagement approaches and strategies aligned with the current use cases?

Activity 4	The community board will lead the direction of and provide specific recommendations on what should be included in the draft community engagement plan.
Output	A draft community engagement plan that includes feedback from the community board and MDPH partners.
Short-term evaluation (2023)	The trusted convener conducts an after-action review of the drafting and feedback process. Questions include: • How long did it take to draft the document? What can be done in the future to improve efficiency? • Did the MAHA partners have sufficient opportunities to coordinate with the community board? • Was the co-design process (including the board and lead MAHA partners) an effective means to instill the community board's leadership in planning activities? • Did the feedback process allow for people's voices to be heard? • Was there conflicting feedback within the community board or from MDPH partners? How was it resolved? • Were there common themes about missing content or sections that could have been expanded? How were those addressed? The trusted convener administers a survey and/or feedback sessions after the draft has been finalized to gauge satisfaction with participation.
Intermediate evaluation (2024-2028)	N/A

Activity 5	The community board and CHI finalize the community engagement plan by June 30, 2023. The plan will guide the community leadership and other community engagement activities for the Metro Denver Connected Community of Care between 2023 and 2026.
Output	A community engagement plan that has been approved by the community board.
Short-term evaluation (2023)	Garner signatures of commitment/support from MDPH partners for the plan.
Intermediate evaluation (2024-2028)	N/A

Evaluation Plan 3. Evaluation of the Connected Community of Care

About This Plan

The final evaluation plan measures the five core functions of implementing an effective connected community of care:

1. Screening and assessment
2. Community resource inventory
3. Referrals
4. Whole-person care coordination
5. Community health analytics

It is not necessary that partner organizations implement all five functions simultaneously. For example, an organization may choose to begin with the first two core functions while assessing internal readiness to engage in subsequent core functions. MDPH is committed to connecting with any partner organization that wishes to participate, regardless of whether that organization is able to implement all five functions.

The goal of this evaluation plan is **to measure the success of the five core functions of implementing an effective connected community of care.** Each of the core functions have set goals in the short and intermediate term — each of which will be evaluated through assessments as outlined in Tables 1 through 10.

Refer to the MDPH Connected Community of Care Implementation Plan for more details about commitments and activities for each core function and patient/client consent practices.

Commitment to Equity

MDPH partners commit to upholding the activities, outputs, and outcomes named in this plan, which serve to preserve the dignity of and respect for all people, while preventing the exacerbation of disparities in access to care, services, and health. All core functions of the connected community of care will be evaluated using an equity lens, an approach that offers all partner organizations, users, and individuals and families an opportunity to participate and succeed no matter their situation. Community outreach and engagement will follow the research and best practices identified by the community board in Evaluation Plan 2, Activity 2.

Next Steps: The Accountability Plan and Continuous Refinement

- The evaluation of these core functions depends on the implementation of the connected community of care, beginning in 2023.
- This plan should be reviewed and updated biennially by MDPH partners and MDPH's trusted convener to capture each function's evolution during initial implementation across use cases.

Evaluation

Screening and assessment tools are used in health care and social service organizations to identify a person's needs and goals to support their overall health and well-being.

- **Activities.** MDPH partner organizations commit to the following activities:
  - Identify and agree on which best practices for social screening tools, policies, and procedures will be utilized among partner organizations.
  - Reach a consensus on the core set of social screening domains (like housing or food) and sub-domains (housing quality, housing safety, etc.) to be included in screening tools.
  - Create a shared repository of screening/assessment tools, policies, and procedures to aid in existing or new tool adoption or to enhance/develop an approach to screening and assessment. Reach a consensus on best practices for continuous analysis and evaluation of the repository's assessments, policies and procedures.
  - Conduct internal/organizational performance reviews to assess screening adoption and barriers.
- **Output.** A standard process for social screenings and assessments.
- **Value of screening and assessment:**
  - Among MDPH partner organizations and users:
    - All organizations have a standard way to collect and share interoperable data, decreasing administrative burden and increasing the amount of time spent with patients/clients.
  - For individuals and families:
    - A more standardized screening assessment process allows people to be screened for their social needs so they can get the tailored care and services they need.

Table 1. Screening and Assessment Short-Term Evaluation (2023)

Goal	Assessments
1. MDPH partner organizations adopt a social need screening process.	A trusted convener conducts a survey of partner organizations to assess the following about screening/assessment adoption and utilization. Survey metrics to include: • Staff training and engagement. Competence using the tool, staff capacity, organizational support for staff to learn about and use screenings. • The type of screening tool(s) being used and the domains and subdomains included in the tool. (Must include the three domains of food, housing/utilities, and transportation.) • Barriers to utilization or the assessment of the results. • Populations being served. Is the adopted tool appropriate for the populations an organization primarily serves? For example, a youth-based organization should have a tool that is designed for children and families. • Workflow. How are the screenings being offered (verbal, phone, paper, computer, etc.)?

2. Partner organizations offer screenings/ assessments to individuals and families.	A baseline is created by using the monthly performance reviews to assess whether partners are screening for social needs. Partners will track their organization's use of the screenings/assessment data. These performance reviews will be tracked during the first year of implementation using a monthly survey. Metrics include: • Screenings/assessments count by staff person • Percentage of eligible individuals screened/assessed • For each question, percentage completed • Frequency of screening for each domain

Table 2. Screening and Assessment Intermediate Evaluation (2024-2028)

Goal	Assessments
3. Partner organizations identify barriers that hinder or prevent partners from conducting social need screenings.	A trusted convener identifies a process to continually monitor and assess barriers to screening tool utilization. An annual survey will be sent to primary users within MDPH partner organizations to assess the following barriers: • Staff training and engagement. Competence using the tool, staff capacity, organizational support for staff to learn about and use screenings. • The type of screening tool(s) being used and the domains and subdomains included in the tool. • Barriers to utilization or the assessment of the results. • Workflow. How the screenings are being offered (verbal, phone, paper, computer, etc.) • Resources needed to adopt and conduct screenings. • Timing, appropriateness, and fit of the screenings.
4. Individuals and families are receiving culturally competent social need screenings.	Partnering organizations will conduct an automatic post-visit survey to request feedback from individuals and families on the following topics: • If a screening was conducted. • Cultural and linguistic competency of the screening. • Respect for individual and family privacy and participation preferences. • If the screening result was beneficial or could be improved. What happened as a result of the screening? • Expectations vs. outcomes of the screening. • Frequency of being screened for the same issue or need. The survey results will be anonymous and reviewed by partner organizations to assess strengths and gaps of the screenings/assessments.

5. Sufficient and necessary screening results are shared with community health analytics tool and care coordinators who will need these screening results included in the referrals they receive.	A trusted convener creates a process to assess whether partner organizations are receiving necessary and sufficient data about screened individuals and families. The trusted convener will conduct a survey of organizations that receive screening results to assess whether results are meeting the agreed-upon standards for shared screening and assessment information. Questions will cover the following metrics: • Data-sharing accessibility (formatting, storage, and timeliness). • Relevance of results and information to further assist the person or family based on the receiving organization's needs.
6. Partner organizations have access to a repository of validated screening/ assessment tools.	A trusted convener creates a process to capture accessibility of the screening/assessment repository. The trusted convener conducts survey to capture the following: • Organizational feedback on access and utilization of the repository. • Usefulness of information included in the repository. • Common tools that should be added to the repository.
7. Results from screening tools are mapped to standard code sets.	A trusted convener creates a process to ensure that results from validated screening tools are mapped correctly to standard code sets such as LOINC coding or USCDI coding. An annual review of screening tools in the repository is conducted to ensure that all tools are mapped to standard code sets.

Community Resource Inventory (CRI). The CRI is a dynamic directory of resources or services available in the community that are provided by health care, human service, and community-based organizations. A comprehensive resource inventory includes a description of services provided, up-to-date eligibility information, availability of resources (e.g., open for service or waitlist), languages offered, cost, application requirements or processes, contact and location information as applicable.

- **Activities.** MDPH partners commit to the following activities:
  - Support an integrated CRI that matches and shares information across multiple platforms, sources, and service providers.
  - Agree upon a set of standards for collecting, updating, and maintaining information needed in all the resources' listings, and identify who is in charge of leading, updating, and synchronizing CRI information.
  - Update and confirm organizational information every six months.
  - Identify and create a set of pathways for primary and secondary users to adopt the CRI and share and/or access its information as needed.
  - Ensure all partners and community members have the training and resources needed to access CRI information.

- **Output.** A CRI with accessible pathways to its information partner organizations and community members.
- **Value of the community resource inventory.**
    - Among MDPH partners and users:
        - MDPH partners and users can easily access information they can use to connect individuals and families to community resources.
    - For individuals and families:
        - Individuals and families can easily access a one-stop shop for information on community resources.

Table 3. Community Resource Inventory Short-Term Evaluation (2023)

Goal	Assessments
1. The CRI includes all the components and standards the MDPH technical partners and platform vendors intended.	A trusted convener conducts a survey to assess technical partner and platform vendor satisfaction with the resource inventory components and data elements. Survey questions will cover the following topics: • Satisfaction with CRI data elements and standards • Ease of use • Barriers to access and use • Does it work with the current workflow/data flow (operational questions)? • Accuracy of the CRI data The accuracy of data from the CRI is checked by conducting quarterly data pulls from the community health analytics function to assess whether certain fields are blank or incomplete. These data pulls will be conducted by a designated partner organization in 2023.
2. Primary users, such as care coordinators, case managers, health care organizations, and community-based organizations, are able to easily access useful and meaningful information from the CRI.	A trusted convener conducts surveys and key informant interviews of CRI primary users to gauge CRI utilization and access of information. Survey and key informant interview questions cover topics regarding: • Ease of use and satisfaction • Access barriers (pathways) • Ability to match needs to referral sites • Information gaps
3. Community members are able to access useful and meaningful information from the CRI.	A trusted convener conducts a survey of community users to gauge CRI utilization and access of information. Survey will assess the following: • Ease of use and satisfaction • Barriers such as digital literacy, language, cultural competency, and technology access • Benefits of having access to the CRI

Table 4. Community Resource Inventory Intermediate Evaluation (2024-2028)

Goal	Assessment
4. The CRI is meeting partner expectations and being accessed and utilized by data stewards, trusted contributors, and consumers as intended.	A trusted convener creates a process to capture satisfaction with access and utilization of the CRI. Survey is conducted to capture feedback on the following: • Use by different positions within partner sites (for example, a health navigator will have different uses and insights than an administrator or clinical provider) • Adoption and use by data stewards, trusted contributors, and consumers A trusted convener creates a process to capture any issues or barriers that partners providing and receiving referrals may encounter. A pop-up survey will appear after someone has searched the CRI and will capture information on: • The different needs/barriers for the CRI across various sectors • The process for addressing barriers in a timely manner • The ease of access to needed information • Any gaps or missing data components A trusted convener creates a process to capture any access barriers among community members/patients. A survey will assess how community access barriers are identified and updated, information on gaps in care (for example, a patient changes doctors or loses insurance), and if beneficial data are available.
5. CRI information offers real-time updates on provider availability and eligibility that does not require manual entry.	A process is created to capture whether partners are satisfied with the process for automatic updates on service availability and eligibility.
6. Technical partners identify a process for missing or out-of-date data components.	Technical partners and a trusted convener identify a process of running analytics reports to identify missing or out-of-date data in the CRI. A designated organization or trusted convener will review CRI data from the community health analytics function quarterly to assess missing or out-of-date data.

Referral. The act of connecting someone to another resource, service, or point of care to address their needs. A referral can be manual, such as making a phone call or sending a fax. A referral can also be sent electronically via an S-HIE system or through shared S-HIE infrastructure. Referral partners may "close the loop" by sending back information on the outcome of the referral (for example, the service was provided, or the family could not be reached).

- **Activities.** MDPH partners commit to the following activities:
    - Identify the process for closing the loop on referrals and ensure all pathways for closing the referral loop are accessible to primary users across different settings.
    - Identify shared interoperability standards and policies that allow referral information to be shared across various referral systems.
    - Identify features of the referral system that all partners need to have access to or need to be in place (for example, messaging capabilities, authentic verification, etc.).
    - Identify individual and family referral needs, especially around privacy, timeliness, and fit/sufficiency of each referral.
- **Output.** A closed-loop referral system.
- **Value of referrals.**
    - For MDPH partners and users: MDPH partners and users have efficient and effective pathways for connecting individuals and families to resources and closing the loop on their needs.
    - For individuals and families: Individuals and families are being connected to tailored care and resources that meet their needs in a timely manner.

Table 5. Referrals Short-Term Evaluation (2023)

Goal	Assessment
1. Partner organizations are satisfied with the process for sending, receiving, and/or accessing referrals.	A trusted convener conducts a survey to assess provider satisfaction and accessibility with the health information transfers. Questions will cover topics regarding: • Barriers to access • Satisfaction with the sending and/or receiving process • Referral records include necessary and sufficient information. ○ Are the right elements provided to act on the referral?
2. Partner organizations send and receive referrals, and clients use referred services.	Partner organizations report the following metrics quarterly to create a baseline and assess whether the referral process is meeting individuals' and families' needs. A designated partner organization or trusted convener will review and assess the quarterly reports. Metrics include: • Number of accepted referrals • Number of refused referrals • Eligibility status of the person or family being referred • Number of instances where client information was incorrect • Number of referral services provided • Number of clients who decline the services • Number of referrals received by receiving partners • Number of staff trained to oversee referrals

Table 6. Referrals Intermediate Evaluation (2024-2028)

Goal	Assessment
3. Partner organizations are connected to the referral network.	A trusted convener creates a process to assess the number of partner organizations that are connected to the referral network. Partner organizations rate their ability to send and/or receive referrals in an annual report that is reviewed by a designated organization or trusted convener.

4. Individuals and families are satisfied with the privacy, timeliness, and fit of the referrals they are receiving for services they need or want.	Partner organizations with input from community leadership partners create a process to capture individuals' and families' experiences with the referral process. Feedback will be collected in the following ways:
	• The referring organization distributes a survey to assess satisfaction and experiences with the referral process. A designated partner organization or a trusted convener processes and reviews the survey results. The survey will assess the following:
	  ○ Whether their need was addressed by the referral
	  ○ Cultural competency of the referral
	  ○ Experience with the referred service provider (Were they eligible? Were the right resources available?)
	  ○ Barriers to seeking referred services
	  ○ Ability to opt in or out of the referral process
	  ○ Whether the referral met the privacy needs of the individual or family
	• Partner organizations will coordinate with a cultural broker to conduct interviews with referral recipients.

5. Primary users are sending referrals in a prompt, accessible manner.	A trusted convener creates a process to capture the partner organization's utilization of the referral process. Partners collect and report the following metrics in quarterly reports that are reviewed by a designated partner organization or trusted convener. • Time between the referral and when services were received • Number of open referrals • Number of closed referrals • Pathways for how referrals are being made or received (pathways being over- or underused) • Staff capacity on sending or acting on received referrals

Whole-Person Care Coordination. Person-centered, trauma-informed, and culturally responsive activities that support individuals and families in accessing and engaging in the physical health, behavioral health, and social services needed to achieve well-being. Whole-person care coordination includes regular communication with the individual or

family over time, in addition to sending and tracking closed-loop referrals as needed. This level of support is typically reserved for individuals or families who have multiple systemic or complex needs and who require assistance to effectively connect with resources.

- **Activities.** MDPH partners commit to the following activities:
    - Create a shared process for identifying and designating an appropriate organization to serve as an individual's or family's lead care coordinator.
    - Identify the types of information that will be shared among care coordinators depending on the permissions given by an individual and family.
    - Identify a shared approach for creating and maintaining information that can be linked to records across the network of partners participating in the connected community of care.
    - Identify how care coordination information will be shared between the lead care coordinator entity and secondary coordinators.
- **Output.** Whole-person care coordination
- **Value of whole-person care coordination.**
    - Among MDPH partners and users: MDPH partners and users have a coordinated approach to support whole-person care, which reduces duplication and clarifies care coordinator roles to ensure whole-person care is achieved.
    - For individuals and families: Individuals and families have agency over who is leading their care coordination and have their whole-person and whole-family care needs met.

Table 7. Whole-Person Care Coordination Short-term Evaluation (2023)

Goal	Assessment
1. Partner organizations and people with lived experience with complex health needs that require care across multiple health and social settings, participate and commit to reaching a consensus on identifying and creating a lead care coordination identification process.	A trusted convener will garner letters of commitment from the partners and equitably offer opportunities for partnering organizations to offer guidance and feedback on the lead care coordinator process.

Table 8. Whole-Person Care Coordination Intermediate Evaluation (2024-2028)

Goal	Assessment
2. Individuals or families who have multiple systemic or complex needs and require assistance have their needs resolved.	A trusted convener conducts quarterly automated data pulls to collect baseline and progress data on client enrollment and whether client needs are being resolved. Data pulls will also assess if data are disjointed and areas to improve data linkages. Assessment includes the following metrics: • Number of clients enrolled (total/unique) • Number of clients for whom care coordination is closed • Number of clients for whom care coordination is open • All client demographic data (age, language, race/ethnicity, sexual identity, disability, veteran status, immigration status, etc.) • Number of clients with care coordination needs by level (1–3) A trusted convener will conduct a focus group and/or key informant interviews of individuals or families with closed cases to assess whether their needs were resolved. Questions will assess: • Satisfaction with care and services received • Feedback on the lead care coordinator process • The impact services had on complex need or needs
3. The lead care coordinator is improving patients' experience and health outcomes.	A trusted convener creates processes to assess if having a lead care coordinator is improving patients' experiences, connection to services, and health outcomes. a. The trusted convener conducts a survey of individuals and families who are currently using or have used lead care coordinators. The survey will assess their satisfaction with the process and their experience with getting connected to needed services. b. The trusted convener conducts a data pull to assess service connection and health outcomes for individuals and families who are currently using or had used a lead care coordinator entity. Data are evaluated annually after the initial data pull to identify whether progress is being made with this process/system.

Community Health Analytics. A cross-sector approach to evaluating the overall health and well-being across a community. Community health analytics allow people to understand the overall health status, needs, and gaps in care or services across communities. Community health analytics can be used to evaluate the effectiveness of programs and services on improving health equity and can be used by partners to make informed investments in service availability and capacity.

For the purposes of this plan, population health is defined as the health and well-being of people served by individual MDPH partner organizations. Community health is defined as the health and well-being of people served collectively across all organizations participating in the Metro Denver Connected Community of Care.

- **Activities.** MDPH partners commit to the following activities:
    - Coordinate how to integrate community health data into a community health and social analytics function that will receive and process these data for aggregate reports and planning activities.
    - Identify how partner organizations will access information from the community health and social analytics function.
    - Share screening results, referral information, and community resources to the analytics function.
    - Identify how screening results, referrals, resource information, and care coordination data will be standardized.
- **Output.** A community health analytics function.
- **Value of community health analytics.**
    - Among MDPH partners and users: MDPH partners and users can better conduct community health planning, evaluation, and research to better understand community needs, recommend interventions, and direct resources.
    - For individuals and families: Individuals and families will receive more tailored interventions, programs, and resources to improve and maintain community health.

Table 9. Community Health Analytics Short-Term Evaluation (2023)

Goal	Assessment
1. Partner organizations commit to creating an agreed-upon process for sharing referral information, screening results, and community resource information to the community health and social analytics function.	A trusted convener will conduct a survey and/or key informant interviews with MDPH partners to solicit feedback on the decision-making process for policies and standards that guide the development of the community health analytics function. The survey and/or key informant interviews will assess: • Satisfaction with the decision-making process • Feedback on additional data points and access pathways that should be considered for the analytics function
2. The trusted convener and partners identify core data that will be collected and shared in the community health analytics function.	A trusted convener will conduct focus groups with MDPH partners to solicit input on what questions they want answered from the community health analytics function. The trusted convener will then work with MDPH partners to discuss and decide on the data metrics that will answer those questions.

Table 10. Community Health and Social Analytics Intermediate Evaluation (2024-2028)

Goal	Assessment
3. The shared S-HIE infrastructure used by partners is operating as partner organizations and community leadership intended.	A trusted convener pulls data from the analytics function to conduct an audit of the shared S-HIE infrastructure's effectiveness and efficiency. Data pulls will occur biannually and include the evaluation metrics identified in core functions 1–4: • Screening and assessment • Community resource inventory • Referrals • Whole-person care coordination
4. Partners have the aggregate screening, referral, resource, and care coordination data they need to evaluate and monitor social needs and develop plans for their community.	A trusted convener conducts an automated data audit of the analytics to assess data gaps, duplications, or modifications that impact MDPH partners' ability to create community health plans or reports. The results of the automated data audit reports are reviewed by designated partner organizations or a trusted convener that will share any issues with the aggregate screening, referral, resource, and care coordination data. The results will also be useful in evaluating the efficiency and effectiveness of screening, referring, and connecting individuals and families to resources. Metrics to be included in the automated data audit report may include: • Staff training and engagement • Barriers to access and utilization • Support needed to use these data • Data presentation
5. The aggregate data are granular enough to allow for health monitoring and community planning activities without causing harm to privacy and confidentiality.	A trusted convener creates a process to capture partner organization feedback on the granularity of the data in the community health analytics function. A trusted convener will conduct focus groups and key informant interviews with partner organizations annually to assess whether and when changes to the aggregate data are needed.

Conclusion

Success in implementing a connected community of care can only be known through ongoing measurement, tracking, evaluation, and accountability measures. This plan is a living document, and as such will provide a road map for MDPH partners on how to monitor and evaluate the implementation of the Metro Denver Connected Community of Care over the next 10 years through short-term, intermediate, and long-term evaluation planning. This plan has an eye toward continuous process refinement, which will be regularly tested, challenged, and updated by MDPH partners and MDPH's trusted convener. Enhanced and more equitable accountability will lead to better implementation of the connected community of care and will support partners in achieving their aims to improve access to resources and care for all individuals and families, tailor services to meet whole-person and whole-family care needs, and bolster an improved sustainable safety net.