Best Practices Toolkit

Community-Clinical Linkages for Chronic Disease Prevention and Management

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METRO DENVER
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Best Practices Toolkit

Community-Clinical Linkages for Chronic Disease Prevention and Management

Background

Public health researchers have long known that a person's health is influenced more by where they live, learn, work, and play than by anything that happens at a clinic. But our health systems often lack connections to community resources that prevent and manage chronic disease. That is where community-clinical linkages come in. Community-clinical linkages are connections made across health care, public health, and community organizations to increase people's access to care and resources and improve population health.

While chronic disease burden disproportionately persists among communities of color and households with low incomes compared with other populations in Colorado, evidence-based programs can help. Evidence-based programs are one type of community resource that provide demonstrated health benefits and are backed by research. Examples of evidence-based programs include the National Diabetes Prevention Program (NDPP), diabetes self-management education and support (DSMES) program, and self-measured blood pressure monitoring programs (SMBP).

The Colorado Health Institute (CHI) established the Metro Denver Community-Clinical Linkages for Chronic Disease Prevention and Management Network in collaboration with the Metro Denver Partnership for Health in 2023. The network is the first community-clinical linkages model of its kind designed to increase access to evidence-based programs and improve chronic disease prevention and management among people living in the Denver region. The network advances these goals by building and strengthening relationships and coordinating services among local community, health care, and public health organizations.

How the Network Works

The organizations in the network maintain unique roles in pursuing their shared goals. In health care settings, clinical partners assess people for diabetes, heart disease, and related risk factors such as prediabetes, high blood pressure, high cholesterol, and food insecurity. Clinical partners then refer those who are eligible to community partners in the network to provide programs and services, including the NDPP, DSMES, and SMBP. These partners may be local community-based organizations, pharmacies, or public health agencies that provide these programs on-site or in settings that are more accessible in the community, such as primary care clinics, recreation centers, or resource centers.

CHI is the backbone hub for the network. CHI is responsible for the recruitment and onboarding of partner organizations, training and technical assistance, implementation, evaluation services, and sustainability planning. The Cancer, Cardiovascular and Pulmonary Disease Grant Program of the Colorado Department of Public Health and Environment is funding the network between July 2023 and June 2026.

Purpose of This Toolkit

This toolkit is a resource for organizations interested in developing and implementing community-clinical linkages to address chronic disease prevention and management in their communities. Its best practices offer guidance to design and implement screening and referral workflows to connect people in health care settings to community-based service providers offering evidence-based programs and other resources. These best practices may be adapted and applied to establish other linkages across organizations, including referrals for food and nutrition or other supportive services.

This toolkit focuses on programmatic and workforce practices to create screening and referral workflows across partner organizations. It outlines basic guidance related to data elements, information governance, and communication technology needed to facilitate these workflows. CHI developed this toolkit using research from recommended sources and subject matter experts and based it on the best practices developed by the network. It does not provide legal advice or counsel. Please consult your or your organization's administrative or legal teams as appropriate.

The network found that these best practices may be implemented most effectively and efficiently when organizations have a trusted convener, such as a backbone hub. The hub provides strategic guidance and mutual support to guide partners through trust-building stages and when working together to establish agreements and practices. The convener fosters accountability among organizations to maintain forward progress in developing and implementing their linkages despite potential challenges along the way. This toolkit may be used by organizations without a backbone hub as needed.

Terminology Used in This Toolkit:

Community-clinical linkages are connections made across health care, community, and public health organizations to increase access to care and resources and improve population health.

Clinical and community organizations broadly include health care organizations, community-based organizations, pharmacies, or local public health agencies involved in linkage efforts.

A **health care provider** refers to a health care professional that delivers clinical care and treatment to people at a clinic, hospital, or other health care setting. Providers may include physicians, nurse practitioners, and physician assistants.

Care coordination staff broadly includes enrollment specialists, care coordinators, case management staff, patient navigators, or community health workers.

Tip: Community-clinical linkages may be implemented most effectively and efficiently when organizations have a trusted convener, such as a backbone hub. However, this toolkit may be used by organizations without a backbone hub as needed.

How to Use This Toolkit

Develop and implement linkages between organizations by working through the four phases outlined in this toolkit:

Phase 1: Identify a Shared Commitment to Equity. Community-clinical linkages should be centered on health equity. This section outlines a tool to identify existing connections, priorities, resource gaps, equity practices, and opportunities among organizations interested in pursuing partnerships.

Phase 2: Address Structural Considerations for Long-Term Impact. Organizations should consider certain structural considerations to increase the long-term impact of their partnerships. Structural considerations include organizational-level agreements to define clear roles and responsibilities among partners, and training and ongoing activities to work toward systems-level changes that support health equity.

Phase 3: Design a Shared Screening and Referral Workflow. This section outlines five recommended steps for a screening and referral workflow, defines the purpose of each step, and provides guidance related to data elements, information governance, and communication technology.

Phase 4: Facilitate Workforce Adoption and Engagement. Community-clinical linkages facilitate coordination among health care, public health, and community organization workforces. This section provides guidance to support the workforce to implement and sustain newly designed workflows and best practices.

This toolkit references terminology that is defined in yellow boxes marked with a dictionary icon

Additional guidance and insights can be found in blue boxes marked with a link icon

Phase 1: Identify a Shared Commitment to Equity

Clinical and community partners must have a shared commitment to equity to be successful in creating effective and lasting linkages across their organizations. Seek partners that practice their own commitments to equity through the care, programs, and services they offer. When pursuing a partnership, staff should talk about their organizational missions and articulate how the programs and services they provide to their priority populations and geographic areas advance that mission. Staff should take the time to understand each other's values and acknowledge the unique contributions each organization can bring to the partnership.

Readiness assessments are tools that can measure preparedness to engage in cross-sector linkages through an equity lens. These tools can identify existing connections, resource gaps, or pain points among organizations that may be leveraged or addressed via linkage efforts. Backbone hubs may be in the best position to circulate these assessments to guide recruitment of partners. However, organizations may also complete their own readiness assessments as needed.

Readiness Assessments

To complete a readiness assessment, organizations should conduct research to understand their community's existing health disparities and identify priority populations they wish to better serve through community-clinical linkages. For example, the Metro Denver Community-Clinical Linkages Network focuses its efforts on increasing access to evidence-based programs for communities of color and households with low incomes. This is because of the disproportionate chronic disease burden that exists among these populations in the Denver region. Understanding the realities of health disparities and inequities across communities can help organizations focus their goals and prioritize the types of cross-sector partnerships to develop.

Guiding questions that may be used to assess readiness include:

- What is your organization's mission?
- What are the programs and services your organization provides to achieve this mission?
- What are the priority communities or populations your organization serves and in what geographic area(s)?
- What challenges or pain points does your organization experience when serving your priority communities?
- How does your staff or organization vet or decide which health care clinics, hospitals, or community-based resources to refer patients to for care and services?
- What health priority(ies) does your organization wish to address through community-clinical linkages (e.g., diabetes prevention)?
- How would you like to see your organization working with or coordinating with health care clinics, hospitals, community-based organizations, local public health agencies, or other organizations in the future to address this health priority?
- What is your organization's vision of success when pursuing this community-clinical linkage?

Addressing organizational alignment early on supports implementation and sustainability of screening and referral workflows. Partners should continue these conversations beyond their initial readiness assessments to support ongoing engagement, alignment, and buy-in across organizations. After this alignment process, partners may move to the next phase of development.

Readiness assessments are tools to measure organizational preparedness to engage in cross-sector linkages rooted in equity and mutually beneficial partnerships.

Phase 2:
Address Structural Considerations for Long-Term Impact

To move from commitment to sustained action, partners should address structural needs to effectively implement and maintain their relationships and shared efforts. Structural considerations include securing appropriate organizational agreements to define clear roles and responsibilities among partners and considering ongoing practices to work toward system-level changes for health equity.

Organizational Agreements

Organizational agreements may include a memorandum of understanding, a business associate agreement, or a data sharing agreement. These agreements create transparency and accountability by outlining clear expectations for partners coordinating screening and referral activities. These agreements are defined in the following list along with recommendations for which type to use in community-clinical linkage networks. Consult your organization's administrative or legal team to determine which is best for you and the partnership you seek:

- A **memorandum of understanding** (MOU) is a nonbinding document between two organizations that outlines general intentions and goals for sharing, handling, and using data. MOUs are typically entered between partners that are initially exploring work together and can lead to a more formalized agreement after agreeing to work together long term. MOUs do not necessarily include adherence to Health Insurance Portability and Accountability Act (HIPAA) requirements by both parties, but such stipulations can be included. Organizations still need to follow their internal policies and procedures related to HIPAA and other regulations.

- A **business associate agreement** (BAA) is a legally binding contract between a HIPAA-covered entity (e.g., health care clinic) and an associated organization that is meant to safeguard a person's protected health information (PHI). Under a BAA, a community organization agrees to properly access, store, and handle PHI to protect privacy and is held to the same standards as a HIPAA-covered entity.

- A **data sharing agreement** (DSA) is a binding agreement between organizations for sharing personal information for a specific research or program objective. DSAs do not necessarily address HIPAA requirements but specify how the shared data can be used by the receiving party. A DSA is also referred to as a data use agreement (DUA).

The best practice for sharing data between partners is to have both organizations sign BAAs so that HIPAA requirements and privacy are explicitly protected. MOUs or DUAs can be used between organizations initially for proof of concept or research initiatives, but BAAs should be executed before exchanging any ongoing referrals, communication, or coordination activities.

Consider including the following details when developing organizational agreements to support mutual understanding and accountability across organizations:

- Define the purpose and goals of the partnership. A clear purpose and goals help partners engage in more informed, productive, and collaborative ways in the referral relationship.

- Discuss practices to gathering and documenting a person's consent to share their data and information for referrals and coordination of care as appropriate.

- Define communication and data sharing practices and methods. These details foster greater trust, security, and efficiency among organizations.

- Discuss definitions of shared language or terms relevant to agreed-upon activities. Such clarification prevents miscommunication and uninformed assumptions. Examples of terms may include referrals, follow-up, closing the loop, social determinants of health, and health-related social needs.

As partners establish organizational agreements, they may also discuss the community organization's funding sources and related data needs. Community organizations that receive grants or insurance reimbursement (e.g., Medicare or Medicaid) for their services may require certain data to stay compliant and operational with their own funding and reporting guidelines. These considerations may be helpful to inform what and how data is shared across organizations.

Equity-Centered Practices for Systems-Level Change

Health inequities are closely related to levels of social disadvantage and discrimination experienced across different groups of people. People of color experience discrimination and interpersonal racism in health care settings and receive poorer quality of care compared to white people with respect to heart disease, stroke, cancer, maternal health, pain management, and surgery. Indigenous people have lower life expectancy compared with non-Indigenous people. Social determinants of health, which the World Health Organization defines as the "conditions in which people are born, grow, live, work, and age, and [their] access to power, money, and resources," can further drive health inequities.

Leaders and staff at partnering organizations should consistently strive to learn and implement person-centered and equity-driven practices when engaging with and serving people through their programs and services. Organizations should consider the following practices to advance toward health equity through their work together.

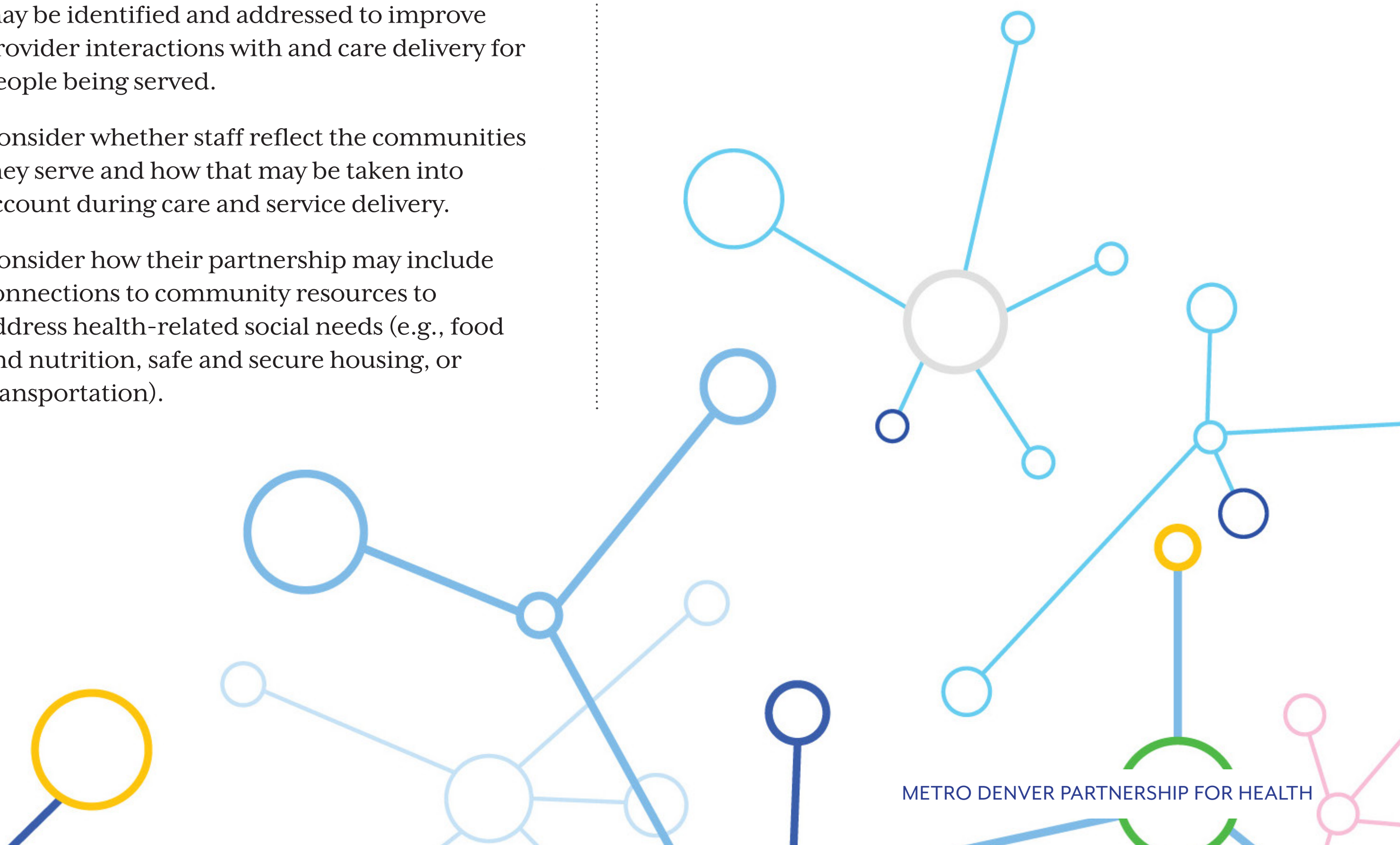
- Determine how screening and referral practices and service delivery take into account people's unique needs, including language or cultural preferences in communication.
- Assess how unconscious bias and assumptions may be identified and addressed to improve provider interactions with and care delivery for people being served.
- Consider whether staff reflect the communities they serve and how that may be taken into account during care and service delivery.
- Consider how their partnership may include connections to community resources to address health-related social needs (e.g., food and nutrition, safe and secure housing, or transportation).

Organizations may already engage in their own training, technical assistance, and practices to support internal goals related to equity. Even so, they should still consider whether completing training together or using shared tools and resources may further advance system-level changes through their ongoing partnership and coordination of care and services. Recommended training courses may cover:

- Language justice
- Trauma-informed approaches in public health programming
- Motivational interviewing
- Anti-racist practices and principles
- Culturally competent care

This phase of addressing structural considerations related to health equity should be iterative as different challenges, opportunities, tools, and resources may emerge over time.

Partners may continue to the next phase of development to design a shared screening and referral workflow while waiting for organizational agreements to be finalized and executed. Discussing desired workflows can be helpful to inform the details included in their organizational agreements.



Phase 3:
Design a Shared Screening and Referral Workflow

To complete this phase of development, partners should first complete the pre-work activities outlined. Then, partners may proceed to establish the five key steps of a screening and referral workflow described in this section.

Pre-Work

Define Programs and Services

To design a shared workflow, partners should understand how each of the organizations delivers its respective programs and services and how the programs and service offerings may differ compared to another organization that provides the same evidence-based program or service. Guiding questions to discuss as partners include:

- When/how are people screened for diabetes, heart disease, and related risk factors (pre-diabetes, high cholesterol, high blood pressure, and food insecurity) in the clinical setting?
- How do community-based organizations receive referrals for and enroll people in evidence-based programs? What are the eligibility requirements?
- What unique strengths or skills does each partner organization bring? For example: Is the evidence-based program delivered in Spanish or other languages? Are services available in person and/or virtually? Is transportation or child care provided? Is care tailored for people with unique needs, such as those with mental or behavioral health needs?

Partners should agree on the programs or services they would like to focus on connecting across their organizations based on the shared health priority they are working to improve. For example, do they wish to set up a referral process to connect people to the community organization's NDPP to prioritize diabetes prevention and/or different evidence-based programs or resources?

Set Initial Referral Goals

Partners should determine a baseline referral goal for their initial phase of implementation based on the service capacity of each organization to send, receive, and process referrals. Not all locations or departments within an organization may initially participate in the linkage. Expanding to additional locations within a community or clinical organization may happen over time. Baseline referral goals may be set for the first month or quarter of implementation. Setting initial referral goals is helpful to establish shared commitments and understanding of what partners are working toward. Setting goals is also helpful to make quality improvement efforts more specific, measurable, and meaningful (see Quality Improvement Activities within the Facilitate Workforce Adoption and Engagement phase). After defining initial referral goals, partners can determine the scope of the shared workflow they wish to develop.

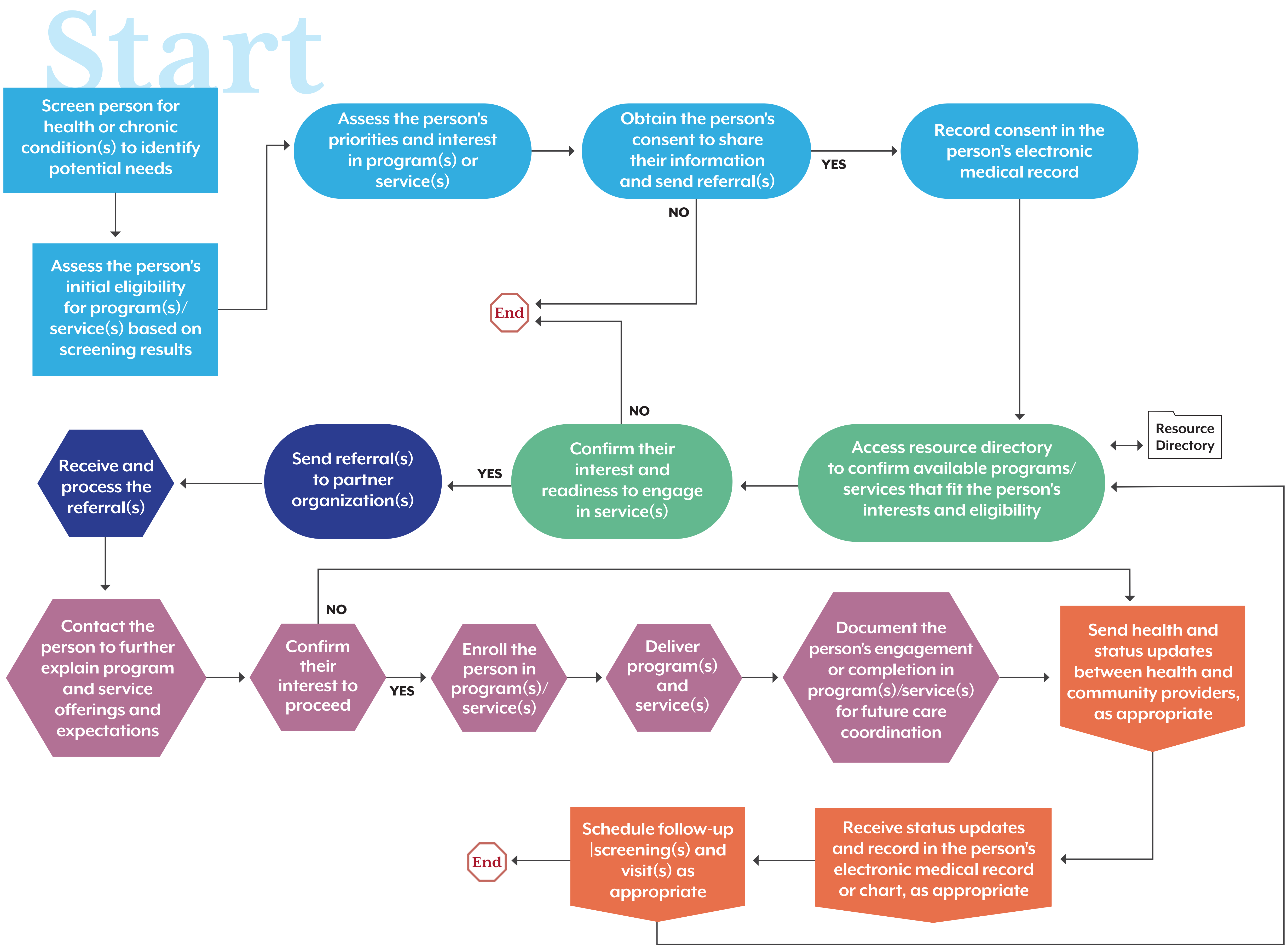
Define the Scope of the Screening and Referral Workflow

A complete screening and referral workflow includes five steps (Figure 1):

- **Step 1.** Assess individual needs and interests and obtain consent for referrals. Clinical partners screen people for the health priority to be addressed (e.g., diabetes, high blood pressure), assess basic eligibility for evidence-based programming or related resources, and obtain consent from the person to share their information for a referral.
- **Step 2.** Identify the best fit and confirm eligibility for available programming and services. Clinical partners use a resource directory to identify the best program fit for a person based on their needs and goals and verify their eligibility for available programs and resources.
- **Step 3.** Pass the baton to send, receive, and process referrals. Clinical partners send the person's referral to the community partner(s) to process.
- **Step 4.** Complete outreach, program enrollment, and service delivery. Community partners build rapport with the person, explain the available program(s) or resources in more detail, confirm their interest, enroll them, and deliver the desired program or services.
- **Step 5.** Close the loop about outreach efforts and program outcomes. Community and clinical partners send health and service status updates to each other to further inform and coordinate care and services for a person's overall health and well-being. Different considerations and options for this step are provided for organizations to choose what may work best for their partnership.

Partners should discuss the full scope of the screening and referral workflow they wish to implement to understand where their work together begins and ends. For example, some organizations may wish to focus on steps one through four in their initial efforts and agree to expand to step five after their shared processes are established and effectively functioning.

Figure 1. Community-Clinical Linkages: Screening and Referral Workflow Diagram



Workflow Steps

- Step 1 Assess Individual Needs and Interests and Obtain Consent for Referrals
- Step 2 Identify the Best Fit and Confirm Eligibility for Available Programming and Services
- Step 3 Pass the Baton to Send, Receive, and Process Referrals
- Step 4 Complete Outreach, Program Enrollment, and Service Delivery
- Step 5 Close the Loop About Outreach Efforts and Program Outcomes

Provider Roles

- ▭ Health Care Provider
- ⬭ Care Coordination Staff
- ⬡ Community Resource Provider
- ⬠ Shared Role Among Health and Community Providers

The following section provides guidance on how to design each step of the workflow. The purpose of each step is defined, followed by recommended activities and practices regarding data elements, communication technology, and information governance to achieve that purpose.

Step 1. Assess Individual Needs and Interests and Obtain Consent for Referrals

The purpose of this step is to identify people who may benefit from available programming and services by screening them for certain health conditions or related needs and obtaining their consent to send referrals, as appropriate. Health care providers and care coordination staff may work together to complete this step.

Activities

To design this part of the workflow, partners should outline and agree on how they will complete the following activities:

- Screening for health or chronic condition(s) to identify potential needs, such as diabetes and high blood pressure through lab results and vital signs.
- Assessing eligibility for evidence-based program(s) or other resources based on lab results and vital signs.
- Assessing the person's priorities and interest in evidence-based program(s) or other resources to address identified needs.
- Obtaining the person's consent to send a referral to and exchange their personal information with community partner(s) to connect them to available programming and resources.

Assess Needs, Interest, and Readiness

Screening for certain health or chronic conditions can occur at multiple points within a clinical setting. A health care provider may diagnose a person with diabetes, high blood pressure, or heart disease during routine visits and testing. During these visits, a health care provider can initiate the rest of the agreed-upon workflow in real time. Clinical organizations may also leverage care coordination or other staff to review electronic medical records (EMRs) or data to systematically identify individual(s) with certain health or chronic conditions. Reviews of EMR data may include recent lab results (such as vital signs) or social determinant of health assessments to identify people to contact about evidence-based programming and resources that may support them.

Whether speaking with people in real time during or after clinic visits or contacting them after EMR reviews, health care providers and care coordination

Data elements are the information to collect, store, and share about a person to create supportive and coordinated experiences that connect them to the health care and community-based services they seek.

Information governance considers the applicable laws and regulations that govern the use of the data being shared and establishes expectations on how partners will collect, store, share, and safeguard that information.

Communication technology practices include guidance on what technology may be used to effectively and securely communicate across organizations and with people being served.

A **Quick Guide to Data Elements, Information Governance, and Communication Technology** (see Appendix) summarizes the data discussed in this toolkit and outlines communication technology to access and exchange these data to facilitate screenings, referrals, and follow-up care.

Electronic medical record refers to a person's electronic health-related information that can be created, gathered, managed, and consulted by authorized clinicians within a health care organization.

staff should take the time to discuss the person's health priorities and goals. They should not assume that anyone is interested, able, or ready to participate in evidence-based programming or other services simply because of the diagnosis of a certain health condition or chronic disease. Health care providers should thoughtfully explain diagnoses, including the risks and impacts of the condition, and share what programs and resources are available for support. Through this discussion, providers or care coordination staff should confirm a person's interest in the services available and obtain their permission to share their information with community partner(s) before referring them.

▸ Obtain Consent to Send Referrals

Clinical partners may obtain oral or written consent from a person to send referrals on their behalf. If the clinical partner anticipates needing to exchange information with a community partner after an initial referral, for example, during or after programming or other services, the best practice is to obtain written consent from the person. Health care providers should document consent in the person's EMR or chart after it is obtained.

Depending on the clinical setting and team, a health care provider may manage the next step or hand off the person's information to care coordination staff to facilitate the remaining referral steps. When passing referral information to care coordination staff, providers do not necessarily need to specify the exact program (e.g. NDPP or DSMES) nor the community partner, but they need to clearly document the needs or diagnoses and the outcome of any relevant conversations, so the person does not need to repeat their story when discussing community program or resource options.

Data Elements and Communication Technology

Health care providers and care coordination staff should share the following minimum recommended data with each other to facilitate this step of the workflow. These data are usually accessible via EMR systems:

- The person's first and last name, primary phone number, primary email address, preferred language, and date of birth
- Diagnosis and/or screening results and the reason for referral (e.g., interested in evidence-based programming or other available resources)
- The person's consent (oral or written) to be referred to community programming or resources
- The provider's latest progress note and date of their last clinical visit, so the person does not have to repeat their story during the next step in the referral process

Supplemental data may include:

- The person's insurance information, as available and applicable
- Home and/or work address(es), ZIP code, or county
- Alternate contact information

Information Governance

The primary information governance consideration for this step involves the health care provider obtaining and documenting a person's consent to refer them to and exchange their personal information with community partners. This is usually referred to as a release of information.

Health care providers should ideally get consent in writing by having the person sign a consent form

Tip: Depending on the organizational agreement established, clinical partners may choose to securely share sets of individual-level data with community partners. These data sets include people that meet eligibility requirements for evidence-based programming based on a health condition or diagnosis. Community partners may then be the first to contact these people to have a conversation to assess their interest in available programming. The network recommends a more personalized approach for the health care provider team to complete the screening step of the workflow, since this usually leads to better engagement. However, this adapted model is feasible and can still be effective to connect people to community-based programs and resources.

electronically or on paper, especially to cover any future exchange of information with community partners after the completion of the initial referral or service. However, oral consent is also acceptable and may be more appropriate and efficient given the provider's time and the person's preference. Regardless of the method of obtaining consent, it is critical that the provider confirm and record in the person's EMR or chart that consent was granted. Contact your organization's administrative or legal team for specific guidance.

Step 2. Identify the Best Fit and Confirm Eligibility for Available Programming and Services

The purpose of the second step is to prioritize the person's goals and experience by identifying programs or other resources that best fit their health condition or diagnosis and personal or family circumstances.

Activities

To design this part of the workflow, partners should outline how to complete the following activities:

- Accessing a resource directory to understand the programs or resources available
- Talking with the person to determine which program(s) or resources from the directory may be the best fit based on their health needs or diagnosis, priorities, school, employment, or family responsibilities, transportation, technology, or other personal or life circumstances
- Confirming their interest and readiness to engage in a program or service
- Verifying their eligibility for that program or service

Access a Resource Directory

Care coordination staff should use a resource directory to identify specific program eligibility criteria and service offerings. When reviewing options, consider the person's insurance plan and the payment options that a community partner may offer. Some organizations may be able to provide programs at no cost, while others may need insurance information to cover their services. Finding a community resource that best fits a person's priorities, and their personal or familial circumstances is critical to support their engagement in and experience with programming and services.

Tip: While health care providers may complete step two, they often do not have the capacity in their schedules. Care coordination staff have expertise and skills in resource navigation and often deep knowledge of the communities they are serving, which can be beneficial when completing this step in the workflow.

Tip: Community organizations often hold evidence-based programs a certain number of times per year. When community partners regularly notify clinical partners about the start of upcoming sessions, referrals and enrollments often increase because the opportunities to participate in programming are more immediate.

Confirm the Person's Interest and Eligibility

Care coordination staff should re-confirm the person's interest and eligibility for programming as part of this step. Circumstances may have changed since they communicated with their health care provider, or they may have had second thoughts about committing to a program or service. By reaffirming their eligibility and interest, clinical teams can ensure success for the person and community partner during subsequent steps of the workflow.

Data Elements and Communication Technology

Minimum recommended data elements that care coordination staff should collect and/or review and confirm during this step include:

- The person's needs and preferences for programs or services, their preferred language, service location, type of service delivery (e.g., in-person or virtual)
- The provider's latest progress note and date of the person's last clinical visit
- The person's screening results or diagnosis and insurance information (as applicable) to confirm eligibility for programming and services

- Community resource directory information including:
    - Programs and services
    - Current service availability (e.g., enrollment open/closed)
    - Type of service delivery (e.g., in-person, virtual, individual or group setting)
    - Eligibility criteria
    - Languages offered
    - Geographic areas served
    - Service locations (if applicable)
    - Insurance accepted (if any)
    - Organization/program contact information (email and phone)

Supplemental data may include:

- Home and/or work address(es), ZIP code, or county (e.g. Someone may want to participate in services closer to their work or home address)

Information Governance

Community resource directories are an important tool for partners to facilitate informed and successful referrals. Partners should consider who is responsible for updating their resource directory and how it will be maintained. Ideally, the resource directory would be web-based and interoperable with other systems, so all partners can access and update it in real time. When this is not possible, partner organizations may consider using existing technologies, such as spreadsheets, that are accessed via a shared site or online drive. Partners may also consider using other local, nonprofit, or commercial resource directories online.

Organizations often keep their own internal resource lists. While partners will likely continue to do so after joining a community-clinical linkages network, they should still maintain a shared understanding of the programs and services they are coordinating within their network to ensure effective referrals. A backbone hub may help support the maintenance of a shared resource directory or list.

After confirming a person's preferences and eligibility for available programming, partners may continue to design step three in their shared workflow.

Step 3. Pass the Baton to Send, Receive, and Process Referrals

The purpose of the third step is to send, receive, and process referrals to connect people to the programs and services they seek.

Activities

To design this part of the workflow, partners should outline how they agree to complete the following activities:

- Sending the referral(s) from the clinical partner to the community partner(s)
- Receiving and processing the referral(s) at the community organization

This step involves a clinical partner sending individual-level referral information to a community partner for intake and processing. Clinical partners should send referrals electronically whenever possible. Oral or more analog methods, such as phone calls or faxes, require manual reentry of data that can lead to errors when processing referrals.

▸ Send Referrals

When a clinical partner sends a referral to a community partner, they should set appropriate expectations for the person about what will happen next. For example, share when they may expect to hear from the community partner to get enrolled (such as three business days or one week). These details should be discussed during the Pre-Work stage of the workflow development (see Pre-Work section).

Ideally, clinical partners send referrals to community partners via interoperable technology. Interoperable technology connects each organization's internal systems, such as EMRs and community program databases, in safe and secure ways. These connections allow organizations to continue using their own systems but also share information across systems.

However, significant resource barriers prevent many organizations from connecting their systems via interoperable technology. While health care organizations received funding from the Health Information Technology for Economic and Clinical Health Act in 2009 to expedite their transition to EMR systems, community organizations have not received the same investment in their technology. EMRs were also historically developed to exclusively send referrals for medical care between HIPAA-covered entities. As a result, third-party commercial platforms

Interoperable technology connects multiple organizations' internal data systems in safe and secure ways, allowing them to efficiently share information to coordinate referrals and care.

have emerged to help address these technology gaps. Examples of third-party commercial platforms include Findhelp and Unite Us.

In the absence of interoperable systems, partners may choose to send referrals using third-party commercial platforms or other existing technology such as encrypted email, secure fax, or other protected tools like Smartsheet. Partners must agree on which technology they will use to send referrals to ensure shared understanding and coordinated implementation. Partners may initially implement simpler technology (e.g., PDF referral forms sent via secure email or Smartsheet) and transition to more advanced solutions as resources become available.

Receive and Process Referrals

After receiving referrals from clinical partners, community partners will process these referrals based on their organizational practices shared during the Pre-Work stage of workflow development (see Pre-Work section). These early conversations are critical, so that community partners receive referrals that are accurate and sufficient to process before proceeding to the next step in the workflow.

Data Elements and Communication Technology

Minimum recommended data elements about a person that clinical partners should share with community partners include:

- The person's first and last name, phone number or email address, preferred language, date of birth, medical record number, and insurance information (as applicable and based on organizational agreements)
- Their diagnosis or screening results and the reason for referral (e.g., desired evidence-based program or resource)
- The date of the referral for follow-up communications
- The referring provider or care coordinator's contact information for follow-up

Supplemental data elements may include:

- Home or work address(es), ZIP code, or county, alternate contact information, the provider's latest progress note (as applicable based on organizational agreements). These data may be helpful for community partners to streamline the next step of the referral workflow.

Information Governance

Partners should ensure that referrals are sent securely using a HIPAA-compliant method of communication. Encrypted email and secure fax are considered HIPAA compliant. Refer to the appendix for guidance on communication technology. Consult your administrative and legal teams for final decisions and practices.

Step 4. Complete Outreach, Program Enrollment, and Service Delivery

The purpose of the fourth step is to engage people who have been referred to complete their enrollment and facilitate their participation in desired programs and services.

Activities

To design this part of the workflow, partners should outline how they agree to complete the following activities:

- Confirming the person's information and interest in the programs and services for which they were referred
- Enrolling the person and scheduling their start date
- Delivering the programs or services
- Documenting the person's completion of programs or services

Outreach and Enroll in Programming and Services

After a community partner receives and processes a referral, staff should contact the referred person. They may use multiple outreach methods, including phone calls, email, or texts, based on the contact information provided on the referral.

After a person is reached, staff should build rapport to better understand the priorities and personal circumstances that may impact how they engage with services. When staff build relationships from the beginning, people feel more supported and engaged in services.

Next, staff should:

- Explain the services available and discuss how they can support them by addressing their health-related priority or goal. These are opportunities for staff who are health coaches to provide additional health education or guidance that may further increase the person's understanding and engagement in services.
- Outline expectations for participation and any resources and supports available (e.g., language or accessibility). Staff should confirm that the person still wishes to proceed. Although previously asked, personal or life situations can arise that can lead to people choosing not to pursue services after initial referrals.
- Gather any additional information needed for enrollment and discuss the next steps and timelines for participation.
- Provide staff or organizational contact information for any follow-up questions, regardless of whether they enroll.

Deliver and Document Programming and Services

Depending on the program or service being provided, people may participate in or receive services over various periods of time. Community partners should monitor and record participation, especially if a program requires a certain level of participation for an evidence-based curriculum. If the person chooses to discontinue programming, if capacity allows, staff may reach out intermittently to support their continued engagement as appropriate. Community partners should keep internal records of when people complete or end their services. This allows for a better understanding of their journey through care and services and helps facilitate the next step in the workflow, if partners choose to include this step in their workflow.

Tip: Staff should build rapport to better understand a person's priorities and personal circumstances that may impact how they engage with services.

Closing the loop is when clinical and community organizations share health and service status updates to further inform and coordinate care and services for a person's overall health and well-being.

Data Elements and Communication Technology

Minimum recommended data elements that community partners should collect and/or confirm about the person (if already provided on referral form) include:

- The person's first and last name, phone number or email address, preferred language, date of birth, medical record number, and insurance information (as applicable and based on organizational agreements)
- Preferred program or service, service location, and type of service delivery (e.g., in-person or virtual)

Supplemental data elements may include:

- Alternative contact information
- Home or work address(es), ZIP code, or county. These data may be helpful to determine the best service location (if receiving in-person services)

Information Governance

The primary governance consideration for this step is that the community partner has internal systems and processes to safely and securely collect and store the personal information of those they serve even if they are not a HIPAA-covered entity. They may have different requirements or considerations depending on the type of data they are receiving or sharing with clinical partners, as defined by their organizational agreements (e.g., MOU, BAA, or DSA). Community partners should consult their administrative and legal teams to set up appropriate internal systems and processes to store and secure data.

Step 5. Close the Loop About Outreach Efforts and Program Outcomes

The purpose of this step is for community and clinical partners to send health and service status updates to one another to further inform and/or coordinate care and services for a person's overall health and well-being. This follow-up communication between health care and community-based service providers is referred to as closing the loop.

Activities

Partners may not choose to or have the capacity to complete any or all suggested activities. However, to fully design this part of the workflow, partners may consider how to complete the following:

- Sending outreach, enrollment, service delivery, and program completion updates from the community partner back to the referring clinical partner
- Processing and recording status updates received from the community partner into the person's EMR at the clinical organization
- Contacting people who did not enroll in or complete programs or services after a referral was sent to a community partner
- Scheduling a post-program follow-up clinical visit or screening with the person to assess improvements in their health or chronic condition
- Sharing updated screening results collected by the clinical partner with the community partner

Due to resource constraints that limit shared technology solutions, organizations often must manually manage communication to close the loop. The workforce and time that are necessary to do this often limit the ability of partners to close the loop. Partners may explore different solutions depending on their available resources. Options include:

- Exchanging shared spreadsheets via encrypted email
- Sending secure messages via the clinical partner's EMR system
- Sharing logs or records via secured Smartsheet, SharePoint, or similar tools
- Using third-party commercial referral platforms with proper storage and security
- Using interoperable technology to exchange status updates across organizations' existing EMRs and program systems or databases (as available)

Closing the loop is a form of communication that benefits the people being served and the organizations working together to make positive health impacts more broadly in their communities. When partners choose to send status updates as part of their workflow, they should agree on a general timeframe for these updates to facilitate shared understanding and accountability.

▸ Send Status Updates to Coordinate Care and Advance a Person's Overall Health and Well-Being

While closing the loop is not essential to providing health care or community-based services, these status updates can be meaningful to create a more whole-person approach to care for a person's overall well-being. For example, when someone does not respond to a community organization reaching out to them after a referral, the health care provider may contact them to understand the reason and provide additional support and encouragement to participate in available programming and services, as appropriate.

Tip: Closing the loop can include sending quantitative data like A1C numbers or qualitative data such as brief, personal comments from individuals about the impact of the program or care they received. Closing the loop in these ways can communicate the value of programming and garner health care and community service provider buy-in for linkage efforts.

When a community partner notifies the health care provider that a person completed a program or service, they can have more informed and supportive conversations about the person's subsequent care or progress in addressing their health, chronic conditions, or social needs.

When a health care provider sends updates about changes in vital signs or screening results that show a person's success to prevent or better manage their chronic conditions, community organizations can better understand and articulate the tangible impacts they are making in their communities.

Data Elements and Communication Technology

Minimum recommended data elements for partners to exchange for this step will vary depending on the type of status update being provided and the organizational agreements in place. With any type of status update, partners should consider including:

- The person's first and last name, date of birth, and medical record number
- Activity status indicators, as defined by the partners and based on the type of status update
- The person's consent, preferably written, to exchange status updates

Supplemental data elements may include:

- Additional referrals or recommendations for follow-up care, programs, or services

Information Governance

Partners should ensure that all information exchanged in status updates is sent securely using a HIPAA-compliant method of communication, such as encrypted email and secure fax. Depending on the type of status update, different information will be exchanged, and different data policies or regulations may apply. If status updates are regularly exchanged, the recommended practice is for the clinical and/or community partner to get written consent from the person being served (versus oral consent only). Refer to the appendix, as well as your organization's administrative and legal teams, for further guidance.

Transition from Planning and Design to Implementation

After partners design a shared screening and referral workflow with agreed-upon activities and expectations for working together, they may proceed to the next phase of developing their linkage which is workforce adoption and engagement.

Phase 4:
Facilitate Workforce Adoption and Engagement

To successfully implement a screening and referral workflow, partners must provide initial training to their teams and regularly participate in quality improvement activities to improve shared practices as challenges or lessons learned arise over the course of the partnership. This ensures that workflows and best practices continue to serve both staff and people seeking care and services.

Initial Training and Technical Assistance

A trusted convener or backbone hub may work with organizations to determine what types of training, tools, or resources are needed to support their teams in adopting new workflows and practices. Options for training and resources may include:

- Developing a one-page handout to outline the goals (e.g., health priority to address), member organizations, roles, and activities of the partnership. This handout may also include an overview of the referral workflow, including links to a resource guide or directory, referral forms, or other applicable resources for staff.
- Designating a practice champion from each organization to act in a train-the-trainer model. The practice champion should be involved in the design of the screening and referral workflow and provide firsthand knowledge and instruction on how to implement the agreed-upon tools and practices.
- Recording training sessions or videos to be used as continued resource tools for new and experienced staff responsible for screening and referral activities.
- Sharing community program flyers with clinical partners so that health care providers and care coordinators can distribute them to people who are eligible.
- Inviting community and clinical partners on-site (e.g., team meetings or lunch-and-learns) to present about their programs and services or see them in action. In-person interactions are more memorable and can encourage staff to use new resources and referrals available through the partnership.

Ongoing Collaboration, Communication, and Decision-Making Processes

Partners should be intentional about creating space to connect and communicate with one another over the course of the partnership. While this may include virtual meetings or electronic correspondence, it is valuable to hold space in person to support continued relationships and collaboration.

At a minimum, monthly one-on-one partner meetings are recommended during the design and initial implementation of shared screening and referral workflows. After workforce training and adoption, partners should continue to meet regularly to ensure success. Options to consider include the following:

- Hosting annual or semiannual meetings for all partners to celebrate collective progress made toward goals and discuss challenges and opportunities for the future. These meetings may also be opportunities for new staff to meet and see the programs and services at partner organizations that they may not have seen before.

- Holding quarterly or semiannual one-on-one partner meetings to focus on more specific ideas, challenges, and opportunities relevant to their work together.
- Coordinating shared training to support continued knowledge and information sharing (refer to Address Structural Considerations for Long-Term Impact section)
- Attending each other's special events (e.g., community resource fairs) to support awareness across organizations.

Quality Improvement Activities

As partners work together, they may identify that workflows, tools, technology, or practices do not work as originally intended. A trusted convener or backbone hub may be best positioned to facilitate quality improvement efforts to refine these approaches over time. Plan-Do-Study-Act cycles and journey mapping are two approaches to consider. Partners should approach quality improvement from a person-centered perspective — thinking about the experiences of people being served and the workforce serving them.

Plan-Do-Study-Act Cycles

The Plan-Do-Study-Act (PDSA) cycle is a quality improvement approach that can work in a variety of settings. The PDSA cycle guides participants to set a defined goal for improvement and plan steps to work toward that improvement (plan), implement the agreed-upon steps (do), analyze the results (study), and refine or respond (act) to improve processes and workflows from those lessons learned.

In the context of community-clinical linkages, partners may set referral goals, such as referring at least 10 eligible people during the first month of implementation. When partners do not achieve their initial goals, the planning stage of the PDSA cycle brings partners together to reflect on what is working well and what specifically they would like to improve during the next stage of the PDSA cycle: doing. The study and act stages enable organizations to remain nimble and responsive to changing organizational or person- or community-centered needs.

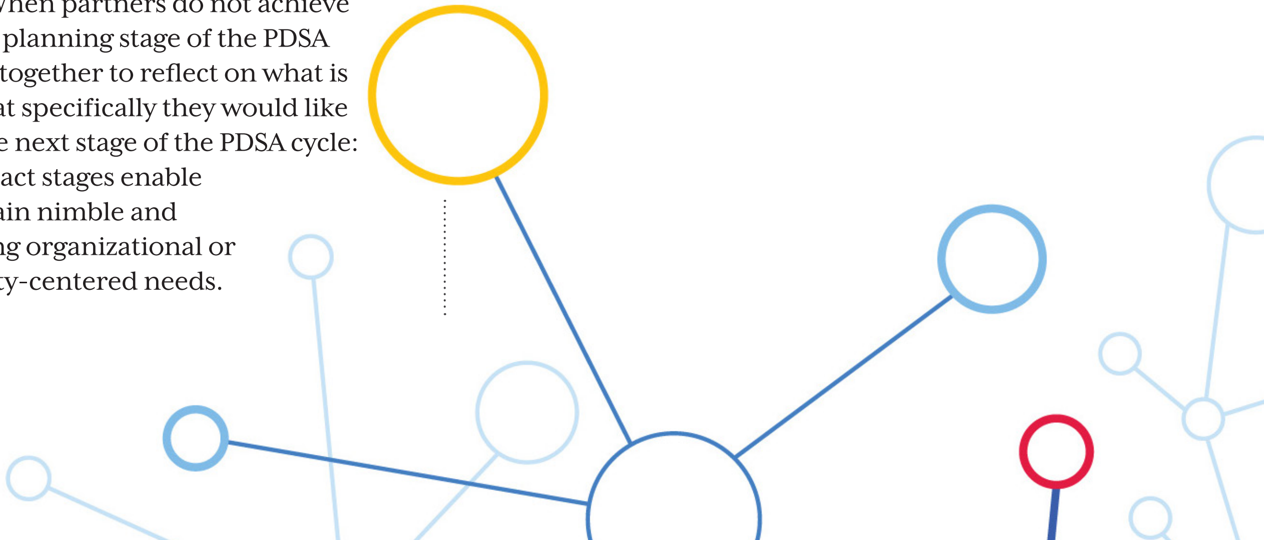
Journey Mapping

Journey mapping assists participants in adopting an empathetic mindset and emphasizes the human experience of providing or receiving services. Perspectives that may be taken into account include a person being served in a clinical or community setting, a health care provider, care coordination staff, or community organization program staff. Through a journey mapping exercise, partners are asked to think about the perceived actions, emotions, bright spots, and pain points of the person's experience.

Through this process, partners can identify opportunities to refine screening and referral practices to improve that person's experience. The outcome of journey mapping — identifying opportunities for improvement and agreeing on next steps — is important. However, active engagement in reflecting on a person's experience through an empathetic lens is also important from an equity perspective. By making continued commitments to shared learning and improvement, organizations can ensure they are making the greatest positive impact in their communities.

Call to Action

This toolkit is meant for organizations that are interested in collaborating across sectors to better care for and advance health in their communities. Community-clinical linkages are a powerful tool to increase people's access to programs and services that support overall well-being. By working together through collective commitments to health equity, addressing structural considerations for long-term impact, and developing shared workflows and best practices that consider workforce engagement needs, organizations can build stronger, more connected systems of care. Together, we can make a far greater impact on the lives of people being served and on population health.



Appendix: A Quick Guide to Data Elements, Information Governance, and Communication Technology

Data Elements

Data elements are the discrete information shared between partners to process referrals and coordinate care to connect people to desired resources and services. Data elements may include a person's name and contact information. Gathering data from people should not be transactional. Staff from these organizations (e.g., health care providers, care coordination staff, health coaches) should frame their conversations based on trust, shared understanding, and mutual support to meet the person's desired goals. To protect the privacy and security of people, only data that has a purpose in the screening and referral workflow should be stored and shared.

Partner organizations should exchange data elements based on standardized vocabulary, content standards, and structured formats whenever possible to reduce errors and make communications efficient and effective. The United States Core Data for Interoperability version 5 was released in July 2024 and can be used for many data elements to be exchanged. While more advanced interoperability vocabularies and content standards exist, such as Logical Observation Identifiers Names and Codes and Continuity of Care Document, these standards are not recommended for this work at this time. These standards are typically for communicating between health care organizations and their systems (and not used for community-clinical communication).

If national standards are not available for certain data elements, partners should consider identifying and adopting terms and definitions to improve communication (e.g., Person Enrolled in Program). When sending data for multiple people at a time, comma-separated values are a common format that most clinical and community systems can import and export.

Information Governance

Information governance consists of standard policies and procedures for using information in a responsible, agreed-upon manner, including adherence to legal and regulatory requirements. Information governance covers a wide range of processes related to obtaining and documenting consent, sharing and storing information securely, and establishing protocols and compliance on how data will be managed and shared. Partners should establish, document, and consistently follow clear data management and process protocols to make sure that responsibility for information is governed adequately throughout the workflow. An overview of data classifications is provided in this section to support organizations deciding what protocols to put in place. Organizations should consult their own administrative and legal teams for specific guidance.

Data elements can be classified based on regulations that govern their use by and exchange between organizations. The Health Insurance Portability and Accountability Act (HIPAA) of 1996 established national regulations to protect sensitive health information from disclosure without a person's consent. While clinical organizations are typically HIPAA-covered entities and community organizations are not, the best practice is for both types of organizations to follow HIPAA-compliant practices when establishing community-clinical linkages.

According to the U.S. Department of Health and Human Services (HHS), community organizations should enter into a written business associate agreement (BAA) with clinical organizations to support the privacy and security of people's data and to be in full compliance with HIPAA. Likewise, when organizations work with third-party technology vendors, a BAA should also be executed. These regulations cover the collection, storage, and transfer of sensitive information so that data is not intentionally or unintentionally disclosed or leaked.

Types of information that are used by and shared between organizations and people being served are subject to different levels of regulation. Data elements included in this toolkit may be classified as personally identifiable information, protected health information, or publicly available information. Personally identifiable information (PII) is any data that can be used to identify a person, such as a street address. Protected health information (PHI) is a specific type of PII that encompasses health-related data protected under HIPAA, such as a Hemoglobin A1c lab result. An example of public information would be the phone number for a community organization. To learn more about HIPAA, PHI, and PII refer to the HHS Summary of the HIPAA Privacy Rule and the National Institutes of Health Glossary.

In addition to federal privacy regulations, information governance also covers informal data sharing expectations and processes agreed to by partner organizations. This type of information governance would include which data elements should be shared and how quickly (e.g., within 48 hours). It also would include expectations about the frequency and accuracy of updating resource directory information by partners. These considerations should be collaboratively determined by partners.

Table 1. Minimum Recommended and Supplemental Data to Exchange via Community-Clinical Linkages to Coordinate Referrals and Services

Instructions: This table summarizes the types of data recommended to exchange between partner organizations to facilitate referrals and services. Use this table to see a consolidated view of the recommended data elements discussed in each step of the screening and referral workflow.

Key:

M = Minimum Recommended Data
S = Supplemental Data
<blank> = Not Needed
*As applicable for the organization/program

Data Element	Example(s)	Is this data PHI?	**Step 1.** Assess Individual Needs and Interest and Obtain Consent for Referrals	**Step 2.** Identify the Best Fit and Confirm Eligibility for Available Programming and Services	**Step 3.** Pass the Baton to Send, Receive, and Process Referrals	**Step 4.** Complete Outreach, Program Enrollment, and Service Delivery	**Step 5.** Close the Loop About Outreach Efforts and Program Outcomes
Personal Information							
First and Last Name	Michael Jones	YES	M		M	M	M
Date of Birth	4/3/1990	YES	M		M	M	M
Medical Record Number	98029384	YES			M	M	M
Preferred Language	English	NO	M	M	M	M	
Preferred Service Location	Neighborhood, City, or Specific Office Location (as available)	NO		M		M	
Preferred Type of Service Delivery	In-Person or Virtual; Individual or Group	NO		M		M	
Primary Email Address	mj@example.com	YES	M		M	M	
Primary Phone Number	123-456-0000	YES	M		M	M	
Alternate Email Address	mikej@example.com	YES	S		S	S	
Alternate Phone Number	123-456-1000	YES	S		S	S	
Home Address	12 River Rd., Broomfield, CO 80038	YES	S	S	S	S	
Home ZIP Code	80038	YES	S	S	S	S	
Home County	Broomfield	YES	S	S	S	S	
Latest Progress Note	<document>	YES	M	M	S*		
Latest Visit/Note Date	12/1/2024	YES	M	M			
Work Address	48 Meadow St., Aurora, CO 80040	YES	S	S	S	S	
Work ZIP Code	80040	YES	S	S	S	S	
Work County	Arapahoe	YES	S	S	S	S	
Primary Insurance (if available for billing)	Medicare	YES	S	M*	M*	M*	
Primary Plan Name (if available for billing)	BCBS Colorado	YES	S	M*	M*	M*	
Primary Plan Member ID (if available for billing)	98-437928	YES	S	M*	M*	M*	
Screening Results							
Lab Test Type	HbA1c	YES	M	M*	M*		M*
Lab Test Result	5.9	YES	M	M*	M*		M*
Lab Test Date	12/1/2024	YES	M	M*	M*		M*
Vital Signs	Blood Pressure	YES	M	M*	M*		M*
Vital Signs Result	135/85	YES	M	M*	M*		M*
Vital Signs Collection Date	12/1/2024	YES	M	M*	M*		M*
SDOH Screening	Food Insecurity Questions	YES	M	M*	M*		M*

Continued on next page

Key:

M = Minimum Recommended Data
S = Supplemental Data
<blank> = Not Needed
*As applicable for the organization/program

Data Element	Example(s)	Is this data PHI?	Step 1. Assess Individual Needs and Interest and Obtain Consent for Referrals	Step 2. Identify the Best Fit and Confirm Eligibility for Available Programming and Services	Step 3. Pass the Baton to Send, Receive, and Process Referrals	Step 4. Complete Outreach, Program Enrollment, and Service Delivery	Step 5. Close the Loop About Outreach Efforts and Program Outcomes
Individual Consent							
Consent Confirmation	Consent obtained (oral, written)	YES	M				M
Date of Consent Confirmation	12/15/2024	YES	M				M
Referral							
Program/Service of Interest	DPP, SMBP, food boxes	YES	M	M	M	M	
Care Coordinator Name and Contact Information	Linh Nguyen, lnguyen@example.org	NO					
Referring Provider Name	Elena Garcia, MD	YES			M		
Referring Facility	Family Health Clinic	YES			M		
Date of Referral	12/15/2024	YES			M		
Resource Directory: Community Partner Programs and Services							
Program and Service Options	DPP, DSMES, SMBP, food boxes	NO		M			
Current Program/Service Availability	Open; Closed	NO		M			
Type of Service Delivery	In-Person or Virtual; Group	NO		M			
Eligibility Criteria	HbA1c 5.7%-6.4%	NO		M			
Language Offerings	Spanish	NO		M			
Geographic Areas Served	Counties or ZIP codes listed	NO		M			
Service Locations (if applicable)	123 Main Street, Lakewood, CO	NO		M			
Insurance Accepted (if any)	Medicaid; BCBS	NO		M			
Email Contact	cp@example.com	NO		M			
Phone Contact	123-456-2000	NO		M			
Status Updates or Indicators							
Program/Service Enrollment Date	1/15/2025	YES					M*
Reason for No Enrollment	Cannot contact	YES					M*
First Class/Service Date	2/1/2025	YES					M*
Program/Service Completion Date	9/30/2025	YES					M*
Individual Outcomes (brief comments about challenges, successes, or impact of services for the person)	Increased self-reported confidence in managing their diabetes	YES					M*
Last Date of Services	3/25/2025	YES					M*
Follow-Up Comments for Future Care or Services	May benefit from additional nutrition counseling	YES					S*

Communication Technology

Communication technology refers to the methods partners use to share data elements with each other and the people they serve. All communication should be secure and adhere to HIPAA standards. While more advanced interoperability transport standards exist, such as [Fast Healthcare Interoperability Resource](), these standards are not recommended for this work at this time. These standards are typically for connecting health care organizations and their systems (and not used for clinical-community communication).

Refer to Table 2 for an overview of recommended communication technologies to use to exchange screening and referral data. These are divided into four tiers based on relative security and efficiency. The highest tier (Tier 4) represents the most advanced, secure, and efficient methods of data exchange:

- **Organizational Interoperability (Tier 4):** Secured centralized data platforms. Examples include EMR or electronic health record platforms including patient portals; interoperable third-party platforms (e.g. Findhelp, Phreesia, etc.).
- **Foundational Interoperability (Tier 3):** Secured data exchange systems. Examples include encrypted email, encrypted online forms (e.g. Smartsheet), and secure file transport protocol.
- **Secured Connectivity (Tier 2):** Secured messaging and communication. Examples include fax, encrypted texting (e.g. secure encrypted texting platform or application), and HIPAA-compliant video conferencing.
- **Unsecured Connectivity (Tier 1):** Unsecured messaging and communication. Examples include postal mail, phone calls, unencrypted texting, and unencrypted email.
    - Certified mail and/or mail with a signature receipt are considered HIPAA compliant.
    - Unencrypted texting can be HIPAA compliant but only in select circumstances, such as when a person initiates contact by text or requests communication by text after being informed of the risks. The person's consent must be documented. Health care and community service providers should not use personal devices when sending unencrypted texts.
    - There are very limited circumstances when unencrypted email can be used while adhering to HIPAA standards, such as obtaining consent from people to provide a referral or follow-up communication, for example.

Communication tier ranking order (Tiers 1-4) does not assume that higher tiers are preferred, especially for communication with people being served. In other words, while Organizational Interoperability (Tier 4) may be a long-term goal across partnerships, Tiers 1-3 may be more effective to successfully move through the screening and referral workflow depending on the partnership's available resources and technology. Finding the right balance depends on how each partnership sends and receives referrals.

This guidance and the recommendations outlined in Table 2 are based on the following resources and lessons learned from the Metro Denver Community-Clinical Linkages Network. Consult your organization's administrative or legal teams for final decision-making and direction for your activities: The HIPAA Journal, The HIPAA Guide, Healthcare Information and Management Systems Society, Inc. Interoperability in Healthcare, OpenLoop, and Healthcare Transformers.

Table 2. Recommended Communication Technology to Exchange Screening and Referral Data

Use this table as a reference to consider different types of communication technology that may be used to access and exchange data to provide referrals and services.

Workflow Step	Purpose of Data Being Accessed/Shared During This Step	Data Accessed/Shared Between	Recommended Tier of Communication Technology to Access/Share Data	Justification or Considerations for Recommended Tier	Example
Step 1. **Assess Individual Needs and Interests and Obtain Consent for Referrals**	Discuss screening and lab results, diagnoses, the person's needs and preferences for care or services; obtain consent to send referral(s)	Health Care Provider and the Person	Tier 2 - Secured Connectivity or Higher	While Tier 3 or 4 communication can also be used by providers, Tier 2 communication is recommended to maximize individual engagement if in-person visits are not possible.	Video conferencing
	Providers communicate with care coordination staff about the person's interest in a referral(s) for program(s) or service(s)	Health Care Provider and Care Coordination Staff	Tier 4 - Organizational Interoperability or Tier 3 - Foundational Interoperability	Providers may request that care coordination staff confirm the person's interest in referrals and obtain consent to send referrals (post-clinical visit), if there is limited time during the clinical visit (see workflow step below).	EMR platform messaging; HIPAA-compliant email
	Care coordination staff access and share registry lists of people potentially eligible and recommended for evidence-based programs (occurs post clinical visits; as an alternative option to live discussions during clinical visits		Tier 4 - Organizational Interoperability or Tier 3 - Foundational Interoperability		EMR platform messaging; HIPAA-compliant email
Step 2. **Identify the Best Fit and Confirm Eligibility for Available Programming and Services**	Use and update the community resource directory to understand available programs and services	Care Coordination Staff and Community Resource Directory	Tier 4 - Organizational Interoperability or Tier 3 - Foundational Interoperability	Tier 3 or 4 communication is recommended to ensure that multiple community organizations can collaborate on a single directory and manual errors are minimized	Third-party resource directory platform; HIPAA-compliant email
	Communicate with the person to identify available programs and services that meet their needs and preferences	Care Coordination Staff and the Person	Tier 2 - Secured Connectivity or Tier 1 - Unsecured Connectivity	Tier 1 communication should only be used to speak over the phone with the person or to convey general or non-personal information (e.g., if care coordination staff is speaking with the person outside clinical visits)	HIPAA-compliant texting; phone calls
Step 3. **Pass the Baton to Send, Receive, and Process Referrals**	Send referral(s) from a clinical setting to a community partner setting for processing	Clinical Organization and Community Organization	Tier 4 - Organizational Interoperability or Tier 3 - Foundational Interoperability	Tier 3 or 4 communication is recommended so there is a centralized repository and log of referrals sent and received between organizations	Third-party referral platform; HIPAA-compliant email
Step 4. **Complete Outreach, Program Enrollment, and Service Delivery**	Engage with the person to enroll them in and deliver programming and services	Community Organization and the Person	Tier 3 - Foundational Interoperability or Tier 2 - Secured Connectivity	Tier 2 or 3 communication is recommended because of the need for secure exchange of personal and confidential information with the individual	HIPAA-compliant email; video conferencing
Step 5. **Close the Loop About Outreach Efforts and Program Outcomes**	Send health and service status updates to inform and coordinate follow-up care and services with and for the person	Community Organization and Clinical Organization	Tier 4 - Organizational Interoperability or Tier 3 - Foundational Interoperability	Tier 3 or 4 communication is recommended so there is a centralized repository and log of health and service status updates for follow-up care and coordination as relevant	Third-party referral platform; secure online shared spreadsheet
	Follow-up communication with the person	Clinical Organization and the Person	Tier 2 - Secured Connectivity or Higher	While Tier 3 or 4 communication can also be used by clinical partners, Tier 2 communication is recommended to maximize individual engagement if in-person visits are not possible	Video conferencing; HIPAA-compliant texting

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