INTEGRATING SERVICES FOR COMMUNITY HEALTH:

A COMMUNITY-CLINICAL LINKAGES TOOLKIT FOR LOCAL WIC AGENCIES

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National WIC Association

Society for Public Health Education

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Table of Contents

Introduction

Intended Audience

This toolkit was specifically created for local WIC agencies aiming to create partnerships between community organizations and clinical settings. Others who might find this toolkit helpful include health care professionals, health education specialists, social workers, hospital benefit managers, and administrators working in clinics, community-based organizations or public health agencies.

How to Use This Toolkit

This toolkit can be used to help assess community gaps in preventive services, which can be addressed through partnerships and relationships that link community and clinical services. The toolkit provides a definition of community-clinical linkages, provides resources and questions to consider throughout the process of establishing new partnerships, and offers examples of successful linkages forged by WIC partners across the nation. Think of this toolkit as a starting point that can be used in conjunction with other materials.

Success stories used in this toolkit originated from CDC's National Implementation and Dissemination of Chronic Disease Prevention (NIDCDP) initiative. Launched in September 2014, NIDCDP is a three-year $28 million initiative to prevent and control chronic diseases through population-based strategies at the community level. The success stories reflect National WIC Association awardees from Cohort 1 of the project (January 2015- March 2016) who engaged in community-clinical linkages to improve access to chronic disease prevention, risk reduction, and management opportunities.

What are Community-Clinical Linkages (CCL)?

Community-Clinical Linkages (CCLs) are effective partnerships between the health care system, community-based programs, and public health agencies in order to support community access to resources that help prevent, manage or reduce risks of chronic diseases.

What are the Goals of a Community-Clinical Linkages (CCL)?

- Developing partnerships across public health, communities, and health care professionals.
- Promoting healthy behaviors and environments by coordinating health care delivery, public health, and community-based activities.
- Encouraging community engagement in coordinating services and developing linkages.

Why are Community-Clinical Linkages Important?

Relationship between the Patient Protection and Affordable Care Act & Community-Clinical Linkages

In 2010, the Patient Protection and Affordable Care Act (ACA) rolled out sweeping health care reforms in the United States. The ACA outlines essential health benefits, including certain preventive and wellness health benefits, which private health care insurance is required to cover[1]. The ACA also emphasizes the role of public health in the health care system by introducing a number of provisions to encourage collaboration between clinical care and public health[2]. In addition to preventive services for adults, women, pregnant women, and children, the law requires private and public plans to cover services such as evidence-based screenings and counseling[3]. Given this emphasis on prevention, WIC staff and clients can engage in many new community opportunities, and share experience and expertise to improve community health.

New Funding Streams for Preventive Health Projects

ACA includes public health-specific funding streams, such as the Prevention and Public Health Fund, to develop and implement disease prevention strategies. Federal agencies, including the Centers for Medicare and Medicaid Services and the Centers for Disease Control and Prevention, as well as state governments, are just a few of the entities funding projects related to community and clinical linkage programming. Many national, state, and local foundations also are supporting partnerships between health care and community service agencies.

- *Action: Find out if there are any funded projects or other existing health coalitions in your community. Get involved, or explore what other communities are doing and start your own project.*

Coverage of Preventive Health Services

Many health care plans cover preventive health services, such as comprehensive breastfeeding support and counseling from trained providers and access to breastfeeding supplies for pregnant and nursing women.

- *Action: Become involved with local and state coalitions to coordinate services and develop payment and service delivery infrastructure for expanded preventive health coverage. WIC has knowledge and community infrastructure to offer to potential partners, particularly related to nutrition and breastfeeding.*

Requirement to Assess Community Needs and Create Plans of Action

An ACA regulation requires that every three years each tax-exempt hospital must conduct a **community health needs assessment**[4]. Hospitals must include input from the community as well as create a plan to address the identified needs identified in the assessment. This is an excellent opportunity for WIC partners to collaborate with their local hospitals and begin developing essential linkages. The details of how to plan a community health needs assessment will be addressed in the next section.

- *Action: Contact your local non-profit hospital and inquire who is responsible for the Community Health Needs Assessment. Introduce WIC and offer ways WIC can be involved in addressing community needs.*

Emphasis on Accountable Care Organizations (ACOs)

The ACA encourages the development of accountable care organizations (ACOs), which are groups of coordinated health care professionals that collaborate to reach target health goals. ACOs should include partners within the community as well as clinicians[5].

- *Action: Discover if there is a local ACO and **get involved**!*

- *ACTION: Use your knowledge and expertise to become a community health advocate. Get involved with these important opportunities to improve the health of mothers, infants and youth!*

Additional Resources
- State Innovation Models Initiative: provides financial and technical support to states to address a variety of issues including Medicaid and CHIP costs.
- Prevention and Public Health Fund
- Women's Preventive Service Guidelines
- Affordable Care Act Rules on Expanding Access to Preventive Services for Women
- Information regarding the ACA for maternal and child health professionals can be found on the AMCHP website.

How CCL Can Help Advance the Goals of Health Equity

Health Equity is achieving the highest level of health for all people[6]. This principle values equality for all and emphasizes the need to address avoidable inequalities and injustices. Ultimately, the mission of health equity seeks to eliminate health and health care disparities. Developing community-clinical linkages is a valuable avenue to making progress towards this goal.

Community-clinical linkages help to identify gaps in services, most of which impact low-income individuals and racially and ethnically diverse communities. In a partnership between a community-based organization and a health care center, services can be provided to address health issues holistically. Health equity not only focuses on a person's health on a surface level, but also the underlying environment within which a person lives, works, plays, and worships. When addressing health equity, it is important to consider the priority population in relation to their:

- Availability of medical and financial resources
- Access to transportation
- Affordability of housing and food
- Community and environmental safety
- Cultural awareness and skills of their health care providers
- Level of health literacy and health numeracy
- Language and educational barriers

In addressing health equity, providers must consider how to care for people from all different walks of life, taking into consideration each person's race/ethnicity, religion, family history, sexuality, and gender. Other considerations include the mental and physical abilities of each person and his/her geographic location (i.e. urban, rural). All of these items influence and shape how, when, and where a person receives health and social services. Those forging community-clinical linkages need to consider how to influence and change the health equity environment in the target community.

Success Story

St. Tammany Parish Hospital Community Wellness Center in Covington, Louisiana implemented **Louisiana Well Ahead/Well Spot Designations**, reaching more than 300 designated spots in St. Tammany Parish. This initiative by the LA Department of Health and Hospitals aims to improve the health and wellness of Louisiana residents by promoting and recognizing healthy choices in public spaces. For more details on the initiative, visit the Well Ahead website: http://wellaheadla.com.

Getting Started

Assessment	Planning	Implementation	Evaluation	Dissemination
•Conduct a community health needs assessment	•Identify stakeholders to participate in developing goals, objectives and action plans	•Create a community resource inventory and identify referral systems	•Analyze the linkages and identify areas for improvement	•Share success with partners and the local community

Conducting a Community Health Needs Assessment

A **community needs and assets assessment** is a review of the health of a community by evaluating health status indicators. These may include the prevalence of chronic conditions and other information such as socioeconomic status and residents' use of and/or access to health services. Assessments consider barriers to care and access to preventive services, as well as individual, social, and environmental factors that influence health. This information can help identify the health issues, including alarming rates of specific diseases or a lack of access to an important resource in a community.[7]

What Should Be Considered in a Health Needs Assessment?

♦ **Define the Community[8]**
  - Communities can be defined in a variety of ways: by the characteristics of local residents, presence of a neighborhood commission or association, a census tract, a zip code, etc. It is important to define the community to determine the best methods to measure or assess this community.

♦ **Collect Data on the Community**
  - Work with clinics and community-based stakeholders to collect data on current referral resources (e.g., clinical assessment, provider surveys, focus groups, etc.)[9].
  - Collaborate with existing organizations or agencies that may also have data (both qualitative and quantitative information) regarding the community (i.e., local health departments).

♦ **Identify Critical Needs and Gaps in Services and Programming in the Community[6]**
  - See *Questions to Consider* (page 10) for more guidance about how to identify needs and gaps.

Success Story

Montgomery County, Maryland is saturated with primary care physicians, availability of preventive services and social programs. However, pockets of poverty rank the county at 39.22 on the disparity index according to its community health needs assessment. An index between 1-40 indicates the county experiences some disparity. CCI Health and Wellness (CCI) centers aim to reduce primary care access disparities. A large percentage of WIC participants are unaware that CCI can be their primary medical home that can address not only their need for WIC services, but also their primary care, behavioral health care, prenatal care, and dental services. A community health needs assessment helped to identify this gap in the community and sparked a linkage between WIC and CCI centers. CCI Health & Wellness, Inc. in Montgomery County created a Resource Navigator program to help connect individuals with chronic disease prevention services. The navigators work with families and bridge the gap between WIC and other preventive services, screen for food insecurity, identify food assistance programs, and provide application assistance for SNAP and other programs. There are resource navigators at 3 CCI-WIC locations, and they have linked hundreds of participants to primary and preventive services.

Additional Resources

- Association for Community Health Improvement's Community Health Needs Assessment Toolkit offers a nine-step pathway for conducting a CHA and developing implementation strategies.
- CDC's CHANGE Action Guide provides step-by-step instructions to assist with community assessments and developing action plans.
- CDC Tools for Community Health Improvement includes needs assessment materials.
- The National Association of County and City Health Officials' Resource Center provides practical, customizable tools and resources for local health departments (LHDs) and their partners in completing community health improvement processes.
- CDC Making the Case for Collaborative Community Health Improvement Stories provides hospitals examples of how they might engage in collaborative public health efforts.
- Community Commons, is a web-based tool, is designed to assist stakeholders in understanding the needs and assets of their communities, identify vulnerable populations, and map health indicators.
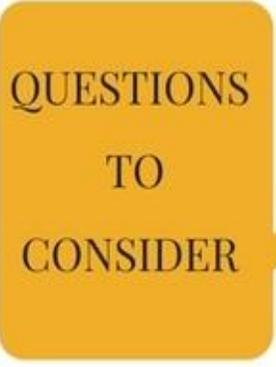
QUESTIONS TO CONSIDER

- How do you define community?

- What does your community do well?

- Where are some opportunities for growth in resources (e.g. shelters, schools, community centers) within your community?

- What resources are already in place in your community? Do they deal with the health issues about which you and your stakeholders are concerned?

- Is there a lack of health services and programming? If so, what can your organization provide to fill this gap?

- Are there language barriers that influence access and acceptability of available resources?

- Are services and programming offered in a location that is acceptable, accessible, and affordable for the community?

Developing Partnerships and Coalitions

Developing the partnerships that lead to successful CCLs often involves organizing or participating in coalitions. Coalitions provide a framework for collaborative, integrated efforts to create environments conducive to healthy lifestyles. They often work on **policy, systems, and environmental (PSE)** changes to modify the environment in order to increase access to healthful resources and reduce the barriers to a healthy lifestyle[10]. Coalitions can aid in further assessment of the community, highlight community resources, provide advice for methods and strategies to implement linkages, and provide feedback on the potential acceptability regarding linkage strategies.

Coalition members should be diverse, including representatives from a variety of sectors, organizations, and businesses that can be impacted by the change. The funding source or project requirements might dictate some sectors that should be represented in the coalition[11]. The following matrix provides examples of the various ways partners could work together.

To help you decide if you should form a coalition, see Is a Coalition Right for You?

Community-Clinical Linkages Stakeholder Examples	
Community Partners	**Clinical Partners**
Community Centers (Example: *A local recreation center offers cooking classes*)	**Hospitals** (Example: *A hospital works with a community partner to organize a health fair for all residents*)
University Programming (Example: *Extension programs offer nutrition or physical activity programs*)	**Pharmacies** (Example: *A local pharmacy offers nutrition counselors while individuals wait for prescriptions to be filled*)
Faith-Based Communities (Example: *Faith-based groups offer spiritually-centered stress reduction programs*)	**Primary Care Practices** (Example: *Local doctors work with a community partner to create a prescription pad referral program*)
Nonprofit Organizations (Example: *YMCA nutrition programs offer guidance on menu selection*)	**Health Care Specialists** (Example: *Health educators provide cultural competency training for health care providers*)
Public Libraries (Example: *Libraries offer nutritionist-led classes or collaborative learning sessions about food labels*)	**Clinical Training or Advocacy Groups** (Example: *Local public health chapters offer capacity-building trainings and resources for physicians, nurses, and other clinicians*)
Farmers Markets (Example: *Local WIC agencies work with special coupons or incentive programs to provide healthy foods to communities that lack access to grocery stores and fresh food*)	**Medical Schools** (Example: *Medical students partner with a local church to offer blood pressure screening and counseling sessions*)
Stakeholders who are able to provide clinical services in diverse settings	
Public Health Government Agencies *State or Local Health Departments*	
Federal Assistance Programs *WIC (Special Supplemental Nutrition Programs for Women, Infants and Children)*	
Community Pharmacists	
Community Clinics	

How to Partner with Stakeholders?

♦ **Engage stakeholders for the coalition[8]**
- Prepare a short, informative introduction about the need for a coalition.
- Use a variety of communication methods: email, social media, phone calls, and meetings.
- Be consistent in communications with stakeholders, and clearly outline expectations and the commitment/demands of participation.
- Involve coalition members in determining the location, timing, frequency and scope of meetings. For sustainability, it is important to maintain a manageable level of coalition engagement.

♦ **Use the community health needs assessment as a tool to develop the coalition[11]**
- The data collected or synthesized during the needs assessment can be used to engage the coalition or gain interest in joining the coalition. Coalition members or interested parties may also have additional data sources that they wish to contribute.

♦ **Identify partners or multi-sector collaborators to join the assessment and subsequent linkage development/implementation**
- Involve members of the defined community (i.e. those persons affected by health disparities) when developing a coalition. They are assets in guiding both the community assessment as well as in developing and implementing community-clinical linkages.
- Reach out to non-profit hospitals as potential coalition members. As discussed in the introduction of this toolkit, nonprofit hospitals must conduct community health needs assessments and engage other local partners and agencies to develop and implement a plan to meet the identified health needs.

♦ **Use existing frameworks and resources to develop the coalition**
- [Community Toolbox Section 5. Coalition Building](#)
- [Map My Community](#)
- [County Health Rankings & Roadmaps](#)

♦ **Move toward a model of partnership**
- Ideally, the coalition will move beyond cooperation, which may involve meeting attendance and shared resources, towards a partnership model. Partnerships involve shared implementation efforts with common goals and objectives and true collaboration efforts[12].

♦ **Develop a Memorandum of Understanding among partners**
- A Memorandum of Understanding (MOU) is a type of contract that indicates the goal of the partnership and the role of each partner. See the appendix in this toolkit for an MOU template.

Matrix of Strategies for Working Together[13]				
	Networking	**Coordinating**	**Cooperating**	**Collaborating**
Definition	Exchanging information for mutual benefit	Exchanging information for mutual benefit, and altering activities to achieve a common purpose	Exchanging information for mutual benefit, and altering activities and sharing resources to achieve a common purpose	Exchanging information for mutual benefit, and altering activities and sharing resources, and enhancing the capacity of another to achieve a common purpose
Relationship	Informal	Formal	Formal	Formal
Characteristics	Minimal time commitments, limited levels of trust, and no necessity to share turf; information exchange is the primary focus	Moderate time commitments, moderate levels of trust, and no necessity to share turf; making access to services or resources more user-friendly is the primary focus	Substantial time commitments, high levels of trust, and significant access to each other's turf; sharing of resources to achieve a common purpose is the primary focus	Extensive time commitments, very high levels of trust and extensive areas of common turf enhancing each other's capacity to achieve a common purpose is the primary focus
Resources	No mutual sharing of resources necessary	No or minimal mutual sharing of resources necessary	Moderate to extensive mutual sharing of resources and some sharing of risks, responsibilities and rewards	Full sharing of resources, and full sharing of risks, responsibilities and rewards

Success Story

Virginia's Cumberland Plateau Health District, in partnership with the Gathering Resources and Opportunities for Wellness (GROW) Coalition, formed a web-based resource guide to educate the community on the healthy eating, wellness, and social service opportunities in Russell and Tazewell Counties. These resources would be unknown to many without the existence of a guide to navigate the positive attributes of their rural landscape. The local library, social service agencies, school faculty, local farmers, and Master Gardeners have been indispensable in the resource guide development and implementation. A "train the trainer" module was conducted at a GROW coalition meeting to instruct community leaders on how to deploy the resource guide in their everyday interactions. Each local agency has been trained to use the GROW Southwest Virginia (SWVA) resource guide in ways that can positively affect their client population. Promotion and outreach has been completed in the form of billboards, newspapers, and physical reminders such as keychains to popularize and familiarize the GROW website in the community. Updates are regularly made to reflect new and changing information so the public can stay up-to-date with local events and health awareness practices. The coalition also worked with a software company to develop a mobile app for the GROW Southwest Virginia website.

Additional Resources

- Prevention Institute's Developing Effective Coalitions: An Eight Step Guide
- Coalitions Work has a variety of checklists, sample templates, and other resources to help build successful coalitions.
- A Spreadsheet Tool for Organizing Community-Clinical Linkage Partnerships
- National Institute for Children's Health Equality Community-Based Organization and Healthcare Professional Partnership Guide

- Who are your identified partners?
- What are the reflections of each partner regarding the community health needs assessment?
- What will each partner contribute to the linkage and why?
- What resources (e.g., staff, materials, funding) will each partner provide to the linkage?
- What are the goals of the partnership?
- What are the intended short/ intermediate/ long-term impacts of the partnership?
- At what stages will partners become involved?
- What are some foreseen strengths and barriers to developing this partnership?

Developing CCL Goals, Objectives & Action Plans

Now that you have identified stakeholders and completed the community health needs assessment, you need to create goals for community-clinical linkages as well as SMART objectives and action plans.

♦ **Goal**: A broad statement of a desired, long-term outcome of a program or project (not always measurable). Each goal has a set of related, more specific objectives – related to the ultimate impact for the program/project.

   o Example: To improve nutrition of pregnant and new mothers

♦ **Objectives**: Specific statements detailing the desired or expected achievements/outcomes of a program or project. They should be measurable and have directional improvements (reduce/increase). Use the SMART criteria to help you create objectives.

The objective above used the SMART criteria.

- **Specific:** State exactly what you want to accomplish (Who, What, Where, Why)
- **Measurable:** How will you demonstrate and evaluate the extent to which the goal has been met?
- **Achievable:** stretch and challenging goals within ability to achieve outcome. What is the action-oriented verb?
- **Relevant:** How does the goal tie into your key responsibilities? How is it aligned to objectives?
- **Time-bound:** Set 1 or more target dates, the "by when" to guide your goal to successful and timely completion (include deadlines, dates and frequency)

Is the objective below SMART?

To increase the percentage of new mothers in Baltimore City who improve their access to postnatal care and breastfeeding support post discharge from the hospital.

♦ **Action Plan:** Action plans help outline steps that need to be taken in order to meet the linkage's goals. A good action plan will follow the 3 C's -- complete, current and clear[14].

- *Complete*: Does it list all the needed steps?
- *Current*: Does it reflect what the organizations are doing now? What barriers or opportunities does the partnership foresee?
- *Clear:* Are roles identified and agreed upon? Who will manage conflict?

Action plans should refer to specific activities required to achieve objectives. They do not demonstrate that a program or project has improved and only indicate what programming needs to be undertaken.

⇨ Example: Conduct nutrition workshops for women receiving WIC in local OBGYN clinics

Be sure to identify information or data now that will help you during evaluation. Do you need to collect a baseline survey? How many people do you need to target? How will you test that the target population engaged in the desired outcome (e.g., survey, interviews)?

Additional Resources
- SMART Objectives Worksheet
- Action Plan Examples and Resources

Success Story

As a result of their community needs assessment, Oceana County, a small rural area of western Michigan, identified high rates of obesity, heart disease and other chronic diseases among its local residents. In 2015, the county set out to tackle preventable chronic diseases through a variety of strategies, including CCL, in partnership with the National WIC Association (NWA). Through this partnership, Healthy Families of Oceana County (HFOC) was created, representing a community coalition of 30 representatives from 16 local agencies/organizations aiming to increase access to healthy foods and clinical services. This coalition brought together partners from across the community, and represents a variety of sectors and leadership from the county to link residents to the preventive services and healthy behaviors needed to prevent chronic disease.

QUESTIONS TO CONSIDER

- Do the goals and objectives of your organization match the ones of the partnership?
- Did you consider the SMART framework in developing your objectives?
- What activities are needed for the short-, intermediate- and long-term?
- How will you evaluate the program? What data and qualitative information will you need to collect?

Implementing Your Plan

Community-clinical linkages are developed through a variety of mechanisms, including but not restricted to: enhanced coordination efforts, resource mapping and collaboration/sharing, and patient referral or tracking systems to improve the management of chronic conditions.

Community Resources Inventory

Understanding resources that exist in a community is a critical step in developing linkages. Available resources or services (e.g., exercise classes, blood pressure screenings, nutrition lessons, diabetes

17

counseling, and cooking classes) may be underutilized due to a lack of awareness. Create an inventory that outlines all of the resources available in the community. Be creative in developing methods to collect information, update the assets and resources inventory, and disseminate this information to community partners, stakeholders, and residents.

- ♦ **Brainstorm ideas for developing a tool to raise awareness about community and clinical resources:**
  - o Create a web-based, interactive map or phone application highlighting resources by service category, location, language accessibility, or other classifications to make it easy for residents to navigate. Check out how the Cumberland Plateau Health District created a mobile app: http://growswva.wix.com/growswva

  - o Identify databases for public health organizations or clinical providers to use, or have their affiliates/staff (e.g., public health nurses, health education specialists, community health workers) recommend preventive care or health promotion resources to patients or clients.

- ♦ **Create a user-friendly way to share community and clinical resources with all stakeholders.** Using the data from the inventory that was developed, create an innovative tool to share this information.

- ♦ **Pilot-test resources developed with a diverse sample of the target audience to ensure usability and understandability.**

- ♦ **Consider developing companion tools for professionals making referrals, such as health care providers.** For example, develop a prescription pad referral program for providers to use in recommending healthy behaviors or supporting behavior change.

- ♦ **Train and utilize referral navigators** to work in clinical settings or in strategic community points (i.e., local libraries, grocery stores, churches). The referral navigators can be community health workers[15], or representatives of the community that follow up with patients or community members regarding the status of referrals, assist with signing up for programs/resources, and provide general support to link individuals to beneficial services.

- ♦ **Determine the mechanism you will use to track these resources and keep your inventory of community assets and resources updated.** Organizations, businesses, and associations are difficult to track over time due to location and contact name changes. Existing resources close or modify their services, and new resources surface. It is important to have an *inventory sustainability plan* in place to keep the contact list up-to-date.

Introduction to Referral Systems

Once the resources and assets have been identified and mapped for a community, the next step is to integrate services and develop referral systems to guide community residents to health promotion resources. Following are three referral system mechanisms for your consideration:

- **Bi-directional Referral Systems** are mechanisms to refer patients from a clinical setting to a public health or community resource. They also have the ability to refer a client from a public health or community resource to primary care health services. Bi-directional referrals can be done through formal and informal processes.

- **Formal Processes Referral Systems** involve modifying Electronic Health Records (EHRs) to prompt a physician to ask specific questions that can lead to discussions about health behaviors and trigger referrals to applicable health promotion partnership programs and resources. Incorporating referral mechanisms into an EHR is an ideal method of implementing a CCL. EHR inputs are a natural part of the workflow for many health care providers. These systems also have the potential for robust referral tracking and monitoring, reducing the burden of new work processes. However, adapting EHRs can take considerable time and financial resources.

- **Informal Processes Referral Systems** incorporate referral mechanisms without use of EHR or other existing electronic patient tracking systems. These types of referrals are often used when minimal resources are available.

Success Story

During Cohort 1 of NWA's CPHMC project, six agencies— East Side Health District (East St. Louis, Illinois), Angelina County and Cities Health District (Lufkin, Texas), District Health Department #10 (Oceana County, Michigan), Gateway CAP (Camden, New Jersey), Wichita Falls-Wichita County Public Health District (Wichita Falls, Texas), and Richmond City Health District (Richmond, Virginia)—developed green prescription pads that included a screening system for food insecurity, breastfeeding support, physical inactivity, and/or medical risk. The pads were distributed in a variety of settings, including through health care providers, Head Start, social service programs, grocery stores, and military bases. Using the pad, care providers made "prescriptions" for fruits and vegetables, physical activity, adequate sleep, adequate water consumption, and referred clients to WIC. For more information see Greater with WIC website.

Additional Resources
- Minnesota Department of Health, Statewide Health Improvement Program developed a CCL for prevention implementation guide.
- National Association of Chronic Disease Directors Bi-Directional Referral System Strategies and Resources

QUESTIONS TO CONSIDER

- Do you have resources available for a formal or informal referral system?
- Who will be in charge of the referral system? Who will refer and who will receive referrals?
- How will you monitor the referral system?
- Are there opportunities for client feedback on the referral system?
- Could any stakeholder help establish this referral process?

REFERRAL SYSTEMS			
LEVEL OF RESOURCES	**PROS**	**CONS**	**EXAMPLES**
More Resource Availability (often uses a formal process)	• May have access to systems like an EHR that are already a natural part of a health care provider's workflow • Can establish a new system if one does not exist • Provides flexibility in providing various types of referral resources to clients	• Modifying EHR may require substantial technical assistance or contractors each time a change is necessary or required • The timeline required to update an EHR can lengthy and referral programs or screening questions may change before the EHR update takes effect • Resources may be needed to be used on other tasks	When resources are more available in the linkage, it can be easier to refer individuals to various programs based on electronic health records. For example, if a patient smokes and a physician documents that on the record, then a note could appear when compiling discharge papers. This note could signal and remind the health facility that a smoking cessation program is needed post-discharge.
Minimal Resources (often uses an informal process)	• Requires more innovation to develop referral programs with minimal resources • Uses already established resources • May take a more interpersonal approach to referring individuals to programs	• May require substantial training of clinical staff or place burden on already over-worked employees to implement • Difficult to track the number of referrals or other outcomes to measure the success of referral programs	Minimal resource referral systems may rely on paper-based templates, such as health promotion flyers given to targeted patients or prescription pad referral programs • a patient that smokes is given a flyer for a local health department smoking cessation class • a sedentary patient is prescribed a YMCA exercise program

Evaluation

An **<u>evaluation</u>** helps identify the strengths and weaknesses of a linkage and identify opportunities for improvement. With evaluations, partners can identify quality improvements to make the system as useful as possible while achieving the identified goals. In addition, to promote sustainability of the linkage, it is important to examine the benefit the program had on the priority population as well as the linkage itself. Oftentimes when evaluating a partnership, evaluators fail to identify strengths and weaknesses of the linkage and its impact on the program results.

Prior to a community-clinical linkage being implemented, stakeholders should identify a mix of process, impact, and outcome indicators that will be used to evaluate the linkage. Developing an evaluation framework prior to implementation and dissemination is necessary to help advance the understanding of what needs to be evaluated and why. It is important to monitor the linkage's progress and challenges in order to develop a more robust evaluation[11]. Monitoring is an ongoing event, whereas evaluations often occur at the end of the project and program.

Recommendations for Evaluating Community-Clinical Linkages

♦ **ESTABLISH** short-, intermediate-, and long-term outcomes based on the intervention prior to beginning the formal linkage
♦ **CLARIFY** details about data collection
♦ **ENGAGE** stakeholders in the evaluation process and consider how they view evaluations and their communication styles
♦ **COLLECT** data in both clinical and community settings
♦ **FOCUS** on the linkage by:
  o Improving coordination of systems
  o Enhancing referral and tracking mechanisms
  o Promoting resource sharing

Additional Resources
- [Clinical–Community Relationships Measures Atlas](#)

- [Clinical–Community Relationships Evaluation Roadmap](#)

- [Robert Wood Johnson Foundation's Practical Guide for Involving Stakeholders in Developing Evaluation Questions](#)

- CDC's Evaluation [Steps](#) and [Standards](#)

- What information will be collected for evaluation? What resources are needed to facilitate this process?
- Who will collect the data?
- Why is the linkage collecting this data? What purpose and answers will it provide that can lead to quality improvement?
- When will the information be collected?
- How will the information be collected, recorded and disseminated?

Dissemination of Your Results

Dissemination of the new partnership or CCL can occur via meetings, reports, flyers, and news releases. Social media — Facebook, LinkedIn, Instagram, and Twitter – also are vital tools and can be targeted to the specific population to be reached. Once the project evaluation is complete, consider using the data to develop a formalized report, journal article and/or conference presentation. Websites can be helpful platforms to consistently promote and transmit information to partners and stakeholders. Make sure to share your results with the National WIC Association and the Society for Public Health Education!

Tips for Social Media

Social media can be a useful tool to disseminate results, but there are a few tips to keep in mind[16]. Messages should be:

- Clear and easy to understand

- Targeted (Who do you want seeing this information?)

- Actionable (Go to the referral clinic, "like" our link)

- Repeated if possible (It is okay to share the same post a couple times in a week)

Sharing Your Linkage Progress and Success

Narratives are a useful mechanism for engaging audiences because they guide a reader through concrete examples and stories of experience or success[17]. Narratives can spread news of progress with community-clinical linkages, and provide recommendations to others aiming to implement linkages in their own communities. Consider sharing success stories about promising community-clinical linkages programs or strategies with community partners, coalition members, project steering committees, the media, policy makers and other potential partners.

Share with National WIC Association

Write to the National WIC Association so the organization can promote your success in its newsletters and/or social media. You can write to NWA's Program Associate, Elisabet Eppes, at eeppes@nwica.org.

Share with the CDC

The CDC's National Center for Chronic Disease Prevention and Health Promotion created a database of success stories, which highlight inspiring examples of chronic disease prevention including community-clinical linkages narratives. The CDC also created "**The Success Stories Application**" to help communities share their results nationally. The application includes templates and other helpful tools to share your experiences.

Appendix

Brief Glossary of Terms

Bi-directional referral systems are mechanisms to refer patients from a clinical setting to a public health or community resource, and also have the ability to refer a client from a public health or community resource to a primary care health services.

Community-clinical linkages are effective partnerships between the health care system, community-based programs, and public health agencies that support community access to various health resources.

Community health needs assessments (CHNAs) provide opportunities for hospitals to engage other local partners and agencies, such as health departments, to assess community health.

Community needs and assets assessment is a systematic review of the health of a community by reviewing health status indicators.

Evaluation is a systematic way of observing the program and identifying ways to improve.

Formal processes referral systems involve modifying Electronic Health Records (EHRs) to prompt a physician to ask specific questions that can lead to discussions about health behaviors and trigger referrals to applicable programs and resources.

Health equity is achieving the highest level of health for all people.

Informal processes referral systems incorporate referral mechanisms without use of an EHR or other existing electronic patient tracking systems.

Policy, systems, and environmental (PSE) change is a public health intervention to modify the environment to increase access to healthful resources and reduce the barriers to a healthy lifestyle.

Acronyms

CDC	Centers for Disease Control and Prevention
CCL	Community-Clinical Linkage
CHNA	Community Health Needs Assessments
EHR	Electronic Health Records
HFOC	Healthy Families of Oceana County Coalition
MOU	Memorandum of Understanding
NWA	National WIC Association
PSE	Policy, Systems, and Environmental (change)
SMART	Specific, Measureable, Achievable, Realistic, Time-bound
SOPHE	Society for Public Health Education
WIC	Special Supplemental Nutrition Program for Women, Infants and Children

<h1 style="text-align:center">Sample Memorandum of Understanding</h1>

THIS Memorandum of Understanding ("MOU") is made this _____ day of _____, 20__, by and between the members of _____ coalition to support work related to improving community-clinical linkages.

I. PURPOSE

This agreement is made in order to define the relationship between coalition partners and to outline the respective roles and responsibilities of each entity engaged in improving our community's health by strengthening community-clinical linkages.

Coalition members share the primary goal to improve the public's health and promote equity in health status for all. Parties enter into this agreement understanding that its provisions will contribute to the capacity of all organizations by strengthening the foundation for mutual support, accountability and partnership. Coalition members do this through the collaborative use of expertise, influence, and resources to grow stronger as organizations and to promote shared priorities in the areas of planning and public health.

II. RESPONSIBILITIES

Please list general membership responsibilities.

For example:

- *ABC organization will provide evaluation support to the coalition;*
- *EFG organization will provide insights and perspective for __X__ sector/group*
- *XYZ organization will provide meeting management support to the coalition.*

IN WITNESS WHEREOF, the parties hereto have caused this MOU to be executed by their duly authorized officers, effective as of the day and year first written above.

_____   _____

Signature   Date   Organization (if applicable)

_____   _____

Signature   Date   Organization (if applicable)

_____   _____

Signature   Date   Organization (if applicable)

Summary of Questions to Consider for Developing Community-Clinical Linkages

I. **Conducting a Health Needs Assessment**
    A. How do you define community?
    B. What does your community do well?
    C. Where are some opportunities for growth in resources within your community?
    D. What resources are already in place in your community? Do they deal with the health issues about which you are concerned?
    E. Is there a lack of health services and programming? If so, what can your organization provide to fill this gap?
    F. Are there language barriers that influence access and acceptability of available resources?

II. **Developing Partnerships and Coalitions**
    A. Who are your identified partners?
    B. What are the reflections of each partner regarding the community health needs assessment?
    C. What will each partner contribute to the linkage and why?
    D. What resources (e.g., staff, materials, funding) will each partner provide to the linkage?
    E. What are the goals of the partnership?
    F. What are the intended short/ intermediate/ long-term impacts of the partnership?
    G. At what stages will partners become involved?
    H. What are some foreseen strengths and barriers to developing this partnership?

III. **Developing CCL Goals, Objectives & Action Plans**
    A. Do the goals and objectives of your organization match the ones of the partnership?
    B. Did you consider the SMART framework in developing your objectives?
    C. What activities are needed for the short-, intermediate- and long-term?
    D. How will you evaluate the program? What data and qualitative information will you need to collect?

IV. **Implementing Your Plan**
    A. Do you have resources available for a formal or informal referral system?
    B. Who will be in charge of the referral system? Who will refer and who will receive referrals?
    C. How will you monitor the referral system?
    D. Are there opportunities for client feedback on the referral system?
    E. Could any stakeholder help establish this referral process?

V. **Evaluation**
    A. What information will be collected for evaluation? What resources are needed to facilitate this process?
    B. Who will collect the data?
    C. Why is the linkage collecting this data? What purpose will it have in driving the evaluation?
    D. When will the information be collected?
    E. How will the information be collected, recorded and disseminated?

Other Resources

*   [Linkages Between Clinical Practices and Community Organizations for Prevention](#)

References

[1] Kaiser Family Foundation. (2015). Preventive Services Covered by Private Health Plans under the Affordable Care Act. Retrieved from http://kff.org/health-reform/fact-sheet/preventive-services-covered-by-private-health-plans.

[2] Bovbjerg, R., Ormond, B., & Waidmann, T. (2011). What Directions for Public Health under the Affordable Care Act? *Health Policy Center: Urban Institute*. Retrieved from http://www.urban. org/research/publication/what-directions-public-health-under-affordable-care-act.

[3] Kaiser Family Foundation. (2015). Preventive Services Covered by Private Health Plans under the Affordable Care Act. Retrieved from http://kff.org/health-reform/fact-sheet/preventive-services-covered-by-private-health-plans.

[4] Hootman, J., Brault, M., Helmick, C., Theis, K., & Armour, B. (2009). Prevalence and Most Common Causes of Disability Among Adults—United States, 2005. *MMWR*, *58*(16), 421–426.

[5] Minnesota Department of Health. (2013). Statewide Health Improvement Program. Retrieved from http://www.health.state.mn.us/healthreform/ship/2013rfp/docs/healthcare_SHIP_3.pdf.

[6] Healthy People 2020. (2016). Disparities. Retrieved from https://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities.

[7] CDC. (2015c). What is a Community Health Assessment? Retrieved from http://www.cdc.gov.proxyum. researchport.umd.edu/stltpublichealth/cha/plan.html.

[8] Sequist, T. D., & Taveras, E. M. (2014). Clinic–Community Linkages for High-Value Care. *New England Journal of Medicine*, *371*(23), 2148–2150. Retrieved from http://doi.org/10.1056/NEJMp1408457.

[9] CDC. (n.d.). Developing Community-Clinical Linkages for WISEWOMAN Programs. *CDC NCCDPHP*. Retrieved from http://www.cdc.gov.proxyum.researchport.umd.edu/ wisewoman/docs/ww_brief_developing_community-clinical_linkages.pdf.

[10] Gregson, J., Foerster, S. B., Orr, R., Jones, L., Benedict, J., Clarke, B., … Zotz, K. (2001). System, Environmental, and Policy Changes: Using the Social-Ecological Model as a Framework for Evaluating Nutrition Education and Social Marketing Programs with Low-Income Audiences. *Journal of Nutrition Education*, *33*, *Supplement 1*, S4–S15. http://doi.org/10.1016/S1499-4046(06)60065-1.

[11] Miller, K. (2016). *Bridging Communities to Chronic Disease Prevention Opportunities: The Role of Needs Assessments and Community Coalitions*. [Powerpoint Slides].

[12] Primary Care and Public Health: Exploring Integration to Improve Population Health. (2012). Retrieved from http://iom.nationalacademies.org/Reports/2012/Primary-Care-and-Public-Health.aspx.

[13] Himmelman, A. (2002). Collaboration for a Change: Definitions, Decision-Making Models, Roles, and Collaboration Process Guide. Retrieved from https://depts.washington.edu/ccph/pdf_files/4achange.pdf.

[14] Community Toolbox. (2016). Section 5. Developing an Action Plan. In *Developing a Strategic plan and Organizational Structure*. The University of Kansas. Retrieved from http://ctb.ku.edu/en/table-of-contents/structure/strategic-planning/develop-action-plans/main.

[15] CDC NCCDPHP. (2015). Addressing Chronic Disease through Community Health Workers: A Policy and Systems-Level Approach (Second Edition). Atlanta, GA. Retrieved from http://www.cdc.gov.proxy-um.researchport.umd.edu/dhdsp/docs/chw_brief.pdf.

[16] AHRQ. (n.d.) Quick-Start Guide to Dissemination for Practice-Based Research Networks. Retrieved from https://pbrn.ahrq.gov/sites/default/files/AHRQ%20PBRN%20Dissemination%20QuickStart%20Guide_0.pdf.

[17] Thompson, T., & Kreuter, M. W. (2014). Using Written Narratives in Public Health Practice: A Creative Writing Perspective. *Preventing Chronic Disease*, *11*, E94. Retrieved from http://doi.org/10.5888/ pcd11.130402.