Metro Denver Connected Community of Care

Implementation Plan

Summer 2023

METRO DENVER
PARTNERSHIP FOR HEALTH

Contents

Acknowledgments

The Metro Denver Partnership for Health Implementation Workgroup members, trusted community partners, and Community Board members contributed to the development of this plan.

Thank you to our Implementation Workgroup members:

- Boulder County Department of Housing and Human Services
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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.

Purpose of This Plan

The purpose of this 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 is a living document. MDPH partners will review the plan annually to determine progress, assess available resources, and determine ongoing work to complete.

The plan focuses on connections among partners, not on the internal implementation of specific programs or activities within any single partner organization. However, to ensure person-centered coordination of care, the plan articulates shared best practices that each partner organization will adopt internally to uphold the dignity and equity of people seeking and receiving services.

Please note: This is not a technical plan.

MDPH does not intend to develop new technology to support the commitments documented in this plan. The partners identified several existing technologies that could be used or enhanced to serve each of the proposed core functions. In addition, the partners are aware of planned or ongoing development efforts to advance interoperability in the region and statewide. MDPH will use existing technologies and coordinate with ongoing development efforts to the maximum extent possible to avoid creating duplicative or unnecessary technologies.

Definitions

MDPH partners: 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.

Trusted convener: An organization that provides strategic planning, technical assistance, facilitation, and project management for a group of organizations working on a shared initiative or priority.

Community Board members: People serving on the MDPH Community Board, which includes individual community members and representatives from community-based organizations.

Community leadership:

- 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.

For a more detailed list of terms and definitions used in this plan, please see the Glossary.

How This Plan Was Developed

The MDPH Implementation Workgroup used the Office of eHealth Innovation's Advancing a Coordinated Ecosystem for a Social Health Information Exchange (S-HIE) in Colorado position paper to inform the development of this plan. The paper describes key elements of S-HIE, which were adapted to describe the core functions of a connected community of care that serve as the framework for this plan.

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 scalable framework that can be used across partner organizations 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.

This plan will not discuss specific implementation details for each use case. For detailed business, functional, and interoperability requirements for each use case, see the Appendix.

A Phased Approach for Implementation

This plan will also not describe specific timelines for implementation activities because use cases will develop and evolve over time, based on the capacity of partners, and initial launch and sustainable funding sources for the connected community of care. This plan will describe recommended phases for implementation of each use case, as follows:

- **Phase One Implementation.** Spans years 1-2 of implementation. Includes initial implementation of shared best practices for screening and assessment, community resource inventory, and referral activities.
- **Phase Two Implementation.** Spans years 2-4 of implementation. Includes expansion and improvement of previously launched activities, and initial implementation of shared best practices for whole-person care coordination activities.
- **Phase Three Implementation.** Spans years 4-5 of implementation. Includes expansion and improvement of previously launched activities, and initial implementation of shared best practices for community health analytics activities.

Important Note: MDPH recognizes that many partners have already started implementation within their own organizations. However, these phases refer to the shared work of implementing coordinated best practices across partner organizations. Coordinated, shared best practices will bolster and sustain the value and core functions of a connected community of care for individuals and families.

MDPH partners commit to continuous quality improvement throughout implementation of the connected community of care. See Continuous Quality Improvement sections in this plan for more details.

What you will find in this plan	What you won't find in this plan
Specific commitments that MDPH partners share to advance a connected community of care in the region	Detailed work plans and timelines for implementation activities
An overview of key governance, system implementation, workforce, technical, and cost components needed to advance interoperability	Lists of all activities, tools, and technologies needed to support interoperability
Plans for alignment with existing tools, technologies, and processes	In-depth discussion of established technologies and principles (e.g., health information exchange, security protocols). Where applicable, references will be provided for other resources pertaining to these topics
Designated activities that each partner organization is responsible for implementing, including references to resources and best practices	Detailed instructions on internal implementation activities within an organization

MDPH Framework for a Connected Community of Care

A connected community of care consists of five **core functions**:

- Screening and Assessment
- Community Resource Inventory
- Referrals
- Whole-Person Care Coordination
- Community Health Analytics

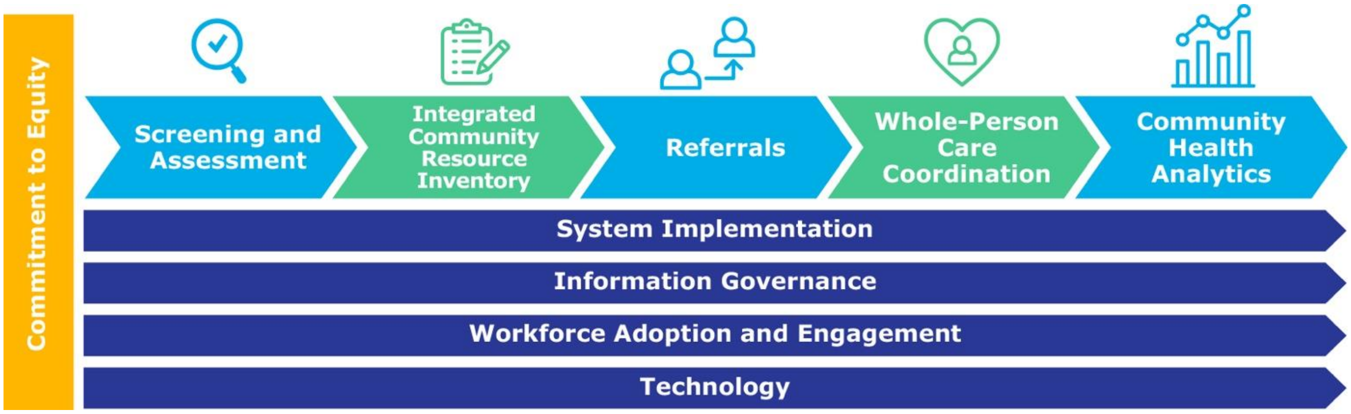
It is not necessary that partner organizations implement all five functions simultaneously. For example, an organization may choose to begin with the first two core functions while assessing internal readiness to engage in subsequent core functions. MDPH is committed to connecting with any partner organization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

Each core function serves a purpose for the community — for individuals, families, and the health care and social service providers working together to serve them. These core functions must be implemented and maintained with fidelity and integrity to ensure progress in health equity. Within this plan are guidance and equity-driven best practices outlined under each core function for partners to learn from and implement across their organizations. These **guidance and best practices** consider:

- System Implementation
- Information Governance
- Workforce Adoption and Engagement
- Technology

Together, these core functions, shared guidance and best practices, and an authentic commitment to equity comprise the framework for an effective connected community of care.

Figure 1. MDPH Framework for a Connected Community of Care



Core Functions of a Connected Community of Care

Part I of this plan outlines the commitments, designated activities, and resources for partners to implement the five core functions of a connected community of care. The five core functions include:

1. **Coordinating screening and assessment activities** to identify the health and social goals of an individual or family. Health care and social service organizations will use person-centered and culturally and linguistically responsive screening and assessment practices. Screening and assessment are usually the first step in developing a coordinated plan to support the overall health and well-being of an individual or family.
2. **Sharing an integrated community resource inventory (CRI)** that is comprehensive and up to date so people can choose the services that best meet their needs and preferences. An integrated community resource directory 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 served, cost, application requirements or processes, and contact and location information as applicable.
3. **Coordinating referrals** so that individuals and families don't have to unnecessarily repeat their stories. Partner organizations use referrals to connect someone to another resource, service, or point of care to address their needs. A referral can be done manually, such as making a phone call or sending a fax. A referral can also be sent electronically via S-HIE technology. Referral partners may "close the loop" by sending back information on the outcome of the referral (e.g., the service was provided, or the family could not be reached).
4. **Facilitating 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 they need it and where they need it. Whole-person care coordination includes person-centered, culturally responsive, and trauma-informed activities that support individuals and families in accessing and engaging in the physical health, behavioral health, and social services needed to achieve overall 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 complex needs and require assistance to effectively connect with resources.
5. **Compiling community health analytics** to inform investments to improve availability and access to services, and advance health equity and resiliency. Community health analytics allow people to understand the overall health status, needs, and gaps in care or services across communities and can be used to evaluate the effectiveness of programs and services in improving health equity. Effective community health analytics require a cross-sector approach to evaluating the overall health and well-being in a community.

Shared Guidance and Best Practices

Part II of this plan outlines guidance and best practices for each core function. The core functions of a connected community of care must be built upon shared guidance and equity-driven best practices to support consistent, coordinated, and supportive experiences across individuals and families in the region. Guidance and best practices consider:

System Implementation

The success of a connected community of care relies on the effective implementation, operation, and coordination of the individual systems used by health care and social service providers. The **system implementation** sections in this plan outline **established tools, recommended workflows, and processes** for partner organizations to adopt to support interoperability between their systems and processes. System implementation is not a one-time activity, but rather a continuous process. Partner organizations should plan to improve, expand, and enhance their systems and processes on an ongoing basis. Each iteration should be refined through extensive user testing with representative groups of users, including staff in the organization and people in the community. An iterative approach to system implementation will allow each partner organization to make realistic, sustainable change while continuing to advance the vision of a connected community of care in the region.

Information Governance

Information governance consists of standard policies and procedures for using information in a responsible, agreed-upon manner. Information governance is especially important in health care, social services, and other settings where personally identifiable information is needed to provide care and other services. Effective information governance promotes accessibility of data across the spectrum of health and social services through secure, trusted mechanisms and ensures those data are appropriately used (see the Colorado Health Information Governance Guidebook).

Consent management and privacy are key components of information governance that deserve focused attention in a connected community of care. Individuals and families must be able to control how, when, and with whom their personal information is shared. Consent is required by law for many types of personal information. Further, MDPH partners agree that informed consent is critical to building effective care relationships with individuals and families. Due to its critical importance, consent is discussed separately from other information governance issues throughout this plan.

Workforce Adoption and Engagement

A connected community of care relies on the health care, public health, and human service workforce that directly serves individuals and families. If the workforce — including care coordinators, case managers, Promotoras de Salud, community health workers, social workers, nurses, and others — does not fully implement the functions nor adopt shared best practices to promote equity and dignity, then the investment in the people, processes, and technology that make up a connected community of care will be wasted. In this plan, **workforce adoption and engagement** sections include **recommended training, best practices, and quality improvement approaches** for the five core functions. While each partner organization is responsible for engaging internal staff, MDPH's integrative governance structure will provide a forum to share successes, address challenges, and identify best practices for workforce engagement. This forum will draw upon transparent sharing of organization-specific data as a way to recognize leaders and identify organizations that may need additional support.

Technology

An effective community of care relies on a **technical infrastructure** that seamlessly supports system implementation, information governance, and workforce adoption and engagement activities. Technical infrastructure supports the business requirements, functional and interoperability requirements, data and information standardization, and quality improvement activities necessary to operate and maintain a connected community of care.

This plan provides **recognized data standards, recommended data workflows, and privacy considerations** related to technology. The plan also articulates information governance decisions to be made by MDPH partners as the connected community of care is established and expanded. See Appendix for initial business requirements, and functional and interoperability requirements, developed by MDPH partners, for the Metro Denver Connected Community of Care.

MDPH intends to leverage shared S-HIE infrastructure to effectively coordinate services and resources collaboratively within its connected community of care. See the MDPH Connected Community of Care Sustainability Plan for more details on opportunities being supported by the Colorado Office of eHealth Innovation and the Department of Health Care Policy & Financing to advance unifying S-HIE architecture.

Commitment to Equity

MDPH commits to upholding the best practices listed in this plan to preserve dignity and respect for all people, in addition to preventing the worsening of disparities in access to care, services, and health. MDPH's framework for a connected community of care calls for all partners to intentionally consider equity at every step.

Community members should have access to their own screening/assessment data, the integrated CRI, access to their own referrals and care coordination records, and access to any of their data used for community health analytics. MDPH partners commit to determining and implementing appropriate methods for people to access their data safely and securely.

MDPH also recognizes that partner organizations have varying levels of resource availability and technical readiness to participate in a connected community of care. These variations could result in disparities in access for communities. MDPH commits to offering technical assistance and support for existing and new partners to participate in the connected community of care to ensure equitable access for all communities.

How to Use This Plan

Follow these steps to implement this plan within your organization:

Step 1. Identify an organizational champion (typically a senior leader or executive) who has decision-making power and can direct resources to support plan implementation.

Step 2. Identify implementation champion(s) (typically a work-lead or supervisor of frontline staff) who oversee implementation and operations and can monitor, evaluate, and support continuous quality improvement of plan activities.

Step 3. Ensure a consistent representative from your organization participates in MDPH integrative governance workgroups to coordinate and align all partners. This individual may be your organizational champion, one of your implementation champions, or another person who stays closely connected with the leadership and management of the organizational and implementation champions.

Step 4. Develop and distribute clear communication to your staff about the purpose and intended activities of the plan, which are in service to building a connected community of care for individuals and families.

Step 5. Begin implementing the plan.

Step 6. Develop continuous quality improvement processes and practices. Continuous quality improvement is a commitment to constant, progressive, and incremental improvement of programs, workflows, and activities. The connected community of care will require ongoing iterations and improvement to ensure all community members have the resources they require to live healthy lives. Refer to the MDPH Connected Community of Care Accountability Plan for additional guidance on developing continuous quality improvement processes.

Part I: Commitments and Designated Activities

Screening and Assessment

MDPH partners commit to assessing and addressing whole-person care needs, recognizing that a person’s overall health includes physical, mental, and social well-being. MDPH partners’ social need screening and assessment processes will include person-centered and equity-focused best practices to uphold dignity and respect for individuals and families seeking care and services.

Commitments
1.a. MDPH partners will implement screening and assessment tools and protocols that are appropriate to their organization's mission and reflect the needs of the people they serve. The connected community of care will not select a single screening tool or assessment for all partners to adopt.
1.b. MDPH partners will implement standardized, evidence-based screenings and assessments whenever appropriate and available and will consider using tools that are already widely used in the connected community of care. MDPH partners recognize that standardized tools may not currently meet the needs of all organizations, individuals, and families, and will work to accommodate non-standardized tools throughout the connected community of care as needed. See the Appendix for recommended screenings and assessments.
1.c. MDPH partners will select screening and assessment tools that include a minimum set of three common social domains: food, housing/utilities, and transportation. Partners are encouraged to adopt more comprehensive tools including other social domains as appropriate for the settings and populations served.
1.d. MDPH partners will collect and/or verify standardized demographic information* for each individual and family who completes a screening or assessment to support identity resolution, care coordination, and community health analytics. See the Information Governance section for standardized data elements. MDPH partners will determine the standardized demographic information* to collect in screening and assessment through the integrative governance process, upholding respect for the dignity and diverse identities of people across the region and following best practices that serve to advance health equity and not reinforce existing disparities. With social need screenings and assessments, MDPH partners will secure consent to collect this information from individuals and families. *See Recommended Tools and Resources

1.e. MDPH partners will work toward sharing screening and assessment results in a tiered approach based on permissions and consent (see the Information Governance section):

A binary screening or assessment record should indicate whether an individual or family completed a social need screening or assessment and the timeframe (i.e., within the last week/month/quarter/year). It will be available to all MDPH partners. The binary record will not include screening or assessment results or where the screening or assessment was completed. The binary record should enable MDPH partners to know whether screening or assessment data are available.

A limited screening/assessment record should include identified needs (food and nutrition, housing security, etc.) and should be available to MDPH partners with appropriate permissions. The limited record should support care coordination between partners.

A full screening and assessment record should include detailed results and should be available to MDPH partners who have appropriate permissions. The full record should support comprehensive care coordination and community health analytics functions.

MDPH partners will evaluate and update the tiered approach through the integrative governance process as the network of health care and social service providers participating in the connected community of care develops and matures. The proposed tiered approach may also be modified based on technological considerations.

1.f. MDPH partners will work toward universal screening of the entire population within each initial use case (see the "How this Plan was Developed" section) in order to reduce stigma, avoid bias, and increase access to services and support.

1.g. MDPH partners will provide individuals and families who have been screened or assessed with a list of appropriate resources for identified needs at the time of screening or assessment. The list of resources is intended to complement, not replace, referrals and care coordination activities. MDPH partners recognize that individuals and families may not complete a referral or engage in care coordination due to a variety of factors; providing a list of resources will ensure that each individual or family is offered a minimum level of support.

Designated Activities and Timelines

All MDPH Partners:

- Participate in the integrative governance process to reach consensus on policies and best practices for a tiered approach to share screening and assessment data.
  Timeline: Phase One Implementation (spans years 1-2 of implementation), ongoing as needed
- Determine whether existing technology can be used for a centralized screening and assessment repository to link new screenings and assessments to an individual's or family's existing record. See the Technology section for more details.
  Timeline: Phase One Implementation (spans years 1-2 of implementation), ongoing as needed
- Contribute to a shared repository of standardized screening and assessment tools to aid new and existing partners in evaluating options for adoption. See the Appendix for the current list of recommended tools.
  Timeline: Phase One Implementation (spans years 1-2 of implementation), ongoing as needed
- Contribute to a shared repository of screening and assessment policies and procedures to aid new and existing partners in developing or enhancing their approach to screening and assessment.
  Timeline: Phase One Implementation (spans years 1-2 of implementation), ongoing as

needed

Health Systems, Regional Accountable Entities, Government Agencies, and Community-Based Organizations:

- Select and implement appropriate screening and assessment tools and protocols within direct service programs and departments.
  Timeline: Phase One Implementation (spans years 1-2 of implementation), ongoing as needed
- Adopt agreed-upon policies and best practices to share screening and assessment data in a tiered approach, including a minimum set of common social domains and demographic information.
  Timeline: Phase One Implementation (spans years 1-2 of implementation), ongoing as needed
- Share screening and assessment data according to the tiered approach.
  Timeline: Phase One Implementation (spans years 1-2 of implementation), ongoing as needed

Trusted Convener:

- Develop and maintain a shared repository of standardized screening and assessment tools and policies and procedures to aid new and existing MDPH partners in evaluating options for adoption.
  Timeline: Phase One Implementation (spans years 1-2 of implementation), ongoing as needed
- Identify and distribute useful resources that provide guidance on implementing screening and assessment tools and protocols in all types of MDPH organizations.
  Timeline: Phase One Implementation (spans years 1-2 of implementation), ongoing as needed
- Facilitate the MDPH integrative governance process. Document and distribute the agreed-upon policies and best practices to support a tiered approach to sharing screening and assessment data.
  Timeline: Phase One Implementation (spans years 1-2 of implementation), ongoing as needed

Recommended Tools and Resources

- Implementation Guidance for Screening for Social Determinants of Health in an Electronic Health Record
- Advocating For Data Disaggregation by Race and Ethnicity — Asian & Pacific Islander American Health Forum
- Creating a Course for an Equity-Centered Data System
- Disaggregating Data: Advancing Health Equity — Robert Wood Johnson Foundation
- Transforming Public Health Data Systems — Robert Wood Johnson Foundation

Community Resource Inventory

MDPH partners commit to providing up-to-date community resource information so that individuals and families have agency, choice, and access to connect with the right resource at the right time in the right place. This commitment will require partners to share information from their own internal resource inventories with one another to support a larger integrated community resource inventory. The integrated community resource inventory will allow individuals and families to consider all services available, rather than a limited list that may not meet their goals.

Commitments
2.a. MDPH partners will support an integrated community resource inventory (CRI) that resolves and distributes information from multiple platforms and sources and allows partners to access all CRI information within their organization's chosen platform or interface.
2.b. MDPH partners will share community resource information collected by their staff or technology vendors through the integrated CRI, to the extent possible under existing technology and agreements. Partners will work to improve technology and update agreements to enable and enhance sharing of comprehensive, up-to-date community resource information through the CRI as the network of health care and social service providers participating in the connected community of care develops and matures.
2.c. MDPH partners will update their own program and service listings every six months, at a minimum, to ensure accurate and up-to-date information in the integrated CRI. Partners are encouraged to modify their own listings within one week of any significant change to service availability or eligibility.
2.d. MDPH partners will provide immediate feedback and suggested corrections when inaccurate, incomplete, or out-of-date information is identified in the integrated CRI. The process and method for providing feedback and corrections will be determined through the integrative governance process, in coordination with technology vendors.
Designated Activities and Timelines
All MDPH Partners: ● Participate in the integrative governance process to develop consensus on policies and best practices to support an integrated CRI, including data standards and a funding model. *Timeline:* Phase One Implementation (spans years 1-2 of implementation), ongoing as needed
Health Systems, Regional Accountable Entities, Government Agencies, and Community-Based Organizations: ● Adopt agreed-upon data standards to facilitate CRI information sharing and/or update agreements with vendors to require the data standards. *Timeline:* Phase One Implementation (spans years 1-2 of implementation), ongoing as needed ● Develop and implement plans to share internal CRI information through the integrated CRI. *Timeline:* Phase One Implementation (spans years 1-2 of implementation), ongoing as needed

Trusted Convener:

- Facilitate the MDPH connected community of care integrative governance process. Document and distribute the agreed-upon policies and best practices to support an integrated CRI.
  Timeline: Phase One Implementation (spans years 1-2 of implementation), ongoing as needed
- Research existing CRIs, best practices, and standards to support an integrated CRI.
  Timeline: Phase One Implementation (spans years 1-2 of implementation), ongoing as needed
- Facilitate relationship-building with community-based organizations and other organizations that provide direct services to support the development of a comprehensive, integrated CRI.
  Timeline: Phase One Implementation (spans years 1-2 of implementation), ongoing as needed

Recommended Tools and Resources

For recommended vocabulary, content, and transport standards, see the Shared Guidance and Best Practices: Community Resource Inventory Technology section.

Initial MDPH Use Case Business Requirements, and Functional and Interoperability Requirements (see Appendix).

Referrals

MDPH partners commit to connect individuals and families with timely and appropriate services and resources to meet their physical, mental health, and social needs. People receive information about services and resources through public websites, outreach efforts, and recommendations from their health and community-based service providers. While this information can lead to successful connections, too many people encounter barriers and never connect with available resources. MDPH partners will reduce barriers by giving individuals and families the choice to be referred and connected directly to services within the connected community of care, reducing the need for individuals and families to navigate confusing and complicated processes themselves.

Commitments

3.a. MDPH partners will work toward a "no wrong door" approach, allowing any partner to send to and receive referrals from any other participating partner. MDPH acknowledges that it may not be appropriate or feasible for all partners to participate as both referral-sending and referral-receiving partners. Partners are encouraged to participate to the maximum extent possible and appropriate.

MDPH partners will support shared interoperability standards (and infrastructure, if needed) that allow referral information to be transmitted among referral systems. Adopting interoperability standards is necessary to allow all partners to exchange referrals regardless of the technology each partner uses.

3.b. MDPH partners will work toward sharing referral data in a tiered approach based on permissions and consent (see Information Governance for more details):

- A limited referral record should be transmitted from the partner sending a referral to the partner receiving a referral. The limited record should include the minimum necessary information for the receiving partner to act upon a referral. MDPH partners will determine a standard minimum set of information for all referrals (person's name, contact information, and service desired) and allow receiving partners to specify additional fields necessary to confirm eligibility and/or provide services.
- A full referral record, including referral history, services provided, and any associated outcomes, should be shared with MDPH partners with appropriate permissions. The full record should support comprehensive care coordination and community health analytics functions. See Information Governance for more information about permissions.

One or more response notifications should be transmitted from referral-receiving partners back to referral-sending partners for both limited and full referral records. Response notifications will provide concise information on the outcome of a referral to close the loop with the referral-sending partner. See 3.d. for more information on response notifications.

MDPH partners will evaluate and update the tiered approach through the integrative governance process as the network of health care and social service providers participating in the connected community of care develops and matures. The proposed tiered approach may also be modified based on technological considerations.

3.c. MDPH partners will review resource eligibility information when evaluating referral options and only provide referrals to organizations that the partner, in good faith, believes can serve the individual or family. This preserves respect for people being served and upholds MDPH partners' commitment to delivering quality, person-centered care. For more details about eligibility information, see the Community Resource Inventory section.

3.d. MDPH partners receiving new referrals will respond within one week to referral-sending partners. Responses may include the following notifications back to the referral-sending partner. The referral remains open until one of the following notifications is sent:

- Referral refused. The receiving partner will not act upon the referral due to eligibility mismatch, lack of capacity, or other issue. The referral is closed. The referral-sending partner is responsible for following up with the individual or family about alternative options.
- Referral accepted. The receiving partner will act upon the referral and provide further updates back to the referral-sending partner, to include:
  - Service provided. The receiving partner has provided (or begun to provide) the requested service or another appropriate service to the individual or family. The referral is closed.
  - No client response. The receiving partner has reached out to the individual or family and has not made contact. The referral is closed. Partners are encouraged to reopen the referral if the individual or family responds later.
  - Incorrect client information. The receiving partner has not been able to reach the individual or family due to incorrect contact information (e.g., inactive phone number, wrong numbers). The referral is closed. Referral-sending partners are encouraged to reopen the referral if corrected contact information becomes available.
  - Client decline. The receiving partner contacted the individual or family and the individual or family declined the service or resource.
  - Referral received. This response type is reserved for receiving partners that are not able to provide any information about the outcome of a referral (e.g., a program that cannot share information about services provided due to government regulations or policies). This response serves as a receipt of a successful referral transmission only and the referral is automatically closed.

MDPH partners will evaluate and update the referral response timeframe and response options through the integrative governance process as the network of participating health care and social service providers develops and matures.

3.e. MDPH partners will work collaboratively to identify, understand, and resolve issues in the referral workflows between partners through the integrative governance process.

3.f. MDPH partners will collect standardized demographic information* for each individual and family who accepts a referral, to support identity resolution and enable the linking of records across the connected community of care. See Information Governance for standardized data elements.

*See Recommended Tools and Resources.

Designated Activities and Timelines

All MDPH Partners:

- Participate in the integrative governance process to reach consensus on policies and best practices to support a tiered approach to share referral data.
  Timeline: Phase One Implementation (spans years 1-2 of implementation), ongoing as needed

Health Systems, Regional Accountable Entities, Government Agencies, Referral Platforms, and Community-Based Organizations:

- Determine the appropriate level of participation for each organization in sending and receiving referrals.
  Timeline: Phase One Implementation (spans years 1-2 of implementation), ongoing as needed
- Adopt agreed-upon policies and best practices to share referral data in a tiered approach.
  Timeline: Phase One Implementation (spans years 1-2 of implementation), ongoing as needed
- Share referral data according to the tiered approach.
  Timeline: Phase One Implementation (spans years 1-2 of implementation), ongoing as needed

Trusted Convener:

- Facilitate the integrative governance process. Document and distribute the agreed-upon policies and best practices to support a tiered approach to sharing referral data.
  Timeline: Phase One Implementation (spans years 1-2 of implementation), ongoing as needed

Recommended Tools and Resources

- Advocating For Data Disaggregation by Race and Ethnicity – Asian & Pacific Islander American Health Forum
- Creating a Course for an Equity-Centered Data System
- Disaggregating Data: Advancing Health Equity – Robert Wood Johnson Foundation
- Transforming Public Health Data Systems – Robert Wood Johnson Foundation

Whole-Person Care Coordination

MDPH partners commit to coordinating across organizations to support whole-person and whole-family care. Whole-person and whole-family care may include having a dedicated care coordination entity to work with an individual or family over time and across different referrals within the connected community of care. Whole-person care coordination is about putting people first, recognizing their unique needs and strengths, and reducing barriers they face to accessing care and resources by building trusted relationships with them and other partners to coordinate their care efficiently and effectively.

Commitments
4.a. MDPH partners will develop and implement a shared process to identify and designate the most appropriate organization to serve as the lead care coordination entity for individuals and families who have multiple or complex needs that require care coordination and who want to receive care coordination services. The process may also include criteria for determining when individuals and families should not be assigned to a lead care coordination entity based on the organization’s expertise and program design. A lead care coordination entity is an organization that is 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, an individual may have several care coordinators assigned to them, based on their insurance status, current housing situation, and mental health care needs. The individual’s lead care coordination entity would be responsible for communicating with all partners, ensuring that the individual’s information, referrals, care, and services are shared and coordinated (via appropriate permissions according to the tiered approach identified in commitment 4.b., so the individual does not need to repeat their information or follow up with each of their care coordinators separately. MDPH partners commit to honoring individual and family preference when designating a lead care coordination entity whenever possible.
4.b. MDPH partners will work toward sharing care coordination information in a tiered approach based on permissions and consent (see the Information Governance section for more details): A binary coordination record should indicate whether an individual or family is currently assigned to a lead care coordination entity and should be viewable by all MDPH partners. The binary record should not reveal the name of the lead entity. This will ensure privacy, especially for those whose data may be protected by certain regulations (e.g., if a person’s lead care coordination entity is a mental health center). Partners with appropriate permissions may access either the limited record or the full record. A limited coordination record should indicate the current MDPH partners involved in an individual’s or family’s care and the services being provided, based on appropriate permissions. The limited record should support coordination between partners and should indicate the lead care coordination entity and include associated contact information. The limited record could also support community health analytics functions. A full coordination record should be shared with MDPH partners with appropriate permissions and should include a compiled view of screening or assessment records, referral records, services provided, outcomes data including individual/family-reported data on whether needs

have been met, and additional communication or notes between coordinating partners. The full record should support comprehensive care coordination and community health analytics functions.

MDPH partners will evaluate and update the tiered approach through the integrative governance process as the network of health care and social service providers participating in the connected community of care develops and matures. The proposed tiered approach may also be modified based on technological considerations.

4.c. MDPH partners will maintain up-to-date demographic information* for each individual and family to support identity resolution and enable the linking of records across the connected community of care.

*See Recommended Tools and Resources and the Information Governance section for standardized data elements.

Designated Activities and Timelines

All MDPH Partners:

- Participate in the integrative governance process to reach consensus on a shared process to identify lead care coordination entities.
  Timeline: Phase Two Implementation (spans years 2-4 of implementation), ongoing as needed
- Participate in the integrative governance process to support capacity of community-based care coordination services. See the MDPH Connected Community of Care Sustainability Plan for more details.
  Timeline: Phase Two Implementation (spans years 2-4 of implementation), ongoing as needed
- Participate in the integrative governance process to reach consensus on policies and best practices to support a tiered approach to share coordination data.
  Timeline: Phase Two Implementation (spans years 2-4 of implementation), ongoing as needed

Health Systems, Regional Accountable Entities, Government Agencies, and Community-Based Organizations:

- Adopt and participate in the agreed-upon shared process for identifying lead care coordination entities, including serving as the care coordination entity for individuals and families as appropriate.
  Timeline: Phase Two Implementation (spans years 2-4 of implementation), ongoing as needed
- Adopt agreed-upon policies and best practices to share coordination data in a tiered approach.
  Timeline: Phase Two Implementation (spans years 2-4 of implementation), ongoing as needed
- Share coordination data according to the tiered approach.
  Timeline: Phase Two Implementation (spans years 2-4 of implementation), ongoing as needed

Trusted Convener:

- Facilitate the integrative governance process. Document and communicate the shared process to identify lead care coordination entities and the agreed-upon policies and best practices to support a tiered approach to sharing coordination data.
  Timeline: Phase Two Implementation (spans years 2-4 of implementation), ongoing as needed
- Support implementation of the shared process to identify lead care coordination entities.
  Timeline: Phase Two Implementation (spans years 2-4 of implementation), ongoing as needed

Recommended Tools and Resources

- See recommended training and best practices in the Appendix.
- Disaggregating Data: Advancing Health Equity – Robert Wood Johnson Foundation
- Transforming Public Health Data Systems – Robert Wood Johnson Foundation
- Recommendations from the National Commission to Transform Public Health Data Systems – Robert Wood Johnson Foundation
- Making the Case for Data Disaggregation to Advance a Culture of Health | PolicyLink

Community Health Analytics

MDPH partners commit to monitoring and improving the services and coordination provided within the connected community of care on an ongoing basis. According to the World Health Organization, "Health is a state of complete physical, mental and social well-being and not merely the absence of disease." Community health analytics will provide deeper data and insights about alignment among available resources, existing gaps, and priorities of the community. Partners commit to ensuring that investment in shared S-HIE infrastructure results in positive systemic changes within the connected community of care, rather than reinforcement of disparities and inequities for people in the metro Denver region.

Commitments

5.a. MDPH partners will work toward coordinating community health data, analytics, planning, and improvement efforts through an integrated community health analytics function. The integrated analytics function should receive and process individual-level data for the purpose of aggregate reporting, analytics, and community health improvement planning to support the connected community of care.

The individual-level data shared through the analytics function should not be reused or redisclosed for any reason beyond supporting the evaluation and evolution of the connected community of care, unless explicitly allowed through written agreement with the partner submitting the data, who is responsible for garnering appropriate consent from the individual or family. Aggregate data and analytics should be released in a manner that ensures privacy of individuals and families.

5.b. MDPH partners will work toward sharing the following individual-level data through the integrated analytics function based on permissions:

- Full screening and assessment records of all individuals and families. See the Screening and Assessment section for more details.
- Full referral records for all individuals and families. See the Referrals section for more details.
- Full coordination records for all individuals and families. See the Whole-Person Care Coordination section for more details.
- Outcome data. Outcome data will be needed to evaluate the effectiveness of the connected community of care and plan for improvements. MDPH partners will respond to requests for individual-level outcome data on a case-by-case basis to facilitate outcome analyses via the integrated analytics function. Outcome data may include quantitative or qualitative measures (see Overall Evaluation below).

5.c. MDPH partners will allow the community resource inventory function to transmit community resource information to the integrated analytics function for the purpose of resource reporting, analytics, and improvement planning. See the Community Resource Inventory section for more details.

5.d. MDPH partners will evaluate whether the connected community of care has the capacity to meet service demand in the community through the cross-sector data and analysis made possible by the integrated analytics function. If services are not adequate to meet community needs, the partners will collaborate to develop strategies to increase the availability of necessary resources through the integrative governance process. See the MDPH Connected Community of Care Sustainability Plan for more details.

5.e. MDPH partners will evaluate the overall efficiency and effectiveness of the connected community of care through the integrated analytics function on an ongoing basis and determine how to make improvements over time. For more information about the metrics that will be used to evaluate progress, successes, and areas for improvement, see the MDPH Connected Community of Care Accountability Plan.

5.f. MDPH partners will share aggregate-level analytics publicly to support community-wide understanding of needs, resources, and opportunities for health and community resource improvements. MDPH partners will determine the content and frequency of public reports through the integrative governance process.

Designated Activities and Timelines

All MDPH Partners:

- Participate in the integrative governance process to develop consensus on policies and best practices for the integrated analytics function, including privacy and consent policies. Review and approve the MDPH Connected Community of Care Accountability Plan and subsequent updates to guide the integrated analytics function.
  Timeline: Phase Three Implementation (spans years 4-5 of implementation), ongoing as needed

Health Systems, Regional Accountable Entities, Government Agencies, and Community-Based Organizations: ● Adopt agreed-upon policies and best practices to share data through the integrated analytics function. *Timeline:* Phase Three Implementation (spans years 4-5 of implementation), ongoing as needed ● Share individual-level screening and assessment, referral, and coordination data through the integrated analytics function according to the tiered approach. *Timeline:* Phase Three Implementation (spans years 4-5 of implementation), ongoing as needed
Trusted Convener: ● Facilitate the integrative governance process. Document and distribute the agreed-upon policies and best practices to support data sharing through the integrated analytics function. *Timeline:* Phase Three Implementation (spans years 4-5 of implementation), ongoing as needed
Recommended Tools and Resources
● Disaggregating Data: Advancing Health Equity — Robert Wood Johnson Foundation ● Transforming Public Health Data Systems — Robert Wood Johnson Foundation ● Recommendations from the National Commission to Transform Public Health Data Systems — Robert Wood Johnson Foundation ● Making the Case for Data Disaggregation to Advance a Culture of Health — PolicyLink

Part II: Shared Guidance and Best Practices

MDPH partners will follow this guidance and uphold these best practices when implementing their designated activities.

Screening and Assessment

System Implementation

Step 1. Select a Screening or Assessment Tool

Each organization will be responsible for selecting screening or assessment tools that are appropriate to that organization's mission and reflect the needs of the people it serves. MDPH partners will compile and maintain a shared repository of available tools (e.g., PRAPARE, the Colorado Family Support Assessment 2.0), including information on which tools are commonly used by participating partners.

The selection of a screening and assessment tool has important implications for health equity and interoperability. Standardized tools are preferred for the following reasons:

Bias Reduction: Validated tools can reduce the impact of individual bias of people administering the tools when tools are thoughtfully selected for the community with culturally competent protocols.

Sensitivity and Specificity: Validated tools are designed and evaluated to accurately identify the type of support needed by an individual or family. These tools avoid questions that are too broad (which lead to false positives) or too narrow (which lead to false negatives).

Mapped to Code Sets: Validated tools are more likely to be mapped to existing code sets and therefore more easily linked to data-sharing processes. New screening or assessment tools may need to be mapped manually.

Easier to Aggregate and Interpret Data: Most validated tools are accompanied by guidance on scoring and interpreting screening and assessment results, which improves the ability to compare and aggregate results across organizations for analysis. For example, many commonly used nationally validated screening tools incorporate the Hunger Vital Sign questions. If MDPH partners collectively asked those questions of a large portion of the metro Denver population, the results could be aggregated to provide powerful insights on the state of food insecurity and where to focus additional resources and support in the region. Validated tools may also have national benchmark data, which allow partners to better understand how the region compares to other areas.

When selecting the appropriate screening or assessment tool for your organization, evaluate:

Domains: Consider the needs of the population your organization serves to determine which domains your assessment should include. At a minimum, ensure the tool aligns with the MDPH core commitment to screen for food, housing/utilities, and transportation needs. Some domains, such as interpersonal violence, are more sensitive than others. Organizations that include these domains may need to identify additional processes to protect privacy, respond to potential needs, and comply with relevant laws such as those around mandatory reporting for children, older adults, and other vulnerable populations.

Population: Assess potential tools for appropriateness for the population you serve. For example, some tools are designed for children and families or have versions of the tool oriented to children and families.

Workflow: Some screening and assessment tools are designed to be administered orally while others are designed to be completed by the person themselves. Consider how the program or department intends to implement and which tool will best align with a desired, person-centered workflow.

Step 2. Develop Person-Centered Workflows

While each organization will develop its own screening and assessment workflow for different programs and departments, MDPH partners recognize the importance of a shared person-centered experience for each individual and family that interacts with partner organizations. To support that shared experience, MDPH partners will strive to develop screening and assessment workflows that align with the following values:

Equity:

- MDPH partners will offer screening/assessment to all people who are eligible. Universal screening within each use case reduces the impact of individual bias when making a subjective decision as to who should be screened or assessed.
- MDPH partners will offer tailored modalities to ensure all individuals and families can be included in screening and assessment activities. Modalities should be considered for people who do not speak English, who have low literacy, who have visual impairment, or who are deaf or hearing impaired.

Coordinated, Person-Centered Care: MDPH partners will develop workflows that reduce administrative burden and potential re-traumatizing experiences by viewing previously submitted screening and assessment results, when available and with appropriate permissions.

Dignity for Individuals and Families:

- MDPH partners will develop screening and assessment workflows that honor privacy and dignity by carefully considering where and when screenings and assessments take place and how conversations about results will occur.
- Individuals and families should have the option to decide whether they want to be screened and how their results may (or may not) be shared. Partner organizations should consider how to effectively implement informed consent or assent into screening and assessment protocols. See details for further consideration under the Information Governance: Consent Management and Privacy section.

Stigma Reduction: MDPH partners will use screening and assessment as a means to reduce stigma and normalize the prevalence of individuals and families who have unmet social needs. To achieve that goal, MDPH partners will engage in robust staff training and develop thoughtful messaging to be delivered to every person receiving a screening or assessment.

Autonomy and Independence: MDPH partners will offer a tailored list of resources for each individual or family at the time of screening or assessment. This list is intended to complement, not replace, electronic referrals when available and appropriate. While electronic referrals are a core function of a connected community of care, a list of resource information offers autonomy and independence to individuals and families. People may prefer to contact a resource themselves, to communicate at a time convenient for them, or to have support from family or friends when making the connection. Resource information is ideally provided in writing in the individual’s preferred language. MDPH partners also recognize that some people will not be reached by an organization receiving a referral. Providing resource information at the time of screening or assessment may reduce the number of people who are “lost to follow-up.”

Acknowledging and Addressing System Limitations: MDPH partners will be transparent, timely, compassionate, and direct with individuals and families who are seeking resources that are not currently available in the community. By providing accurate information on the availability of resources, MDPH partners can reduce frustration for individuals or families who might otherwise encounter unexpected wait times or barriers. Transparency also allows MDPH partners to help people explore whether alternative support such as behavioral health care or whole-person care coordination may be available while the person waits for the primary resource they are seeking.

Prioritizing Whole-Person Health: MDPH partners will develop implementation strategies and workflows with the intention of implementing each applicable use case to the fullest extent possible. If an organization chooses to implement screening or assessment in phases (e.g., initially launching partial screening versus universal screening), MDPH partners still commit to working toward full implementation (e.g., universal screening, then referrals, and care coordination). MDPH partners recognize that implementation will have challenges for every organization and these challenges should be seen as common growing pains that occur with significant, meaningful systems change. This upfront commitment to full implementation and thoughtful change management will enable organizations to be more successful in supporting whole-person health across systems and the region.

Step 3. Use Shared Screening and Assessment Information

MDPH partners will work toward sharing screening and assessment results in a tiered approach based on permissions. See the Commitments section for a high-level description of each tier. The three tiers support different functions within the connected community of care:

Binary screening/assessment records support the screening and assessment function. The binary record allows all MDPH partners to know whether an individual or family has completed a social need screening or assessment covering at least the minimum domains (food, housing/utilities, transportation) within a certain timeframe (e.g., in the past week, month, or year).

For example, staff could be notified when opening an electronic record that a person completed a screening within the past week. The staff can then ask the person if they would like to complete a new screening, grant the organization permission to see a limited record of the previous screening, or opt out of screening at their current visit. The binary record should never be used to omit screening altogether unless the person actively opts out of screening.

Limited screening and assessment records support three core functions: screening and assessment; referrals; and whole-person care coordination. The limited record allows MDPH partners with appropriate permissions to know what needs (food/nutrition, housing security, etc.) an individual or family identified in previous screenings or assessments. This information can help staff avoid duplicative screenings and support follow-up activities across participating organizations.

For example, a family could grant permission to share its limited screening or assessment record with all MDPH partners. In this case, when the family visits a new partner organization within the connected community of care, staff could see that the family identified a need for utility assistance in a previous assessment completed at another partner organization. Staff could then ask the family if they received the assistance they needed or if anything else has changed related to food, housing, or transportation. The family could also be screened for additional domains that were not included in previous screenings. Limited records can also support referrals and whole-person care coordination.

Full screening and assessment records support two core functions: whole-person care coordination and community health analytics. Full records provide detailed screening and assessment results, including screening and assessment questions and an individual's or family's specific responses.

Information Governance

MDPH partners will continue to collaborate through the integrative governance process to make shared decisions on key information governance issues related to sharing screening and assessment information, including:

Step 1. Regulatory Compliance

MDPH partners are subject to a wide variety of regulatory requirements, depending on the organization type, funding, and services provided. Screening and assessment information collected at one organization may be subject to different regulations than the same information collected at another partner organization. To share this information across organizations, it is likely that all partners will need to comply with all applicable regulations. At a minimum, the entire network of health care and social service providers participating in the connected community of care will need to meet the requirements of the Health Insurance Portability and Accountability Act (HIPAA) and applicable Colorado regulations for personally identifiable information. MDPH will explore options to ensure HIPAA compliance without placing undue burden on community-based organizations and other partners that are not HIPAA-covered entities.

Ongoing work (MDPH partners/Trusted convener): Identify additional regulations that apply to screening and assessment information collected by MDPH partners, especially government agencies and community-based organizations. Ensure that applicable regulations are met before screening and assessment information is shared.

Step 2. Data Elements

MDPH partners have a basic framework for a tiered approach to sharing screening and assessment information (see the Commitments section). The next step is to determine the specific data elements to be included in each tier. The following examples demonstrate the types of decisions that will be made:

- Should the binary record indicate which screening tool was used?
- Will the limited record indicate only the high-level domain for identified needs (e.g., housing) or more granular information within each domain (e.g., currently experiencing homelessness vs. risk of eviction)?

- Will all domains be shared or only the common domains (i.e., food, housing/utilities, and transportation)? Will all domains be shared unless deemed sensitive by the partners (e.g., interpersonal violence)?

Ongoing work (MDPH partners/Trusted convener): Discuss and determine specific data elements for each tier, which must be considered in coordination with applicable regulations and consent policies (see Consent Management and Privacy section below).

Step 3. Permissions

The tiered approach to sharing screening and assessment information will rely on appropriate assignment and management of permissions for different partners. MDPH partners must thoughtfully balance the advantages of more granular permissions with the complexity of managing those permissions from an organizational and individual/family's standpoint. Many large connected communities of care efforts across the nation (including the 2-1-1 Community Information Exchange in San Diego) avoided this issue by adopting a blanket approach, where all screening and assessment information is shared with all participating partners. MDPH's tiered approach will be considerably more complex but may offer individuals and families more control and agency over their data. The tiered approach also has considerable implications for consent policies, which are discussed in the Consent Management and Privacy section.

Ongoing work (MDPH partners/Trusted convener): Develop policies and procedures for assigning and managing permissions for each tier of data sharing, including who has access to different tiers and how user permissions will be authorized and managed.

All information governance discussions and decisions will be informed by collaboration and discussion among MDPH partners and technical partners (including technology vendors). Input and feedback from technical partners will help to clarify the information governance decisions to be made and provide a pathway to effectively implement those decisions through technology. For example, technical partners may propose technical options for sharing limited screening/assessment records and clarify the information governance decisions that might lead to choosing one option over others.

Step 4. Consent Management and Privacy

Individual and Family Rights: MDPH partners believe in the right of individuals and families to control how their screening and assessment data are collected, stored, shared, and used. MDPH partners will enact legally compliant policies and procedures and strive to develop informed and culturally responsive consent practices.

MDPH has developed the following consent practices to consider based on conversations throughout the partnership; however, these practices will be reviewed, refined, and finalized through the integrative governance process.

Consent Practices to Consider: Screening and Assessment

Baseline Consent Practices to Consider

Each individual and family should be offered, at a minimum, the ability to opt out of:

- Screening and assessment
- Answering specific questions on a screening or assessment
- Sharing any or all screening and assessment information outside of the organization collecting the information. This option would exclude all three tiers of data sharing (binary record, limited record, and full record).

Individuals and families should be informed that if they do not opt out, their screening and assessment records will be shared among MDPH partners according to the tiered approach. The tiered approach should be explained in simple, but thorough, terms to each person to support informed consent.

Note: Program regulations, for example, hospital data sharing with Regional Accountable Entities for Health First Colorado (Colorado's Medicaid program) members, may supersede individual or family consent to share their information in some cases. These cases should be clearly communicated to enable individuals and families to make informed choices about whether to participate in screening and assessment.

Additional Consent Practices to Consider

In addition to the baseline consent practices listed, MDPH partners will strive to offer additional layers of control over how screening and assessment data are shared. For example, the partners might consider the following:

- Should individuals and families have the ability to opt out of sharing certain screening and assessment information (e.g., interpersonal violence information), while sharing all other data according to the tiered approach?
- Should individuals and families have the ability to opt in to sharing information with specific partners without sharing with all participating partners?
- Should individuals and families have the ability to revoke their consent and opt out of redisclosure of prior screening and assessment information?

MDPH partners understand that additional consent options require more sophisticated technical approaches and more nuanced governance relationships. Some of these options are offered by certain technical vendors, while other options may not be readily available in existing technology. These differences can create significant barriers to interoperability. MDPH partners will carefully consider the opportunities and barriers to adopting this additional level of control through the information governance process and may adopt a phased approach to introducing these options over time.

Compliance with Relevant Laws and Regulations: The options proposed are rooted in compliance with HIPAA and Colorado regulations for personally identifiable information, which are the minimum regulations governing screening and assessment information in the MDPH connected community of care. The available options will be continuously evaluated and updated as additional regulations are identified and incorporated into

MDPH's information governance framework. Additionally, MDPH partners may agree upon different options for certain types of data. For example, hospitals participating in the Hospital Transformation Program (HTP) will screen for interpersonal violence as required by HTP but will not share the results of those screenings through the connected community of care. Information pertaining to interpersonal violence will remain internal at each organization until adequate policies and procedures can be developed, agreed upon, and implemented across the connected community of care to protect that sensitive information.

Culturally and Linguistically Responsive Practices: MDPH partners recognize the complexity of options available and will work to develop shared policies and best practices to enable informed, culturally, and linguistically responsive consent across the connected community of care. The partners will consider accessibility for special populations, including youth and people with developmental disabilities. Complex situations must also be considered, including families with divorced parents and youth who are not legally but are functionally emancipated.

Each organization should allow for verbal consent and should document electronically that the individual or family has provided or revoked consent to share their screening and assessment information.

Workforce Adoption and Engagement

Step 1. Staff Support

Implementing a new screening or assessment tool into an organization's workflow can require changes in staff routines, job descriptions, administrative procedures and more. MDPH partners will support the dignity of internal staff by thoughtfully evaluating how to reduce the impact of these activities on workload. MDPH partners recognize that staff responsible for these activities may also be experiencing unmet social needs and may require additional support and resources to do this challenging work effectively. MDPH partners will evaluate:

- Whether their organization can reduce or remove other responsibilities for staff accepting additional screening and assessment responsibilities.
- Whether their organization can offer a salary adjustment to staff accepting additional screening and assessment responsibilities in recognition of the additional workload and the complexity and skill required.
- Whether their organization can offer additional support to staff who may be facing unmet social needs themselves.

Step 2. Staff Training

MDPH partners are responsible for providing initial and ongoing training to their organization's staff involved in screening and assessment. The vision for a connected community of care will require significant culture change, and training is the key to unlocking a shift in values, beliefs, knowledge, and skills. Staff training can reduce potential harms (increased stigma, shame, or confusion about unmet social needs and challenges) and improve health equity for all.

Who: All staff, supervisors, and leadership involved in or overseeing social need screening and assessment activities should participate in initial and ongoing training. This includes staff who are not part of primary workflows but who may serve as back-up support when primary staff are out of the office, when positions are unfilled, or when unexpected organizational demands require shifting roles.

What: While all staff will require training, the individual needs of different staff members will vary. For example, clinical staff may already receive training on social determinants of health through continuing medical education while other members of the team may not have had those learning opportunities. MDPH partners should consider internally developing 1) training to connect screening and assessment activities to the organization's mission and goals and 2) training on the program or department's implementation workflow (for the designated use case).

In addition to securing internal training specific to each organization's needs, MDPH partners will develop recommendations for a regular cadence of shared training opportunities on meaningful, relevant topics to better serve communities in the Denver metro area. This may include existing training that is publicly available as well as new training developed or offered through MDPH. See Recommended Trainings and Best Practices in Appendix.

When: Organizations should train staff prior to implementing any new screening or assessment activities. New staff should complete initial training before conducting any screenings or assessments. Ongoing training should be required for all staff on a regular basis, at a frequency appropriate for each role in screening and assessment activities.

Step 3. Continuous Quality Improvement

MDPH partners are committed to continuous quality improvement in all five connected community of care functions. Each organization that conducts screening and assessment activities is responsible for implementing the processes needed to track, evaluate, and improve those activities. At a minimum, organizations should implement the following:

- Ability to track agreed-upon metrics (e.g., the number of screenings and assessments completed, number of screenings declined, percentage of individuals or families screened) in real time. All metrics should be tracked at the individual staff level to allow organizations to identify best practices and training needs. Specific metrics will be recommended in the MDPH Connected Community of Care Accountability Plan.

- A dedicated quality improvement team that will closely monitor screening and assessment metrics throughout implementation, determine quality improvement goals, and design and implement improvements.

When developing initial quality improvement goals, each organization should hypothesize potential barriers to screening and assessment activities (screening people who are late to appointments, screening people with low English literacy, or screening when the organization is not fully staffed). These potential barriers should be closely monitored with metrics and goals related to these specific populations or processes.

The quality improvements efforts of MDPH partners will also support efforts to continuously improve screening and assessment across the entire connected community of care. See the Community Health Analytics section for more information.

Technology

Step 1. Collecting and Storing Screening and Assessment Information

MDPH partners will collect and store screening and assessment information according to internal policies, procedures, and workflows. Each organization should store screening and assessment results electronically (in an electronic health record, case management system, referral platform, or other interoperable technology). Partners will use the technology that best meets the needs of their organization. Commercial examples include Epic, findhelp, MEDITECH, Salesforce, Unite Us, and others. Partners also developed in-house solutions, such as Boulder County Connect. Whether using a commercial product or an in-house solution, all partners will work toward interoperability to enable sharing screening and assessment information, based on MDPH's agreed-upon tiered approach and relevant laws and regulations.

Step 2. Sharing Screening and Assessment Information

MDPH partners will work toward sharing screening and assessment information in a tiered approach based on permissions. Existing technologies could potentially be enhanced to support this approach; however, this functionality does not yet exist. MDPH will explore options to enhance existing technology or to coordinate with planned development efforts to achieve this functionality. See the Commitments section for a description of each tier.

Binary screening/assessment records should be automatically shared (pushed) to a centralized repository within 24 hours of the screening/assessment taking place. The binary record should indicate the date a social need screening was completed and include basic demographic information (e.g., a person's name, address, date of birth) to support identity resolution. This is the minimum amount of information necessary for other MDPH partners to know whether an individual or family has recently completed a prior screening. The centralized repository should enable all partners to search for (pull) binary records for an individual or family and view whether a screening has been completed within a certain timeframe (e.g., within a week, month, or year).

Limited screening/assessment records should be available to MDPH partners with appropriate permissions. The limited record should indicate identified needs (e.g., food insecurity) to reduce duplication in screenings and assessments and increase informed support for people with those needs. Different technical approaches could be employed to enable MDPH partners with appropriate permissions to access these records, including centralized, federated, or distributed systems that rely on either push or pull transmissions. The appropriate technical approach will likely depend on information governance options that are yet to be decided. See the Information Governance section for more information on the process to determine the appropriate technical approach.

Full screening and assessment records should be automatically shared (pushed) to lead care coordination entities and the community health analytics function within 24 hours of the screening taking place. The full record should include detailed results of screenings and assessments, including negative responses (e.g., I do not need help with transportation). Full screening and assessment records let organizations perform community health analytics for the populations they serve and also facilitate community health analytics at a regional scale. See Community Health Analytics for technology considerations for this function. The full record also supports comprehensive care coordination for individuals and families who are working closely with a lead care coordination entity. See Whole-Person Care Coordination for technology considerations for comprehensive care coordination.

Step 3. Content of Shared Screening and Assessment Information

MDPH partners will determine a standard set of data elements to be included in each tier: binary records, limited records, and full records. See the Information Governance section for more information on the process to determine the standard data sets.

Step 4. Standards for Shared Screening and Assessment Information

MDPH partners will use vocabulary, content, and transport standards whenever possible and avoid proprietary and custom methods for storing, formatting, and sending information. The Gravity Project defines the following standards:

Vocabulary standards: Allow for the ability to represent concepts (e.g., health or social needs) in an unambiguous manner between a sender and receiver of information. To communicate with one another, information systems must have structured vocabularies, terminologies, code sets, and classification systems to represent concepts.

Content Standards: Define the structure and organization of an electronic message or a document’s content that is shared between information systems. Content standards include the definition of common sets of data used for specific message types.

Transport Standards: Address the format of messages exchanged between information systems. Transport standards include “push” and “pull” methods for exchanging health and social information.

MDPH partners will review and approve common standards through the integrative governance process. See the Environmental Scan: Standards and Recommended Requirements for existing standards for sharing screening and assessment information.

Step 5. Centralized Repository Function

A centralized screening and assessment repository function would be needed to receive binary records from each participating organization and automatically link new binary records to a unique person using an identity resolution function. The link should include or update any binary record previously received and stored by the repository, as appropriate. The system should provide all MDPH partners access to the binary record by request, rather than pushing updates to every system in the connected community of care. MDPH partners will evaluate the ability of existing or planned technologies (e.g., health information exchange) to serve this function, rather than developing new technology, through the integrative governance process.

Community Resource Inventory

MDPH partners will follow this guidance and uphold these best practices when implementing their designated activities.

System Implementation

Step 1. Determine Community Resource Inventory Role

Each organization will be responsible for determining the appropriate role(s) for that organization to support the integrated community resource inventory (CRI). MDPH partners identified three potential roles:

Data Stewards: The organization plays a significant role in updating, maintaining, and sharing community resource information through the integrated CRI. Data stewards may be designated as responsible for curating information on a specific set of community resources on behalf of the entire partnership. For example, a local public health agency may be designated as the data steward responsible for information related to vaccination clinics in a county.

Trusted Contributors: The organization receives community resource information through the integrated CRI and provides feedback and corrections back to the network's shared S-HIE infrastructure. These organizations are not responsible for curating information but can provide a valuable service by identifying and helping to correct inaccurate, incomplete, or out-of-date information. This may include updates about the services the organization provides directly, as well as identifying needed updates for other services in the connected community of care.

Viewers: The organization receives community resource information through the integrated CRI. This role may be appropriate for organizations that benefit from viewing community resource information but are unlikely to provide regular updates back to the network's shared S-HIE infrastructure (e.g., a research partner or a partner organization that typically receives and does not send referrals). Organizations who function as viewers receive the same information that is available to members of the public through web portals.

MDPH anticipates that most participating organizations will eventually serve as either data stewards or trusted contributors to support the integrated CRI as the connected community of care develops and matures; however, participating organizations may initially function as viewers due to capacity or technical barriers. See the Workforce and Technology sections for more information on these barriers.

Step 2. Develop Workflows to Update and Share Community Resource Information

MDPH partners will collaboratively develop and adopt best practices to ensure high-quality community resource information is shared through the integrated CRI. Each organization will develop its own CRI workflow that incorporates best practices according to its role. Organizations that serve as either **data stewards** or **trusted contributors** will ensure their workflows generate the following content and functionalities to support the integrated CRI:

Relevant resources: All partners share the responsibility to identify and curate resources for each use case and ensure those resources are included in the directory. Partners may utilize use case personas and user stories as tools to evaluate relevant resources. See Appendix for initial MDPH connected community of care business requirements, which include examples of personas and user stories.

Complete and accurate resource information: A goal of the integrated CRI is to ensure resource listings contain accurate eligibility information, application processes, and status updates so that partners can make appropriate and successful referrals for individuals and families. Common eligibility parameters include age criteria, income criteria, disability status, veteran status, citizenship status, county of residence, other geographic criteria, or gender-based criteria. The availability of resources, such as utility assistance, can change day to day. Timely updates are critical to ensure the integrated CRI remains accurate and relevant and that partners only refer individuals to organizations that have the ability to serve them. MDPH partners will develop a process and method for curating and updating resource information through the integrative governance process, in coordination with technology vendors as applicable.

Ability to export resource information: Each organization should develop processes that promote person-centered delivery of resource information. Examples include exporting and providing a printable version, text version, or email attachment of resource information to an individual or family. Exported resource information should be at appropriate reading levels and in a person’s preferred language whenever possible. Organizations may also find it helpful to have resource information that can be exported and shared with the community in alternative formats, such as a newspaper insert.

Step 3. Assess Community Resource Capacity

MDPH partners will assess resource capacity to address the levels and types of community needs. Partners may use population-level estimates of need, organization-specific information, or referral/service data from other participating organizations (e.g., Mile High

United Way 2-1-1). Each participating organization should incorporate capacity tracking into its CRI workflows.

For example, if an organization receives an unexpected surge of referrals that reduces near-term capacity to accept additional referrals, that organization should proactively send an update to the integrated CRI. Organizations should also assess the availability of resources that serve their population. For example, individuals with diabetes or celiac disease may face unique challenges in addressing their food insecurity if many of the local food resources aren't able to meet their dietary needs. Community members who primarily speak Spanish will need resources available to them in Spanish. A comprehensive capacity analysis will examine both overall availability of the need but also how it aligns with the population experiencing the need. In addition to organizational-level tracking and analysis, regional analysis of community resource capacity will occur as part of the community health analytics function. See the Community Health Analytics section for more details.

Step 4. Building Capacity and Sustainability of Community Resources

MDPH partners will evaluate resource capacity gaps through the community health analytics function. If community resources lack capacity to address the needs that MDPH partners identify through screening and assessment, the partners will leverage the integrative governance process to develop strategies to address those gaps. These strategies should prioritize communities that disproportionately experience disparities in resource access and health outcomes, especially those that have been historically harmed by racism and other discrimination.

MDPH partners may consider other methods of support, including:

Financial Support: If partners are referring a high volume of individuals or families to certain community resource organizations, the partners might provide financial support to increase the capacity of those in-demand resources.

In-Kind Support: Partners might offer meeting rooms, staff time, language interpretation service lines, technology support or other assets that could expand delivery of certain resources and/or offer the space for partners to participate in learning opportunities, communities of practices, or regional convenings.

Collaborative Support: Partners might support each other in attaining additional funding for programs and resources by submitting letters of support for grant proposals, offering relevant data (with appropriate permissions), and advocating for legislative or regulatory policy change (when feasible and appropriate).

See MDPH Connected Community of Care Sustainability Plan for more details.

Information Governance

Step 1. Regulatory Compliance

Community resource information is generally not covered by the privacy laws and regulations that apply to personal information. For example, the Colorado Privacy Act does not cover the personal data of individuals acting in an employment context. MDPH has not identified any laws or regulations that would prohibit the sharing of community resource information, including the sharing of contact information for individual staff members.

Step 2. Data Elements

MDPH partners intend to share comprehensive community resource information with all partners (see the Commitments section). The next step is to determine the specific data elements to be included. The following examples demonstrate the types of decisions that will be made:

- Which data elements should be included in a community resource record to be considered complete? Should incomplete records be shared or flagged for review (or both)?
- Which types of resource records should not be shared (services that are only available to specific, limited populations, etc.)?
- Should contact information for individual staff members be shared with all partners or shared publicly?

Ongoing work (MDPH partners/Trusted convener): Discuss and determine specific data elements to be shared through the integrated CRI.

Step 3. Permissions

All MDPH partners should have the same permissions to receive information through the integrated CRI. Organizations may have different permissions to send or verify updates depending on their role in supporting the integrated CRI as data stewards, trusted contributors, or viewers. See System Implementation for a description of each role.

Step 4. Consent Management and Privacy

The integrated CRI should not manage any personally identifiable information or protected health information (PHI) for individuals or families. Community resource information may include names and contact information for individual staff members at a participating organization. While this data is not currently protected by laws or regulations, MDPH partners may determine that it should not be shared in the same manner as other community resource data elements. The partners will work collaboratively through the integrative governance process to review and approve a process to appropriately manage any staff information.

Workforce Adoption and Engagement

Step 1. Strong Relationships Support an Effective Community Resource Inventory

MDPH partners will increase utilization of the integrated CRI by establishing and maintaining strong relationships among organizations in the connected community of care. Relationships foster trust, and trust facilitates a shared commitment to update and maintain community resource information to sustain its quality and relevance. A trusted convener can help partners initiate and maintain connections through regular resource learning opportunities, communities of practice, and annual regional convening events.

Step 2. Continuous Quality Improvement

A high-quality integrated CRI is essential for an effective and efficient connected community of care. MDPH partners will implement a continuous quality improvement process, which may include evaluating quantitative and qualitative feedback on internal workflows, resource directories, and the integrated CRI to identify and act upon areas for improvement through the integrative governance process.

Technology

Step 1. Collecting, Updating, and Maintaining Community Resource Information

MDPH partners will collect, update, and maintain community resource information according to internal policies, procedures, and workflows as appropriate for the organization's role as a data steward, trusted contributor, or viewer. See System Implementation for a description of each role. Each organization should maintain community resource information electronically (e.g., in a referral platform or other interoperable technology). Partners will use the technology that best meets the needs of their organization. Several partners developed in-house solutions, such as 2-1-1 Colorado, Hunger Free Colorado’s Food Finder, Boulder County Connect, and Network of Care. Commercial referral platforms, including findhelp and Unite Us, also developed community resource inventories specific to Colorado. Whether using an in-house solution or a commercial product, all partners will work toward interoperability to share community resource information.

Partners recognize the significant cost associated with curating, updating, and maintaining community resource information, which is a time-intensive activity. MDPH partners will collaborate to identify and implement a sustainable model to fund this work through the MDPH connected community of care integrative governance process. See the MDPH Connected Community of Care Sustainability Plan for more details.

Step 2. Sharing Community Resource Information

MDPH partners will share community resource information with one another to ensure community-wide access to accurate, up-to-date, and comprehensive community resource information through the integrated CRI. Partners agree to share information in a timely manner as soon as they are aware of new/corrected information.

Several pilot projects have already been conducted or are in progress in the metro Dener region to match and exchange community resource information. These pilots are led by MDPH partners and consultants, including Mile High United Way, Contexture, Hunger Free Colorado, findhelp, and Unite Us. The partners began to explore the roles of data steward, trusted contributor, and viewer through these pilot projects and started to identify the barriers and opportunities to achieve an integrated CRI that incorporates these roles.

MDPH intends to support an integrated CRI that includes a comprehensive view of all available community resources and services in the region; however, partners recognize that some resources and services are only available to specific, limited populations. For example, a health system may offer a program tailored to patients who meet certain criteria, such as a grocery store gift card for new parents who delivered a baby at one of their hospitals. The health system would only include that program in an internal resource directory and not through the integrated CRI.

MDPH partners will determine a standard set of required data elements to be shared through the integrated CRI. Through this process, MDPH partners may identify additional types of community resource information that should not be shared. See the Information Governance section for more information on the process to determine the standard data sets.

Step 3. Standards for Shared Community Resource Information

MDPH partners will use vocabulary, content, and transport standards whenever possible and avoid proprietary and custom methods for formatting and sending information. MDPH partners will review and approve common standards through the integrative governance process. See the Environmental Scan: Standards and Recommended Requirements for existing standards for community resource information.

Step 4. Community-Based and Government Programs Updates

Community-based organizations and government entities should be able to easily update their information (organization name, program, services) using a partner platform of their choosing without having to update/correct their information in multiple places. When community-based organization/government program staff provide an update, that update should be shared automatically and in a timely manner through the integrated CRI. A logging system is important to ensure there is an audit trail of who updated what information and at what time. Data stewards may also play an important role in verifying updates before making changes in their own system and pushing the updated information out to the network’s shared S-HIE infrastructure. The process and method for providing feedback and corrections will be determined through the integrative governance process, in coordination with technology vendors.

Step 5. Public Access

MDPH partners are committed to providing public access to the most accurate, up-to-date, and comprehensive list of organizations, programs, and services available to the community. Several existing technologies, including 2-1-1 Colorado, Hunger Free Colorado's Food Finder, Boulder County Connect, Network of Care, and findhelp, offer a public-facing website with a "look-up" feature that is free and available to the public, nearly 24 hours a day, seven days a week. The integrated CRI should enhance existing public access options by providing more accurate and comprehensive community resource information.

Certain data elements shared between partners may not be appropriate to share publicly. For example, partners might share contact information (email, phone number) for individual staff members at an organization, which could be shared with staff at MDPH partner organizations or with individuals and families receiving a referral but should not be disclosed on a public-facing website. MDPH will determine the data elements to be shared publicly through the integrative governance process.

Referrals

Referral records will be shared in a tiered approach based on permissions. See the Commitments section for a high-level description of each tier:

- **Limited referral records** support the referrals function in a connected community of care. The limited record provides the information needed for referral-receiving partners to act upon a referral.
- **Full referral records** support two core functions: whole-person care coordination and community health analytics. See the Whole-Person Care Coordination and Community Health Analytics sections for more details.

MDPH partners will follow this guidance and uphold these best practices when implementing their designated activities for referrals:

System Implementation

Step 1. Select a Referral Method

Each organization will be responsible for selecting a referral method that is appropriate for its organization. MDPH partners will compile and maintain a list of available methods (e.g., electronic referral, web portal, fax), including information on which methods are compatible with a connected community of care.

MDPH partners recognize that participating organizations will have significant differences in funding, staff, and technology to implement referral activities. The connected community of care should include a range of referral options for organizations with different levels of connectivity. MDPH partners will consider four levels of connectivity (Level 0-Level 3):[1]

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[1] Based on Family Connects Colorado Functional and Interoperability Requirements, Colorado Community Managed Care Network

Level 0 Connectivity: The organization is not connected to any kind of referral network and may rely on a paper filing system for internal tracking. These organizations may prefer referral methods that are compatible with paper systems (i.e., fax or secure email). An electronic referral can be automatically converted to fax to send referrals to these organizations; however, additional steps are required for follow-up. The organization would need to track each referral internally and manually respond (via fax or secure email) to provide information on referral outcomes back into the network's shared S-HIE infrastructure. The organization may or may not be able to initiate a new referral at Level 0 connectivity.

Level 1 Connectivity: The organization uses one or more systems, also known as referral intermediaries (e.g., findhelp, Unite Us), that allow staff to send, receive, and respond to referrals by logging into a hosted web-based portal. These organizations may need to manually enter referral information into internal systems, as well as manually copy response and outcome information from internal systems back into the web-based portal.

Level 2 Connectivity: The organization is connected directly to one or more referral intermediaries (e.g., findhelp, Unite Us), either integrated into internal systems or by using the intermediaries' referral platform(s) internally. All referral activities (including sending, receiving, processing, and updating) are completed within one application with responses and outcomes sent back to the network's shared S-HIE infrastructure through the same connection.

Level 3 Connectivity: The organization has an internal electronic referral system that eliminates the need for a referral intermediary (e.g., findhelp, Unite Us). These systems connect directly with referral partners through the connected community of care.

Level 0 and Level 1 connectivity are associated with a higher administrative burden for staff conducting referral activities. While these levels may be an appropriate and feasible starting point for partners, the administrative burden may be a barrier to sustainability. MDPH partners will pursue opportunities to support organizations in moving to Level 2 or Level 3 connectivity over time. See the Technology section for more details on the technical considerations associated with each connectivity level.

Step 2. Develop Person-Centered Workflows

MDPH partners have a vision for all participating organizations to send and receive closed-loop referrals. In the short term, some organizations (e.g., health care providers) are likely to focus on sending referrals while other organizations (e.g., social service organizations providing food and transportation resources) may focus on receiving referrals.

The following guidance recognizes those differences and establishes best practices for full, closed-loop referral functionality in the future. While each organization will develop its own referral workflow for different programs and departments, MDPH partners recognize the importance of a shared person-centered experience for each individual and family across the connected community of care. To support that shared experience, MDPH partners will strive to develop referral workflows that align with the following practices:

Use Shared Information

The referral function is supported by three types of information shared by MDPH partners: limited screening and assessment records, community resource information, and referral records.

Limited screening and assessment records support three core functions: screening and assessment; referrals; and whole-person care coordination. When attached to a referral, a limited screening or assessment record allows MDPH partners to view the identified needs for an individual or family. While it is not necessary to send limited screening and assessment records with every referral, it can be helpful for the receiving partner to have additional information about why a referral was made and to understand other identified needs that might affect the success of the referral.

For example, a food pantry might receive a referral for a family that has also identified transportation as a challenge. If the food pantry does not offer transportation services, food pantry staff can explore other options that might be more appropriate rather than having the family visit for a bulk pick-up of food. Limited screening and assessment records can also support whole-person care coordination. See the Whole-Person Care Coordination section for more details.

Community resource information supports two core functions: referrals and community health analytics. Shared community resource information allows MDPH partners to view a comprehensive list of services and resources. While organizations have historically maintained internal resource lists and inventories, shared community resource information will enable partners to send better referrals by providing more comprehensive and accurate resource information than any one organization can maintain alone. This improves the chances of successful referrals and helps individuals and families connect with the right support faster.

Send Person-Centered Referrals

Holistic Support: Unmet social needs are an indication of broader economic insecurity. As a result, individuals or families who screen positive on any social domain (e.g., food insecurity, housing insecurity) should be supported in enrolling in any benefits available to them and be made aware of other community resources that they can access even if they did not screen positively in every screening or assessment domain. Individuals and families may benefit from a complementary set of services and resources that expand beyond one identified need. For example, a family that reports transportation issues may benefit from enrolling in a food program that allows them to reallocate money they are spending on food to address their transportation needs. Organizations are encouraged to use screening and assessment results as a compass, not a map, and consider all referral options that might provide holistic support.

Appropriate Referral, not All Referrals: MDPH partners recognize that each new referral represents a time commitment for an individual or family, as well as for the referral-receiving organization. Referral partners should strive to identify the most appropriate referral(s) rather than sending all possible referrals. Partners should avoid sending referrals to multiple organizations for the same service and aim to make referrals that are likely to be successful, based on eligibility.

Reduce Barriers to Access: Referral-sending partners should work with individuals and families to proactively identify and address potential barriers that may prevent access to recommended services or resources. For example, an individual may not be able to access a food resource that is located outside of their usual means of transportation (e.g., a bus route). Another food resource that is further away but easier for the individual to access (e.g., near a connecting bus line) may be a better fit. Organizations should make every effort to reduce potential access barriers, such as transportation or language, to increase the chances of a successful referral.

Collaborative Triage: The experience of each individual and family is different. Even when two people are referred to the same service, one may need that service more urgently than the other. Referral-sending partners can help referral-receiving partners understand the level of urgency associated with each referral by sending relevant information to triage requests. This information will likely vary based on the referral type or services needed. Referral-sending partners should attempt to provide all information requested by the referral-receiving partner to expedite triage and service delivery, as available and appropriate. See the Information Governance section for more details on data elements.

Receive Referrals with Dignity and Equity in Mind

Timely Outreach: MDPH partners will respond to each new referral within one week. This ensures timely outreach to individuals and families who have been referred, while also allowing sufficient time for referral-receiving partners to process and act upon referrals. MDPH will monitor and evaluate this timeline through the integrative governance process as the network of health care and social service providers participating in the connected community of care develops and matures. Receiving partners are also encouraged to offer multiple options for individuals and families to respond to outreach attempts. Examples might include providing a direct line to call back, extended hours, or asynchronous methods such as text or email.

Equitable Access: Organizations may receive referrals through multiple channels, including but not limited to the connected community of care. Receiving partners should thoughtfully integrate all receiving channels into a primary workflow, to ensure that individuals and families are offered equitable access to services and resources. For example, a person who is referred electronically should not automatically be prioritized for a service over someone who called the organization directly, or vice versa.

Compassionate Refusal: Referral-sending partners will attempt to send only appropriate referrals that are likely to be successful; however, partners recognize that some referrals will be refused due to eligibility mismatch, capacity, or other issues. When a referral cannot be completed, the receiving partner will uphold the dignity of the individual or family by providing a clear explanation of why the referral was refused. This explanation should be provided directly to the individual or family if contact is made. Receiving partners should also include a note in the response back to referral-sending partners to help improve the rate of successful referrals.

Referral Response Notifications: MDPH partners will close the loop between referral-sending and referral-receiving partners by sharing response notifications. Response notifications will a) provide information about the outcome of a referral back to a sending partner, b) support the referral-sending partner to follow up with an individual or family if needed, and c) support continuous quality improvement by providing information on rates of successful referrals and reasons for unsuccessful referrals.

Accurate Capacity Status: Capacity is a driving factor for referral success rates. Each referral-receiving partner should develop workflows to accurately track its capacity to accept new referrals. Organizations should send regular capacity updates through the integrated community resource inventory (CRI) and notify the MDPH network immediately if they are unable to manage the volume of referrals. See the Community Resource Inventory section for more details.

Information Governance

MDPH partners will continue to collaborate through the integrative governance process to make shared decisions on key information governance issues related to sharing referral information, including:

Step 1. Regulatory Compliance

MDPH partners are subject to a variety of regulatory requirements, depending on the organization type, funding, and services provided. Referral information managed at one organization may be subject to different regulations than the same information managed at another. To share this information, it is likely that all partners will need to comply with all applicable regulations. At a minimum, the connected community of care will need to meet the requirements of the Health Insurance Portability and Accountability Act (HIPAA) and applicable Colorado regulations for personally identifiable information. MDPH will explore options to ensure HIPAA compliance without placing undue burden on community-based organizations and other partners that are not HIPAA-covered entities.

Ongoing work (MDPH partners/Trusted convener): Identify additional regulations that apply to referral information managed by MDPH partners, especially government agencies and community-based organizations. Ensure that applicable regulations are met before referral information is shared.

Step 2. Data Elements

MDPH partners have a basic framework for a tiered approach to sharing referral information (see the Referrals: Commitments section). The next step is to determine the specific data elements to be included in each tier. The following examples demonstrate the types of decisions that will be made:

- Which data elements (e.g., person's name, contact information, and service desired) should be included in the limited referral record for all referral types? What is the process for each receiving partner to customize incoming referrals by adding additional data elements required for their services?
- Which data elements should be entered as structured data to support community health analytics and care coordination features? Will unstructured data also be shared for additional context?

Ongoing work (MDPH partners/Trusted convener): Discuss and determine specific data elements for each tier, which must be considered in coordination with applicable regulations and consent policies (see Consent Management and Privacy section).

Step 3. Permissions

The tiered approach to sharing referral information will rely on appropriate assignment and management of permissions for different partners. MDPH partners must thoughtfully balance the advantages of more granular permissions with the complexity of managing those permissions from an organizational and individual/family's standpoint. The tiered approach also has considerable implications for consent policies, which are discussed in the Consent Management and Privacy section.

Ongoing work (MDPH partners/Trusted convener): Develop policies and procedures for assigning and managing permissions for each tier of data sharing, including who has access to different tiers and how user permissions will be authorized and managed.

All information governance discussions and decisions will be informed by collaboration and discussion between MDPH partners and technical partners (including technology vendors). Input and feedback from technical partners will help to clarify the information governance decisions to be made and provide a pathway to effectively implement those decisions through technology. For example, technical partners may propose options for managing permissions and clarify the information governance decisions that might lead to choosing one option over others.

Step 4. Consent Management and Privacy

Individual and Family Rights: MDPH partners believe in the right of individuals and families to control how their referral data are collected, stored, shared, and used. MDPH partners will enact legally compliant policies and procedures, while striving to go above and beyond to develop informed and culturally responsive consent practices.

MDPH has developed the following consent practices to consider based on conversations throughout the partnership; however, these practices will be thoroughly reviewed, refined, and finalized through the integrative governance process.

Consent Practices to Consider: Referrals

Baseline Consent Practices to Consider

Each individual and family should be offered the following, at a minimum:

The ability to opt in to each recommended electronic referral, which requires sharing a limited referral record with the referral-receiving partner organization. Individuals and families should be informed that if they do not opt in, an electronic referral cannot be made in the connected community of care, but they still have the option of contacting the organization directly themselves.

The ability to opt out of:

- Sharing a full referral record with a designated lead care coordination entity (if one has been assigned).
- Sharing a full referral record through the community health analytics function. Individuals and families who opt out of sharing the full record should be given the option to share a limited referral record for analytics instead.

Individuals and families should be informed that if they consent to an electronic referral and do not opt out of sharing full records, their full referral records will be shared among MDPH partners according to the tiered approach. The tiered approach should be explained in simple, but thorough, terms to each person to support informed consent.

Additional Consent Practices to Consider

In addition to the minimum consent options, MDPH partners will strive to offer additional layers of control over how referral data are shared. For example, the partners might consider the following:

- Should individuals and families have the ability to opt in to share referral records with all participating partners?
- Should individuals and families have the ability to revoke their consent and opt out of redisclosure of prior referrals?

MDPH partners understand that additional consent options require more sophisticated technical approaches and more nuanced governance relationships. Some options are offered by certain technology vendors, while other options may not be readily available in existing technology. These differences can create significant barriers to interoperability. MDPH partners will carefully consider the opportunities and barriers to adopting this additional level of control through the information governance process and may adopt a phased approach to introducing these options over time.

Compliance with Relevant Laws and Regulations: The options proposed are rooted in compliance with HIPAA and Colorado regulations for personally identifiable information, which MDPH partners identified as the minimum regulations governing referrals in the connected community of care. The available options will be continuously evaluated and updated as additional regulations are identified and incorporated into MDPH's information governance framework. Additionally, MDPH partners may agree upon different options for certain types of data.

Each organization is responsible for obtaining consent (written or verbal) from an individual or legal family representative (e.g., parent or legal guardian) and documenting that consent was obtained prior to sending each referral. Proof of consent should not be required to be sent with the referral. Referral-receiving partners should be able to assume that proper consent was obtained and documented prior to sending the referral. If individuals and families are offered the option to revoke consent, organizations would be responsible for documenting this change as well.

Culturally Responsive Practices: MDPH partners recognize the complexity of options available and will work to develop shared policies and best practices to enable informed, culturally, and linguistically responsive consent across the connected community of care. The partners will consider accessibility for special populations, including youth and people with developmental disabilities. Complex situations must also be considered, including families with divorced parents and youth who are not legally but are functionally emancipated.

Workforce Adoption and Engagement

Step 1. Staff Support

Most organizations that will send or receive referrals through the connected community of care currently send or receive referrals through manual methods (e.g., fax, email, phone call) and other systems (e.g., findhelp, Unite Us, Boulder County Connect). MDPH partners will support the well-being of internal staff by thoughtfully considering how new referral channels in the connected community of care will integrate into existing workflows. Partners may also expect an increase in referral volume with the connected community of care, increasing access for individuals and families. MDPH partners will evaluate:

- Whether existing referral workflows can be improved to be more efficient, e.g., reducing or removing duplicative activities resulting from multiple referral channels.
- Whether additional staff are needed to manage an increase in referral volume and whether back-up support can be provided to manage temporary surges.

Step 2. Staff Training

MDPH partners are responsible for providing initial and ongoing training to their staff involved in referral activities. The vision for a connected community of care will require significant culture change. Training is key to shift values, beliefs, knowledge, and skills.

Staff training can improve the rate of successful referrals and improve health equity for all.

Who: All staff, supervisors, and leadership involved in or overseeing referral activities should participate in initial and ongoing training. This includes staff who are not part of primary workflows but who may serve as back-up support when primary staff are out of the office, when positions are unfilled, or when unexpected organizational demands require shifting roles.

What: While staff may already be conducting referral activities, MDPH partners should develop or update training on referral workflows with the connected community of care to include any new tasks or activities.

In addition to internal training specific to each organization, MDPH partners will develop recommendations for a regular cadence of shared training opportunities on meaningful, relevant topics to better serve communities in the Denver metro area. This may include existing training that is publicly available as well as new training developed or offered through MDPH. See Recommended Trainings and Best Practices in the Appendix.

When: Organizations should train staff prior to implementing any new referral activities. New staff should complete initial training before sending or receiving any referrals. Ongoing training should be required for all staff on a regular basis, at a frequency appropriate for each role in referral activities.

Step 3. Continuous Quality Improvement

Each organization that conducts referral activities is responsible for implementing the processes needed to track, evaluate, and improve those activities. At a minimum, organizations should implement the following:

- Ability to track agreed-upon metrics in real time (e.g., number of outreach attempts, eligibility determinations, services provided). Specific metrics will be recommended in the MDPH Connected Community of Care Accountability Plan.
- A dedicated quality improvement team that will closely monitor referral metrics throughout implementation, determine quality improvement goals, and design and implement improvements.

In addition, the referral function is unique because it will require coordination between sending and receiving partners. Quality improvement teams may need to monitor shared metrics and develop shared improvement goals across multiple organizations. The integrative governance process will help to facilitate this collaboration.

When developing quality improvement goals, sending and receiving partners should hypothesize potential barriers to successful referrals (e.g., confusion about eligibility criteria, ability to contact individuals experiencing homelessness, incomplete referral information). These potential barriers should be closely monitored with metrics and goals related to these specific populations or processes.

The quality improvement efforts of MDPH partners will support efforts to continuously improve referral activities across the connected community of care. See the Community Health Analytics section for more information.

Technology

Step 1. Managing and Storing Referral Information

MDPH partners will manage and store referral information according to internal policies, procedures, and workflows. Each organization should store referral information electronically (in a case management system, referral platform, or other interoperable technology). Partners will use the technology that best meets the needs of their organization. Commercial examples include findhelp, Salesforce, and Unite Us. Partners also developed in-house solutions, such as Boulder County Connect. Whether using a commercial product or in-house solution, all partners will work toward interoperability to enable sending, receiving, and sharing referral information, based on MDPH's agreed-upon tiered approach and relevant laws and regulations.

Step 2. Access to Shared Community Resource Information

When selecting technology for sending and receiving referrals, MDPH partners should prioritize systems that can exchange information with an integrated CRI. This will enable partner organizations to view and access the resources that are comprehensive and most appropriate for each individual or family. See the Community Resource Inventory section for more information.

Step 3. Sending, Receiving, and Sharing Referral Information

MDPH partners will send, receive, and share referral information according to their organization's referral method:

Organizations with Level 0 connectivity will rely on manual methods (e.g., fax or secure email) to send, receive, and share referral information. Information from these organizations must pass through a translator function, which converts analog or free text communication into formatted data that can be stored electronically to enable the exchange. Existing technology, such as the Community Resource Inventory Service for Patient e-Referral, can provide this functionality. Referral information should be automatically pushed to the appropriate destination after passing through the translator function.

Organizations with Level 1, 2, or 3 connectivity will send, receive, and share referral information directly through their chosen technology. Partners using the same technology can exchange referrals directly through that system. Existing commercial products and in-house solutions (see previous examples) offer this functionality. Partners using different technologies will exchange referrals via shared interoperability standards that enable the transmittal of referrals across systems. MDPH will assess emerging standards, such as those being developed by The Gravity Project, and build consensus on adoption through the integrative governance process. MDPH partners will also evaluate whether additional infrastructure is needed to facilitate interoperability. Referrals should be sent and received automatically (pushed) in real-time.

MDPH partners will work toward sharing referral data in a tiered approach based on permissions. See the Referrals: Commitments section for a description of each tier. Partners will share all three tiers according to the organization's referral method, as previously described. Full referral records should be automatically pushed to both the community analytics function and lead care coordination entities, if assigned, in real time.

Step 4. Using Resource Capacity to Inform Referrals

MDPH partners will strive to send the most appropriate referral, rather than all possible referrals for individuals and families. In some cases, this will depend on the capacity at referral-receiving organizations. MDPH will explore the possibility and feasibility of technical solutions that offer real-time service capacity information of partner organizations, which may include the following options:

- **Crowdsource Capacity:** This option relies on technology that sends a single request to several organizations but only allows one receiving partner to accept the referral; otherwise, duplicate referrals can cause confusion and unnecessary work. At least one existing technology, Julota, provides this functionality.
- **Manual Updates:** Referral-receiving partners regularly update their capacity through the integrated CRI. See the Community Resource Inventory section for more details.

Step 5. Standards for Referral Information

MDPH partners will use vocabulary, content, and transport standards whenever possible and avoid proprietary and custom methods for storing, formatting, and sending information. MDPH partners will review and approve common standards through the integrative governance process. See the Environmental Scan: Standards and Recommended Requirements for existing standards for referral information.

Whole-Person Care Coordination

MDPH partners will follow this guidance and uphold these best practices when implementing their designated activities.

System Implementation

MDPH partners provide varying levels of care coordination services. MDPH partners will need to evaluate their internal workflows and processes to determine how to best collaborate with other partners providing care coordination services.

While organizations will continue to provide services according to their community's needs as well as relevant program and funding requirements, MDPH partners need to understand each other's scope and capacity to ensure individuals and families do not fall through gaps in care, and to designate lead care coordination entities for individuals and families when appropriate and feasible. Partners will collaborate to develop shared processes and workflows that build upon the strengths of each participating organization as identified in internal evaluations.

MDPH partners will consider the following steps when evaluating their internal care coordination workflows and processes and working collaboratively to develop shared workflows and processes:

Step 1. Assess Your Population's Care Coordination Needs (Internal)

Only a small percentage of individuals and families need and desire whole-person care coordination.[2] A person may benefit from whole-person care coordination if they have complex needs requiring services across multiple systems or if they do not have alternative personal support to help them navigate their care or services. By understanding the percentage of individuals and families who need comprehensive care coordination, MDPH partners can set up appropriate workflows internally and determine processes to refer to other partners when they do not have the skills or capacity for a particular individual or family's needs.

Step 2. Design A Shared Care Coordination Infrastructure (Shared)

Each MDPH partner must evaluate its own organization's strengths, resources, and infrastructure to provide care coordination services, to whom, and in what capacity. Partners can then develop intra- and interorganizational workflows to ensure individuals and families are connected to the level of care coordination services they need and desire. Partners will develop and adopt a shared definition of care coordination that supports a care coordination infrastructure. Partners will determine definitions through the integrative governance process. Three recommended definitions include:

Level 1 Care Coordination: Addressing straightforward needs through information and occasional assistance to help navigate the complexities of the physical and behavioral health care and social service systems. Typical Level 1 care coordination might include providing information on resources, brief application assistance or guidance, and warm handoffs to appropriate services.

Organizations or programs that are not able to engage with an individual or family over time (e.g., emergency departments) often provide Level 1 care coordination services. Level 1 care coordination services will be provided by all screening and referral partners as appropriate. A lead care coordination entity would not be designated to provide Level 1 services.

Level 2 Care Coordination: Addressing complex needs requiring multiple partners across sectors to work together as a team with the individual and family. This care

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[2] Accountable Health Communities (AHC) Model Evaluation: First Evaluation Report (cms.gov)

coordination team provides dedicated support through trusted relationships with the individual/family and other partners involved in their care. Level 2 care coordination might include activities such as developing a comprehensive care plan, conducting outreach, coordinating with, or convening needed services and providing advocacy, problem-solving education, planning, and self-management support. Level 2 care coordination requires more skill and interactions with individuals/families but is still episodic (e.g., initiated by a new event or need) versus long-term coordination in Level 3. A lead care coordination entity would be designated to provide Level 2 services.

Level 3 Care Coordination: Addressing complex needs requiring multiple partners across sectors to work together as a team with an individual and family. This care coordination team provides intensive support through trusted relationships. At Level 3, the typical Level 1 and Level 2 services are provided at a higher frequency or length of time and may include intentional outreach and engagement to build necessary trust and support. A lead care coordination entity would be designated to provide Level 3 services.

Step 3. Designate Lead Care Coordination Entities (Shared)

Individuals and families who are involved with multiple organizations may benefit from having a designated lead care coordination entity. A lead care coordination entity would be responsible for serving as the primary point of contact for the individual/family and for coordinating with other partners that are serving the individual or family. All organizations that have the skills and capacity to provide Level 2 and Level 3 care coordination services should be considered as potential lead care coordination entities to ensure the network of health care and social service providers is efficiently using available capacity.

MDPH partners will determine a process for identifying and designating lead care coordination entities in the connected community of care, which includes adopting person- and family-centered practices to honor individual/family preferences when designating a lead care coordination entity. The process will also include default designations when the individual or family has not designated a lead care coordination entity themselves. MDPH acknowledges that an individual or family’s preference may not always be feasible due to capacity issues, funding, or regulatory authority.

Step 4. Map Care Coordination Capacity (Shared)

After partner organizations determine their internal capacity to provide varying levels of care coordination, partners will collaboratively evaluate the level and types of care coordination services that are available throughout the connected community of care. Capacity mapping might reveal gaps in services for particular populations or geographic areas. Partners will evaluate how to address these gaps in care coordination services through the integrative governance process.

Step 5. Develop Person-Centered Workflows (Internal)

After each MDPH partner clarifies its scope (level and type) of care coordination services, MDPH will consider developing a care coordination framework that partners can adopt and implement to ensure consistent, whole-person care is offered throughout the connected community of care. Key considerations include:

Strengths-Based Assessment: Screenings and assessments should identify needs and structural inequalities affecting an individual and family, resiliency factors (skills, informal support systems, etc.), and resources (insurance, eligibility, or enrollment in federal and state benefits). MDPH recognizes that an individual's needs and resources are dynamic, and partners should proactively reassess and update support plans over time. Lead care coordination entities will commit to creating opportunities for reassessing individuals and families engaged in Level 3 care coordination at regular intervals, at minimum on a 6- to 12-month basis.

Person-Centered Care Planning: MDPH partners will commit to evaluating whole-person care needs, which include an individual's or family's short-term and long-term goals. Goal-oriented care planning can support lead care coordination entities and participating providers in empowering individuals and families in their care.

Shared Information: The whole-person care coordination function is supported by four types of information shared by MDPH partners: screening and assessment records, community resource information, referral records, and care coordination records. Care coordinators with appropriate permissions can view these four types of information to gain a holistic view of identified needs, potential resources to address those needs, existing and past referrals to those resources, and the status of services being provided. Care coordination workflows should incorporate this shared information to ensure that people do not have to needlessly repeat their stories or receive duplicative referrals to resources that have not met their needs. See the Screening and Assessments, Community Resource Inventory, and Referrals sections for more information on those records.

Step 6. Sustainability (Shared)

MDPH partners understand that continuity of care coordination services affects how individuals and families trust and engage with care, programs, and resources. MDPH partners commit to collaboratively evaluating funding strategies and structures to ensure a sustainable care coordination infrastructure. The community health analytics function may be used to analyze demand and capacity for care coordination services to inform funding solutions. See the MDPH Connected Community of Care Sustainability Plan for more details.

Information Governance

MDPH partners will continue to collaborate through the integrative governance process to make shared decisions on key information governance issues related to sharing coordination information, including:

Step 1. Regulatory Compliance

MDPH partners are subject to a variety of regulatory requirements, depending on the organization type, funding, and services provided. Care coordination information created at one organization may be subject to different regulations than the same information created at another partner organization. To share this information across organizations, all partners will likely need to comply with all applicable regulations. At a minimum, the entire network of participating health care and social service providers will need to meet the requirements of the Health Insurance Portability and Accountability Act (HIPAA) and applicable Colorado regulations for personally identifiable information. MDPH will explore options to ensure HIPAA compliance without placing undue burden on community-based organizations and other partners that are not HIPAA-covered entities.

<u>Ongoing work (MDPH partners/Trusted convener)</u>: Identify additional regulations that apply to care coordination information created by MDPH partners, especially government agencies and community-based organizations. Ensure that applicable regulations are met before coordination information is shared.

Step 2. Data Elements

MDPH partners have a basic framework for a tiered approach to sharing coordination information (see the Whole-Person Care Coordination: Commitments section). The next step is to determine the specific data elements to be included in each tier. The following examples demonstrate the types of decisions that will be made:

- Will the limited record indicate only the services provided (e.g., housing vouchers) or will it also include information on status and outcomes (e.g., stable housing vs. risk of eviction)?
- Will the limited record include all identified needs or only those tied to services being provided?
- How will outcomes[3] (e.g., food delivered vs. food need addressed) be defined and reported in coordination records? How will this information be standardized to facilitate sharing and analytics?

<u>Ongoing work (MDPH partners/Trusted convener)</u>: Discuss and determine specific data elements for each tier, which must be considered in coordination with applicable regulations and consent policies (see Consent Management and Privacy section below).

Step 3. Permissions

The tiered approach to sharing care coordination information will rely on appropriate assignment and management of permissions for different partners. MDPH partners must thoughtfully balance the advantages of more granular permissions with the complexity of managing those permissions from an organizational and individual/family’s standpoint.

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[3] Note: Participating organizations may require different types of information about outcomes. This should be carefully considered during conversations about standardization.

Ongoing work (MDPH partners/Trusted convener): Develop policies and procedures for assigning and managing permissions for each tier of data sharing, including who has access to different tiers and how user permissions will be authorized and managed.

All information governance discussions and decisions will be informed by collaboration and discussion among MDPH partners and technical partners (including technology vendors). Input and feedback from technical partners will help to clarify the information governance decisions to be made and provide a pathway to effectively implement those decisions through technology. For example, technical partners may propose technical options for sharing limited coordination records and clarify the information governance decisions that might lead to choosing one option over others.

Step 4. Consent Management and Privacy

Individual and Family Rights: MDPH partners believe in the right of individuals and families to control how their care coordination data are created, stored, shared, and used. Partners will enact legally compliant policies and procedures and strive to develop informed and culturally responsive consent practices.

MDPH has developed the following consent practices to consider based on conversations throughout the partnership; however, these practices will be thoroughly reviewed, refined, and finalized through the integrative governance process.

Consent Practices to Consider: Whole-Person Care Coordination
Baseline Consent Practices to Consider
Each individual and family should be offered, at a minimum: • The ability to opt in to care coordination services, which requires the creation of a whole-person care coordination record and the sharing of coordination records according to the tiered approach (including binary, limited, and full coordination records). • The ability to opt out of sharing limited and full coordination records with the community health analytics function. Individuals and families should be informed that if they opt in to care coordination services, their coordination records will be shared according to the tiered approach unless they opt out of sharing a full record with the analytics function. The tiered approach should be explained in simple, but thorough, terms to each person to support informed consent.
Additional Consent Practices to Consider
In addition to the baseline consent practices listed, MDPH partners will strive to offer additional layers of control over how coordination data are shared. For example, the partners might consider the following: • Should individuals and families have the ability to opt in to share coordination records with all participating partners? • Should individuals and families be offered the ability to revoke their consent and opt out of redisclosure of coordination records?

Compliance with Relevant Laws and Regulations: The options proposed are rooted in compliance with HIPAA and Colorado regulations for personally identifiable information, which have been identified as the minimum regulations governing care coordination within the connected community of care. The available options will be continuously evaluated and updated as additional regulations are identified and incorporated into MDPH's information governance framework. Additionally, partners may agree upon different options for certain types of data.

Each organization is responsible for obtaining consent (written or oral) from an individual or legal family representative (e.g., parent or legal guardian) and documenting that consent was obtained prior to creating a whole-person care coordination record. If individuals and families are offered the option to revoke consent, organizations would be responsible for documenting this change as well.

Culturally Responsive Family-Centered Practices: MDPH partners will work to develop shared policies and best practices to enable informed, culturally responsive consent across the connected community of care. The partners will consider accessibility for special populations, including youth and people with developmental disabilities. Complex situations must also be considered, including families in divorce proceedings and youth who are not legally but are functionally emancipated.

Workforce Adoption and Engagement

Step 1. Hiring Practices

While many MDPH partners have existing care coordination staff, all partners will have an opportunity to evaluate whether current hiring practices align with the needs and goals of shared care coordination infrastructure (see Whole-Person Care Coordination: System Implementation section). For example, an organization that chooses to focus its efforts on providing Level 1 care coordination services may determine that it no longer needs to require staff to have nursing degrees to provide care coordination services. Thoughtful and intentional hiring practices ensure that staff operate at their highest skill and capacity.

MDPH partners commit to equity-driven hiring practices. Partners will hire staff who culturally, linguistically, racially, and ethnically reflect the communities being served, whenever possible. Partners also commit to recognizing the value of lived experience and providing culturally responsive care by making a significant effort to hire people who share experiences with communities being served.

Step 2. Staff Training

MDPH partners are responsible for providing initial and ongoing training to their organization's staff involved in care coordination activities. Hiring a diverse workforce may require more robust continuing education, training, and workforce support due to differences or disparities in access to education and employment. Partners will work with a trusted convener to identify and distribute information and training that supports the professional development of staff working across the connected community of care. Refer to the Appendix for a list of recommended training.

Step 3. Continuous Quality Improvement

MDPH partners commit to continuous quality improvement across all five functions of the connected community of care. Each organization that conducts care coordination activities is responsible for implementing the processes needed to track, evaluate, and improve those activities. At a minimum, organizations should implement the following:

- Ability to track whether the needs of individuals and families are being met, which may include self-reported outcomes from those receiving services. Specific metrics will be recommended in the MDPH Connected Community of Care Accountability Plan.
- A dedicated quality improvement team that will closely monitor care coordination metrics throughout implementation, determine quality improvement goals, and design and implement improvements.

Quality improvement processes for whole-person care coordination will be facilitated through the integrative governance process. Lead care coordination entities will have a primary role in quality improvement processes due to their care coordination roles. Partners will consider systemic barriers, availability of resources, service delivery, individual/family goals, and individual/family self-reported outcomes when evaluating success and improvement opportunities for care coordination services. See the Community Health Analytics section for more information.

Technology

Step 1. Managing Care Coordination Information

MDPH partners will manage care coordination information according to internal policies, procedures, and workflows. Each organization should store care coordination information electronically (in an electronic health record, case management system, or other interoperable technology). Partners will use the technology that best meets the needs of their organization. Commercial examples include Epic, findhelp, MEDITECH, Salesforce, Unite Us, and more. Partners also developed in-house solutions, such as Boulder County Connect. Whether using a commercial product or an in-house solution, all partners will work toward interoperability to enable sharing care coordination information, based on MDPH's agreed-upon tiered approach and relevant laws and regulations.

Step 2. Importing Screening/Assessment and Referral Data

Screening/assessment and referral data should be automatically shared (pushed) to care coordination partner organizations with appropriate permissions based on the tiered approach for each type of information and individual consent. See the Screening and Assessments and Referrals section for more information. Each organization should ensure that internal care coordination systems can receive and incorporate this data into a comprehensive care coordination record for the individual or family.

MDPH will explore existing and planned shared identity resolution solutions and work toward shared data standards to ensure that records can be linked to unique individuals. The partners are also interested in connecting individual records to families, as appropriate and allowed by relevant laws and regulations. These shared functionalities would enable care coordinators to view an entire longitudinal care record that incorporates information from multiple sources into the care coordinator's system of record. Lastly, screening and referral information should be parsed and loaded into a data repository to enable creation of various data marts for reporting to care coordinators. Data marts are condensed and more focused versions of a data warehouse that reflect the specific processes, needs, or function of a department or user group within an organization.

Step 3. Accessing Community Resource Information

Shared community resource information allows MDPH partners to view a comprehensive list of services and resources. See the Community Resource Inventory section for more information. Each organization should ensure that internal care coordination systems can import this data to allow care coordinators to search for community resources within their system. This functionality will streamline care coordination workflows and allow care coordinators to seamlessly identify additional resources to address gaps in an individual or family's plan of care.

Step 4. Sending, Receiving, and Sharing Care Coordination Information

MDPH partners will work toward sending, receiving, and sharing care coordination information in a tiered approach based on permissions. Existing technologies could potentially be enhanced to support this approach; however, this functionality does not yet exist. MDPH will explore options to enhance existing technology or to coordinate with planned development efforts to achieve this functionality. See the Whole-Person Care Coordination: Commitments section for a description of each tier.

All coordination records will be generated by the lead care coordination entity, if and when an entity is designated. MDPH assumes that coordination records will not be created or shared for individuals and families who do not have a designated lead coordination entity. Individuals and families reserve the right to access their full coordination records.

Binary coordination records should be automatically pushed to a centralized repository within 24 hours of a change in status of the lead care coordination entity for an individual or family (assigned/designated, transferred, or removed). The binary record should include the lead care coordination entity generating the status update and basic demographic information (e.g., a person's name, address, date of birth) to support identity resolution. This is the minimum amount of information necessary for other MDPH partners to know whether an individual or family has an active, designated lead care coordination entity and to track that record back to the lead entity if the partner has the appropriate permissions. The centralized repository should enable all partners to search for (pull) binary records for an individual or family and view whether or not a lead care coordination entity is designated for an individual/family, but only partners with appropriate permissions should be able to view the name of the lead care coordination entity. The repository may also return a null response if no binary record has been generated for an individual or family.

Limited coordination records should be available to MDPH partners with appropriate permissions. The limited record should indicate the current partners serving the individual or family and the services provided, including contact information for the lead care coordination entity. Different technical approaches could be employed to enable MDPH partners with appropriate permissions to access these records, including centralized, federated, or distributed systems that rely on either push or pull transmissions. See the Information Governance section for more information on the process to determine the appropriate technical approach.

Full coordination records should be generated and maintained by the lead care coordination entity. The full care coordination record should incorporate data from multiple sources to include screening and assessment records, referral records, services provided, outcomes data including individual/family-reported data on whether needs have been met, and additional communication or notes between coordinating partners. Full coordination records (or updates to the records) should be automatically pushed to the community analytics function on a regular basis. The full coordination record may be shared with a new lead care coordination entity when an individual or family is transferred between leads. MDPH partners do not anticipate a need to share full coordination records beyond lead care coordination entities or the community analytics function; however, the partners will assess this assumption through the governance process and through community input to ensure community-centric permission and consent practices.

Step 5. Receiving Care Coordination Updates

Lead care coordination entities will work with multiple partners to coordinate care for an individual or family. Coordinating partners should proactively share updates about significant changes in the services provided to an individual or family (e.g., completion of a program, moved off a waitlist, service is no longer available). Each organization should ensure that internal care coordination systems can receive and record updates from external partners and incorporate those updates into the full coordination record for the individual or family.

In the current state, MDPH recognizes that updates are often entered manually by care coordinators based on emails, faxes, and phone calls between organizations. The partners will explore technical approaches to automate those updates between organizations through the integrative governance process.

Step 6. Content of Shared Coordination Information

MDPH partners will determine a standard set of data elements to be included in each tier: binary coordination records, limited coordination records, and full coordination records.

See the Information Governance section for more information on the process to determine the standard data sets.

Step 7. Standards for Shared Care Coordination Information

MDPH partners will use vocabulary, content, and transport standards whenever possible and avoid proprietary and custom methods for storing, formatting, and sending information. MDPH partners will review and approve common standards through the integrative governance process. See the Environmental Scan: Standards and Recommended Requirements for existing standards for sharing care coordination information.

Step 8. Centralized Repository Function

A centralized coordination repository function would be needed to receive binary records from each lead care coordination entity. Shared S-HIE infrastructure should provide all MDPH partners with access to the binary record by request, rather than pushing updates to every system in the network. MDPH partners will evaluate the ability of existing technologies (e.g., health information exchange) to serve this function, rather than developing new technology, through the integrative governance process.

Community Health Analytics

MDPH partners will follow this guidance and uphold these best practices when implementing their designated activities.

System Implementation

MDPH partners will develop internal and shared analytics processes to support and enhance:

- Quality improvement processes of core functions
- Overall evaluation of the connected community of care
- Population health outcomes
- Community health outcomes

For the purposes of this plan, population health is defined as the health and well-being of people served by individual partner organizations. Community health is defined as the health and well-being of people served collectively across all organizations in the connected community of care.

Step 1. Implement and Enhance Quality Improvement Processes (Internal and Shared)

The Workforce Adoption and Engagement sections of this plan articulate the importance and approach to quality improvement processes for partner organizations to enhance the efficacy of core functions across the connected community of care. Each organization is responsible for implementing internal quality improvement processes that facilitate shared quality improvement across the network. MDPH partners will determine shared metrics to collect and analyze where improvements in core functions can be made across organizations. See the MDPH Connected Community of Care Accountability Plan for more details on recommended quality improvement metrics.

Step 2. Design Community-Wide Evaluation (Shared)

While quality improvement efforts are focused on ensuring that a program or use case's intended activities are implemented with fidelity, evaluation is focused on assessing whether a program or use case (e.g., chronic disease screening and referral) is making the desired impact on population-level and community health outcomes. MDPH partners will determine and adopt measurable time-bound outcome metrics to continually evaluate the impact of the connected community of care on population and community health. Partners will design outcome metrics based on the three pillars of the interoperable connected community of care value proposition:

- All individuals and families have easy access to resources and care.
- Tailored care and resources meet whole-person and whole-family care needs.
- An improved and sustainable safety net is achieved.

See the MDPH Connected Community of Care Accountability Plan for more details on overall evaluation.

Step 3. Implement Population Health Improvement Activities (Internal)

MDPH partners should receive aggregate screening, resource, referral, and care coordination data through the integrated analytics function to inform internal population health strategies, which may include using connected community of care data in community health needs assessments and public health improvement plans. For example, if data reveal that hospital readmissions for diabetes are linked to food insecurity in the region, a health care organization may partner with a local food pantry to fund a food prescription program. Partners could use the integrated analytics function to develop multiyear priorities and strategies for system transformation, potentially highlighting further opportunities for cross-sector community health improvement activities.

Step 4. Implement Community Health Improvement Activities (Shared)

MDPH partners will use data from the integrated analytics function to inform cross-sector, community health improvement activities, including:

- Better understanding the type and prevalence of unmet health-related social needs across the region, by population and geography
- Refining community resource and care coordination capacity mapping
- Determining how to allocate resources and services to address disparities across communities
- Measuring improvements in community health outcomes through shared, community-driven metrics

For example, community health analytics may identify that people with high rates of food insecurity are working adults. Through resource and care coordination capacity mapping, MDPH partners may determine that many food assistance resources are only available during business hours. Partners can collaborate on a shared strategy to adjust certain programs, resources, and services hours, as feasible, to address this community need. In another example, resource and care coordination capacity mapping may reveal that certain food assistance resources are significantly underused. Partners may use this information to spread knowledge and awareness across the network of participating health care and social service providers and to ensure available resources are accessible to community members who need them most.

Partners may be able to holistically assess the impact and return on investment of the connected community of care on community health outcomes through the analytics function, providing further data to inform long-term investments in the sustainability and capacity of community-driven priorities and resources. The MDPH Connected Community of Care Accountability Plan and its evaluation processes will provide more information on health monitoring of the community over time and also on the value and efficiency of the connected community of care as it develops and matures.

Step 5. Use Analytics to Advance Equity (Shared)

Data are powerful tools that can unearth but also reinforce disparities and inequities. More detailed and accurate data that are culturally sensitive and appropriately collected are needed to inform and advance health equity. Disaggregating data, for example, by collecting more specific racial/ethnic data on individuals and families — with consent — honors the diverse identities of people and allows for higher quality of information to understand people's different experiences, existing disparities, and how to address them.

The Robert Wood Johnson Foundation established the National Commission to Transform Public Health Data Systems to develop recommendations on how data can be collected, shared, and applied to identify opportunities for private and public sector investments to modernize data infrastructure and improve health equity. The Commission's recommendations include:

- Changing how stories are told about the health of people and communities so that equity meaningfully informs narratives
- Prioritizing governance of data infrastructure to ensure equity is at the center
- Ensuring that community health measurements capture and address structural racism and other inequities

Partners will consider these recommendations and continuously evaluate other best practices and through community input to drive improvements and action on community health data and outcomes.

Information Governance

Partners will continue to collaborate through the integrative governance process to make shared decisions on key information governance issues related to sharing coordination information, including:

Step 1. Regulatory Compliance

Partners are subject to a variety of regulatory requirements, depending on the organization type, funding, and services provided. The integrated community health analytics function will need to comply with all applicable laws and regulations that cover data created by any partner in the connected community of care. At a minimum, the analytics function will need to meet the requirements of the Health Insurance Portability and Accountability Act (HIPAA) and applicable Colorado regulations for personally identifiable information.

Ongoing work (MDPH partners/Trusted convener): Identify the specific requirements for analytic functions included in applicable laws and regulations. Laws and regulations may allow sharing for aggregate analytics purposes where other sharing is not allowed. Ensure that applicable regulations are met before information is shared.

Step 2. Data Elements

Partners will collaboratively determine the specific data elements included in screening and assessment, referral, and coordination records shared with the analytics function, which must be considered in coordination with applicable regulations and consent policies. See the Screening and Assessments, Referrals, and Whole-Person Care Coordination sections for more information.

Step 3. Permissions

The connected community of care will rely on appropriate assignment and management of permissions for different partners. The integrated community health analytics function should have permissions to view full screening and assessment records, full referral records, and full coordination records for all individuals and families, unless the individual or a legal representative of the family chooses to opt out.

Step 4. Consent Management and Privacy

Individual and Family Rights: Partners believe in the right of individuals and families to control how their data are created, stored, shared, and used. Partners will enact legally compliant policies and procedures and strive to develop informed and culturally responsive consent practices.

MDPH has developed the following consent practices to consider based on conversations throughout the partnership; however, these practices will be thoroughly reviewed, refined, and finalized through the integrative governance process.

Consent Practices to Consider: Community Health Analytics
Baseline Consent Practices to Consider
Each individual and family will have the ability to opt out of sharing screening and assessment, referrals, and coordination records with the integrated community health analytics function. See the Screening and Assessments, Referrals, and Whole-Person Care Coordination sections for more information.
Additional Consent Practices to Consider
In addition to the baseline consent practices listed above, MDPH partners will strive to offer additional layers of control over how data are shared. For example, the partners might consider offering individuals and families the ability to revoke their consent and opt out of sharing data with the integrated community health analytics function.

Compliance with Relevant Laws and Regulations: The options proposed are rooted in compliance with HIPAA and Colorado regulations for personally identifiable information, which have been identified as the minimum regulations governing information exchange within the connected community of care. The available options will be continuously evaluated and updated as additional regulations are identified and incorporated into MDPH's information governance framework. Additionally, partners may agree upon different options for certain types of data.

Culturally Responsive Practices: MDPH partners will work to develop shared policies and best practices to enable informed, culturally responsive consent across the connected community of care. The partners recognize that data have been used to reinforce disparities and inequities between populations, resulting in a deep and valid mistrust of data analytics in some communities. With this knowledge, the partners may choose to incorporate more stringent privacy requirements or offer more individual control than strictly necessary to comply with relevant laws and regulations for analytics purposes. MDPH will carefully consider the benefit of these options in building trust with communities versus the additional complexity required to implement them.

Workforce Adoption and Engagement

Step 1. Collect Quantitative and Qualitative Data

This plan details the importance of and approach to overall collection, aggregation, and analysis of screening and assessment, resource, referral, and care coordination services across the connected community of care. However, a complete impact analysis of the value of the connected community of care on population-level and community-driven health priorities will likely require additional data. Additional data may include the following, with appropriate permissions, consent, and compliance with relevant laws and regulations:

- Program costs and resources (internal organizations)
    - Full-time care coordination employees or time allocations
    - Total program/use case costs
- Cross-sector outcomes (shared across organizations)
    - Individual/Family: How well individuals and families report feeling supported to meet their health and social needs across the network of participating health care and social service providers
    - Community-based organizations: Duration of wait time before service delivery can begin
    - Health care: Total cost of care, emergency department use, inpatient stays, well visits
    - Government services: Individuals eligible and/or enrolled but underutilizing government services
    - Criminal justice system involvement: Reduction in instances of individuals leaving the criminal justice system with unmet social and employment needs
    - Educational outcomes: How well individuals and families report children are able to focus in school after food security needs are met

Community Involvement

The MDPH Connected Community of Care Accountability Plan will include community-identified metrics to measure and evaluate meaningful community health and equity outcomes as the network of participating health care and social service providers develops and matures.

Step 2. Continuous Quality Improvement

Data and analytics are only useful if they are regularly reviewed, analyzed, and translated into action. Partners will be responsible for analyzing and presenting data within their organizations to inform internal program and population-level strategies and improvements.

Through the integrative governance process, partners will collaboratively develop forums, processes, and timeframes for reviewing, evaluating, and presenting cross-sector data and analytics to inform improvements in the connected community of care's core functions. Partners may consider using regional or state-level benchmarks (e.g., county health rankings) to evaluate areas for improvement.

Technology

Step 1. Receiving Screening and Assessment, Referral, and Coordination Data

The integrated community health analytics function should receive individual-level screening and assessment, referral, and coordination records from all participating partners. See Community Health Analytics: Commitments section for more information. The analytics function must be able to securely receive and store millions of individual-level records in compliance with applicable laws and regulations.

MDPH will explore existing and planned shared identity resolution solutions and work toward shared data standards to ensure that records of unique individuals can be linked across multiple partners. Partners are also interested in connecting individual records within families, as appropriate and allowed by relevant laws and regulations. These shared functionalities would enable longitudinal analyses that evaluate the impact of services across entire families.

Step 2. Accessing Community Resource Information

Shared community resource information allows partners to understand the full breadth of services and resources available in the region. The analytics function should be able to access shared community resource information to perform gap analyses and track trends in resource capacity over time. This functionality may require different systems than the ones used to support the Referral and Care Coordination functions.

Step 3. Generating Aggregate Reports

The integrated community health analytics function would be responsible for securely generating reports based on aggregated individual-level screening and assessment, referral, and coordination records and community resource information. The analytics function should also be able to meet requests for specific outcomes data from partners. Several technologies with these functionalities exist. They include the Colorado Health Observation Regional Data Service (CHORDS) and the Linked Information Network of Colorado (LINC). Partners will explore opportunities to build upon these and other technologies to create the integrated community health analytics function. The analytics function should only provide aggregate reports.

Step 4. Standards for Shared Analytics Information

MDPH partners will use vocabulary, content, and transport standards whenever possible and avoid proprietary and custom methods for storing, formatting, and sending information. Partners will review and approve common standards through the integrative governance process. See the Environmental Scan: Standards and Recommended Requirements for existing standards for analytics information.

Summary: Consent Practices to Consider for Person-Centered Care

MDPH partners believe in the right of individuals and families to control how their data are created, stored, shared, and used. This table summarizes the consent practices outlined in further detail in the preceding sections of this plan.

Core Function	Consent	Consent Practices to Consider
Screening and Assessment	Opt-Out	People should be able to opt out of sharing any or all screening and assessment information outside of the organization collecting the information. This option would exclude all three tiers of data sharing (binary record, limited record, and full record).
Referrals	Opt-In	People should be able to opt in to each recommended electronic referral, which requires sharing a limited referral record with the referral-receiving partner organization. Individuals and families should be informed that if they do not opt in, an electronic referral cannot be made in the connected community of care, but they still have the option of contacting the organization directly themselves.
Community Resource Inventory	N/A	Not Applicable. No personally identifiable information or protected health information is included.
Whole-Person Care Coordination	Opt-In	People should be able to opt in to care coordination services, which requires the creation of a whole-person care coordination record and the sharing of coordination records according to the tiered approach (including binary, limited, and full coordination records).
Community Health Analytics	Opt-Out	People should have the ability to opt out of sharing their screening and assessment, referral, and coordination records with the community health analytics function.
Please note: The practices listed here are not intended to determine or recommend any particular consent model, technology, or requirements. MDPH will review and discuss these practices through the integrative governance process.		

Additional Consent Practices to Consider

In addition to the consent practices identified for each core function, MDPH will consider the following practices that may apply across all core functions:

- **Policy Disclosures:** Screening, referring, and care coordination organizations should provide connected community of care data-sharing policy disclosures to people when they first become patients or clients and then at least once a year after that.
- **Verbal Consent:** People should be able to provide verbal consent (written or oral) for opting in or revoking consent, and the screening, referral, care coordination, or storage authority should record their consent electronically in its system.
- **Privacy Compliance:** The consent practices identified for each core function are rooted in compliance with HIPAA and Colorado regulations for personally identifiable information. These practices assume that MDPH partners are either operating as a HIPAA-covered entity or under a Business Associates Agreement with the MDPH connected community of care. The practices may need to be modified to comply with additional regulations or alternative data-sharing arrangements as appropriate.
- **Substance Use:** MDPH is closely tracking the progress of proposed changes to 42 CFR Part 2, which regulates access to substance use information, and will update recommended consent practices as appropriate through the integrative governance process. Also, patient records may contain commingled information covered by HIPAA and 42 CFR Part 2, which should be considered in the approach to consent.
- **Revocation of Consent to Share Data:** People have the right to revoke consent for redisclosure of certain information. MDPH will incorporate revocation of consent into recommended practices as appropriate through the integrative governance structure.
- **Redisclosure of Previously Shared Data:** MDPH partners that have received a person’s information may not re-disclose that information to another organization without the person’s consent.
- **Break the Glass:** Entities should be able to request information in emergency situations but must attest to their authorized use.

Glossary

Better cross-sector coordination begins with shared vocabulary. The following are definitions for terms used within the Metro Denver Connected Community of Care initiative.

Business Requirements: Step-by-step needs of a use case as well as the criteria for its success. Business requirements describe why a project is needed, whom it will benefit, when and where it will take place, and what standards will be used to evaluate it. Business requirements do not define how a project is to be implemented and do not describe technical development or feasibility.

Community-Based Organization (CBO) or Service Provider: A private, nonprofit organization, which may include faith-based organizations, that provides direct services and/or advocates for a certain population in the community. Direct services may include food pantry services, home-delivered meals, transportation, utility assistance, housing navigation assistance, temporary housing or shelter, or other services that address an individual or family's social needs.

Connected Community of Care: 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.

Data Mart: A condensed and more focused version of a data warehouse that reflects the specific processes, needs or function of a department or user group within an organization.

Family: May refer to adults who are responsible for the care of children or minors or vulnerable adults, or an older adult being cared for by another relative. A person served through guardianship may be another example when referring to a family unit. MDPH partners must follow applicable laws when managing privacy and consent of family members.

Functional/Interoperability Requirements: Specific technical details on how systems and functions should ideally operate to support business requirements. These requirements include technical standards, dataflows, system features, and security.

Governmental Services: Services provided by local public health agencies, local human service agencies, or other government-funded programs. Examples include

Supplemental Nutrition Assistance Program and Special Supplemental Nutrition Program for Women, Infants, and Children.

Health Insurance Portability and Accountability Act (HIPAA): 1996 federal law that requires the creation of national standards to protect sensitive patient health information from being disclosed without the patient's consent or knowledge.

Identity Resolution: The process of matching identifiers (e.g., first and last names, date of birth, home address) across different systems and touchpoints into a single profile for an individual.

Information Governance: Standard policies and procedures for using information in a responsible, agreed-upon manner. Information governance is especially important in health care, social services, and other settings where personally identifiable information is needed to provide care and other services. Effective information governance promotes accessibility of data across the spectrum of health and social services through secure, trusted mechanisms and ensures those data are appropriately used. (Source: Colorado Health Information Governance Guidebook_09.2021 Update)

Integrative Governance: The organizational and decision-making structure required for shared leadership, responsibility, and accountability in the development and management of the Metro Denver Connected Community of Care initiative. The Metro Denver Connected Community of Care integrative governance structure is based on the ReThink Health integrative activities. Within its integrative governance structure, MDPH commits to collaborative decision-making with community leadership to ensure the connected community of care is community-driven and responsive to individuals' and families' needs.

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.

MDPH Partners: 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.

Opt-In Consent: A person must explicitly consent to sharing their information, otherwise that information cannot be shared with any other MDPH partner.

Opt-Out Consent: By default, people agree to share their information with MDPH partners per policy disclosures unless they opt out or revoke their consent.

Personally Identifiable Information: Any information that permits a person's identity to be directly or indirectly inferred, including any information that is linked or linkable to that person.

Personas: Fictional characters that represent a potential person who will use or be served by the connected community of care.

Protected Health Information: Any information in the medical record or designated record set that can be used to identify a person and that was created, used, or disclosed in the course of providing a health care service such as diagnosis or treatment.

Regional Accountable Entity (RAE): An organization responsible for coordinating Health First Colorado (Medicaid) members' care, ensuring they are connected with primary and behavioral health care and community resources when needed.

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.

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.

Social Service Providers: A general term used to collectively describe community-based service providers and human service agencies.

Trusted Convener: An organization that provides strategic planning, technical assistance, facilitation, and project management for a group of organizations working on a shared initiative or priority.

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).

User Stories: Short abstracts that identify a persona's needs and goals and include how the connected community of care will work to meet their needs and goals.

Trusted Convener: An organization that provides strategic planning, technical assistance, facilitation, and project management for a group of organizations working on a shared initiative or priority.

Appendix

Initial Metro Denver Use Cases for a Connected Community of Care

Chronic Disease Screening and Referral, in support of the prevention and management of diabetes, cardiovascular disease, and associated risk factors: MDPH partners recognize the inequities in chronic disease burden that exist across counties and communities of color in the Denver region. MDPH partners developed a chronic disease prevention and management plan, supported through a connected community of care, to address diabetes, cardiovascular disease, and related risk factors such as food insecurity, high cholesterol, and high blood pressure. One of the key pillars in the plan is to ensure people's clinical care is coordinated with evidenced-based programs and food and nutrition resources.

- Chronic Disease Business Requirements
- Chronic Disease Technical Requirements (functional/interoperability requirements)

Postpartum Care and Community Connections, in support of Family Connects Colorado: Family Connects is an evidence-based model that is designed to support whole-person and whole-family care by connecting parents with newborns to in-home nurse visits and community resources to address their and their babies' health and social needs. Local public health, hospital, and community partners are launching Family Connects Colorado. MDPH partners are offering guidance on how the Family Connects program can function within a connected community of care to ensure parents and families are getting coordinated care and community resources across the region.

- Family Connects Business Requirements
- Family Connects Technical Requirements (functional/interoperability requirements)

Social Need Screening and Referral, in support of the Hospital Transformation Program: The goal of the Hospital Transformation Program (HTP) is to improve the quality of care provided to Health First Colorado (Medicaid) members. HTP requires hospitals to offer a social need screening to people who are admitted to hospitals to identify any food, housing, transportation, utility, and safety needs that a person may have and refer to community resources and other services to address those needs.

- HTP Business Requirements
- HTP Technical Requirements (functional/interoperability requirements)

Recommended Screening Tools and Assessments

Colorado Family Support Assessment (CFSA): The CFSA is the primary tool used by the Family Resource Center Association network to assess families' strengths and needs. It assesses self-reliance and family stability, factors that protect against child maltreatment, and motivation for change including mutual goal setting.

Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) Screening Tool: PRAPARE is a tool that was created by the National Association of Community Health Centers, Association of Asian Pacific Community Health Organizations, and the Oregon Primary Care Association beginning in 2013. The tool is widely used and validated. There is no pediatric-specific version, however, a pediatric version is planned.

Safe Environment for Every Kid (SEEK): A pediatric-specific tool oriented around strengthening families, supporting parents and parenting, and promoting children's health, development, and safety.

The Accountable Health Communities (AHC) Health-Related Social Needs Screening Tool: The AHC Screening Tool was developed in 2017 for the Center for Medicare and Medicaid Innovation by a team of national experts. It is a validated tool that contains five core domains — housing instability, food insecurity, transportation problems, utility help needs, and interpersonal safety — and eight supplemental or optional domains.

Recommended Trainings and Best Practices

- Applied Suicide Intervention Skills Training
- Mental Health First Aid
- Motivational Interviewing
- National Care Coordination Standards for Children and Youth with Special Health Care Needs
- National Center on Domestic Violence, Trauma & Mental Health
- Patient Navigation and Community Health Worker Training
- The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care
- Trauma Informed Care Training

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