Jefferson County Health Alliance
Technology Action Team

May 3, 2021 11:00-12:30pm
Microsoft Teams

Notes

Meeting Objectives:

- Describe scope and requirements for the two possible project areas
- Decide on project priorities

Action Team Overview:

We will connect systems by sharing data to create greater efficiencies and improved client outcomes.

These systems include community organizations, home visitation programs, therapies and services for people with special needs, health care organizations, protective services and benefit services. The data we will share include demographics, benefit status, support and safety planning, referral and follow-up, health care utilization, health outcomes and screening/assessment results.

To get us toward this objective we will:

1. Streamline processes and requirements across systems
2. Assure efficient and effective methods to refer a customer somewhere else and know what happens with that referral (closed loop referral process).
3. Share data (including 3rd party data) to improve efficiencies and health outcomes
4. Improve access to benefit information

Participants: Melissa Palay, Candace Cooledge, Jason Greer, Jane Barnes, Ben Wiederholt, Brandon Ward, Mary Rueda, Sam Taylor

	Activity	**Action**
	Discussed: Programmatic examples of service delivery alignment and data sharing in Jefferson County i. Porchlight – Candace Cooledge - A newly opened non-profit (February 2021) providing a single location with 19 different agencies housed at the same place for victims in our community. The ideal is the guests to Porchlight only have to tell their story story one time, fill out one application, and received coordinated services. - Using GenApp platform through Jefferson County Human Services to efficiently share information and help with workflow. o Guest comes in. Fills out basic information about self, person who cased them harm and why they are here. Then navigator meets with guest to learn about what they are hoping to accomplish, hear story, and review waiver of confidentiality/sharing of information. Information is then entered into GenApp o As client directs, information is shared with on-site partners as well as tags the partners with whom the guest would like to meet. o GenApp tracks services, shares notes of Porchlight visits	Explore what other tools are being used for care coordination, data sharing and resources and referrals. – Kelly and Jason will draft a survey for Alliance partners and other organizations serving Jefferson County residents.

	o Each partner continues to use their own system for their own work-flow. o Porchlight expects to adapt GenApp as their needs evolve. o Human Services is supporting the buildout and maintenance of GenApp for Porchlight. ii. Human Services (Mary Rueda) – Jefferson County Human Services also uses GenApp to coordinate client experience across Human Services programs. It has a goal of increasing more staff to use the system to streamline workflow and make the process of working with Human Services programs easier for clients. iii. Home Visitation Collaborative – Melissa Palay - In Jefferson County, 13 programs have some programming related to serving clients in their own homes, "home visitation". These organizations work together within the "Home Visitation Collaborative." They share resources and are continually improving their referrals to each other's programs. - Currently, the Collaborative uses Aunt Bertha through a curated page at JeffcofamiliesColorado.org. The referral loops are closed within the system among the Collaborative partners, who have committed to the system and process. - The work with Aunt Bertha is funded through a grant from Community First Foundation. - Successes: HV Collaborative partners are really engaged, referrals are increasing and the referral loop does close among partners. New users to JeffcoFamilies is also increasing demonstrating intentional resource building is paying off. - Challenges: Duplication of effort, with organizations being asked to join the multiple resource and referral systems, keeping information up-to-date. Aunt Bertha does a good job managing services, but trust is lacking for referrals sent to organizations outside the HV Collaborative network. - Value of closed loop referrals – For the individual – the services for their care plan are in place and they are getting the services they are looking for. For the referring parties – Closing a referral loop, builds trust and partnership if the referral was successful. If the referral is closed it improves their own credibility.	
	Discussed: State and regional efforts supporting and linking work together - social health information exchanges, resource and referral networks, and the like – Jason Greer - State and regional work aims to build interoperability across multiple tools to improve referrals to and information sharing across social health services. In this way, communities, organizations and people can continue to make decisions regarding the tools that work for them. - Work is also underway toward a comprehensive resource directory (2-1-1 is working with COHRIO) and expand on the idea of a Unique ID for resources across systems.	

	- Next steps could involve: o Short term – organizations are looking for the tool(s) that meet their work flow and that their key community partners are using. For example, clinical partners are looking at Aunt Bertha because of its EHR integration. - Middle term – How to community partners encourage interoperability across systems. - Other state efforts: Family Connects – State model to engage all families post-partum to link to education, childcare, home visitation and other supports. In this model they are also looking at local resource and referral systems	

	Next meeting – June 7, 2021 at 11:00
	- Topics –
	  o Discuss positions on regional and state social health information exchanges (S-HIE)
	  o Review data sharing, care coordination and resource and referral tools being used and considered by organizations serving Jefferson County residents.	