American Heart Association.

Community-Clinical Linkages Playbook

Contents

Executive Summary

Community-Clinical Linkages are connections between clinical and community sectors to improve population health. They are relationships — a collaborative approach that bridges healthcare and community resources to help prevent and control chronic diseases, such as hypertension. Community-Based Organizations (CBOs) can identify people with high blood pressure and connect them to Health Care Organizations (HCOs) to manage hypertension. The graphic below summarizes the core components.

Community-Clinical Linkages

Determine Internal Readiness

Organizations can take an assessment to determine their internal capacity, alignment, and commitment to ensure their efforts are strategic, sustainable, and responsive to community needs.

Assess and Formalize Partner Relationships

Use this tool to determine the best partnerships. Once a shared interest in collaboration is established, formalizing the relationship helps ensure accountability and sustainability.

Design Screening Process

CBOs should set up a blood pressure self-management station that's accessible and easy to use. Ensure staff are trained.

Create the Referral Process and Feedback Loop

Referrals are most effective when they are warm handoffs, culturally and linguistically appropriate and closed-loop referrals. Patient navigation closes care gaps and improves outcomes.

Evaluate and Share Outcomes

Effective tracking of outcomes and referrals ensure patients receive timely, coordinated care and organizations identify areas of improvement.

Introduction

The Community-Clinical Connections Linkages Playbook (Playbook) is a practical guide for people and organizations working in community-based and clinical settings who encounter people with high blood pressure. Nearly half of adults in the United States have high blood pressure, and many are unaware of their condition. Alarmingly, fewer than half of those diagnosed have their blood pressure under control.[1]

Community-based blood pressure self-measurement stations empower people — whether diagnosed or undiagnosed with hypertension — to check their blood pressure using free, publicly available, validated devices. Community-based blood pressure stations provide access to people to monitor their readings for self-management and can prompt people with high readings to seek more timely medical support.[2] While this Playbook centers on blood pressure, many of its principles can be applied to other health concerns, such as food insecurity, diabetes, tobacco use, and blood glucose screening and referrals.

This Playbook is intended for a wide range of professionals, including public health practitioners, librarians, social service staff, school personnel, clinic staff (both medical and non-medical), care coordinators, and community health workers. Its goal is to foster collaboration between community and clinical sectors, helping each understand the other's role and work together using best practices to address interconnected health needs.

Inside, you'll find background information, evidence supporting community-clinical linkages, planning guidance, recommended processes, staff training considerations, and case examples. Additional educational materials and resources are in the appendix.

To quickly find information about your sector, look for the following icons throughout the Playbook:

Foundational Concepts

Key Definitions

Throughout this playbook, the following terms are used to describe components of community-clinical linkages:

Community-Clinical Linkages (CCLs)

Clinical and community sectors to improve population health. They are relationships — a collaborative approach that bridges healthcare and community resources to help prevent and control chronic diseases. Research shows that community-clinical linkages can enhance outcomes related to heart disease, blood pressure, diabetes and cholesterol and support behavior changes in areas such as nutrition, physical activity, and smoking cessation.[3]

Community Sector

Organizations that serve community members outside of traditional health care settings including nonprofit organizations (e.g., YMCAs), faith-based groups, barbershops, salons, libraries, food pantries and community centers like senior centers or parks and recreation facilities.

Clinical Sector

Organizations that serve patients in health care settings. In the context of hypertension, these include primary care practices, including Federally Qualified Health Centers (e.g., community health centers, migrant health centers), rural clinics, and specialty care settings, such as cardiology, endocrinology, and hospitals.

Evidence on Community-Clinical Linkages

When community and clinical sectors collaborate rather than operate in isolation, they can improve health outcomes. These partnerships ensure that people at risk of chronic conditions have access to the resources and services needed to support their health and well-being.[3,4]

CCLs have been shown to improve outcomes in hypertension control, cholesterol management, and diabetes prevention and care. They also support improvements in nutrition, physical activity, medication adherence, and smoking cessation.

Community-based organizations play a vital role by offering preventive services and addressing non-medical drivers of health. Trusted community-based and health care organizations are ideal partners, especially those with community health workers who can build strong relationships and facilitate connections with clinical health care professionals. Integrating community resources into patient care plans can enhance chronic disease management and overall well-being.[5-9]

Each sector — community, clinical, and public health — plays a vital role in creating seamless community-clinical connections for people.

Section 1: Determine Internal Readiness

This section offers practical guidance on:

- **Organizational self-assessment and readiness**

Key Readiness Indicators

Before launching any community-clinical initiative, organizations must assess their internal capacity, alignment, and commitment. This step ensures that efforts are strategic, sustainable, and responsive to community needs. Use these prompts to evaluate your organization's preparedness. Consider having someone from each team in your organization self-score (1=not ready; 5=very ready) and identify gaps and then discuss as a group.

Criteria for Assessing Internal Readiness to Support a Community-Clinical Linkage

	Internal areas of readiness	Rating (1-5)	Gaps
Leadership buy-in	There is visible support from senior leadership for cross-sector collaboration and a champion identified.		
Strategic alignment	Community-clinical connections align with our mission, values, and strategic goals.		
Staff capacity	There are dedicated staff or champions who can lead and sustain the effort, including providing and receiving referrals.		
Data collection infrastructure	Our organization already collects, shares, and acts on relevant health and social data.		
Built infrastructure	There is room to create a dedicated space for a blood pressure self-management station. (Note: community organizations only)		
Partnership experience	Our organization has previously worked with other sectors (e.g. community-based organizations or clinical partners).		
Funding flexibility	There is budgetary room, grant funding or potential to support partnership activities.		

If readiness is low in one or more areas, consider starting with small pilots, internal education, or stakeholder engagement to build momentum.

Section 2: Assess and Formalize Partner Organization(s)

This section offers practical guidance on:

- **Identifying potential partner organization(s)**
- **Defining internal roles and responsibilities**
- **Formalizing relationships to support effective linkages**

Identifying Partner Organizations and Continuums of Engagement

- Levels of Community-Clinical Linkages with Stakeholders (pgs. 6-8)
- How to Identify and Engage Key Stakeholders (pgs. 12-14)

Community and clinical sectors often operate independently. Health care organizations may be unaware of the community programs and services that can support their patients and vice versa. Building cross-sector relationships helps mobilize local resources, improve access to care, and strengthen community ties.

Establishing an impactful and sustainable partnership begins with assessing whether your partner organization is prepared to support a community-clinical linkage. Strong partnerships enable coordinated care, improved health outcomes, and shared accountability — especially important when addressing complex conditions such as hypertension.

Use the following criteria to evaluate an organization's readiness to participate in a community-clinical linkage.

Criteria for Identifying Organizations That Can Support a Community-Clinical Linkage

	Areas of readiness	Rating (1-5)	Gaps
Individual level	There is a champion or strong leadership to oversee a community-clinic linkage at each organization.		
Institutional level	The organization's resources are easily available.		
	The organization's resources are perceived as credible or valuable to patients/community members.		
	The community and clinical organizations are in close geographic proximity to each other.		
	In the clinical setting, patient risk screening is quick and easy.		
	There is a way to receive and make referrals, ideally using technology.		
	Funding is stable or there is a potential to strengthen funding through community-clinic linkage.		
Community level	The organization has previously worked with another sector.		
Policy level	There is a policy or mandate requiring collaboration (e.g. Affordable Care Act, grant requirement, etc.).		

Adapted from Centers for Disease Control and Prevention (CDC) Community-Clinical Linkages Playbook, Resource 2[3]

If readiness is low in one or more areas, consider starting with small pilots, internal education, or stakeholder engagement to build momentum.

Establishing or enhancing CCLs may require additional resources, financial investment, developing new standard operating procedures, and ongoing training. It's essential to include key decision-makers, implementers, and patients from both clinical and community sectors in conversations to build trust, ensure transparency, and align shared goals.[10]

The intensity and complexity of these linkages will vary depending on mission alignment, organizational capacity, and available resources. The CDC's "Continuum of a Community-Clinical Linkage" model, (pages 6-8; PDF pages 10-12), illustrates how community and clinical organizations can work together in five different ways by increasing sharing of resources, time and trust.

- **Networking** involves CBOs, HCOs and/or public health stakeholders sharing information with each other about their programs and how people can access services.
- **Coordinating** involves sharing goals and establishing informal referral processes, such as a YMCA setting up a community self-measured blood pressure station with a list of local clinics who can serve people with high blood pressure.
- **Cooperating** involves sharing resources and formal agreements. For example, the YMCA and a clinic create a formal MOU about how they agree to partner and refer people to one another.
- **Collaborating** builds on previous levels of partnership and adds data sharing. This could be multiple organizations working together to improve care. The YMCA may receive data on how many people are now receiving clinical services. The clinic may receive data on which patients attend classes at the YMCA.
- **Merging** is a long-term vision where community and clinical care operate seamlessly. There is a backbone organization that provides governance for funding and accountability.

The primary goal of community-clinic linkages is synergistic collaboration between sectors to ensure that people receive seamless, integrated services to support their health. This can be accomplished at earlier levels of the continuum and evolve over time; it does not necessarily need to result in merging.

Once an organization has been identified, consider the tailored recommendations for each sector to support effective relationship-building:

Recommendations for Community-Based Organizations (CBOs)

- Understand the health care organization's patient population, including commonly spoken languages, cultures, and barriers their clients encounter.
- Confirm whether and how the health care organization accepts referrals and how soon they can see new patients, which is important if someone needs timely medical care.
- Identify which performance measures the health care organization tracks (particularly nonclinical measures) and determine how your services support those measures.
- Assess patient or community needs that your organization can help address.
- Identify stakeholders who can facilitate introductions.
- Find a champion(s) within the health care organization (e.g., a community health worker, social worker, patient navigator, or clinical health care professional).

Recommendations for Health Care Organizations (HCOs)

- Learn about the community-based organization's services, populations served — including commonly spoken languages and cultures — and geographic reach.
- Identify stakeholders who can facilitate introductions.
- Designate internal and external champions to support the linkage.
- Confirm whether and how the community organization accepts referrals.
- Facilitate necessary Memorandum of Understanding or Business Association Agreements.

Recommendations for Public Health Stakeholders

- Make connections between organizations.
- Build consensus and support for linkages across sectors.
- Help CBOs and HCOs demonstrate their value to each other.
- Understand the population served by the CBO and HCO.
- Identify which nonclinical performance measures the CBO supports.
- Assess patient or community needs that the CBO can address.
- Recommend appropriate validated devices, screening tools, and referral procedures for use by CBOs.

Defining Internal Roles and Responsibilities

To ensure successful implementation of community-clinical linkages, both community-based and health care organizations must clearly define internal roles and responsibilities. Below are recommended elements for each sector:

Recommendations for Community-Based Organizations (CBOs)

- Community organizations play a vital role in providing services and resources in non-clinical settings. By partnering with health care organizations, they can support patients and complement care delivery. To initiate and sustain linkages, CBOs interested in supporting blood pressure control should:
- Host and maintain a designated blood pressure measurement station. See the next section for details.
- Use only validated blood pressure measurement devices.
- Train staff in proper blood pressure measurement techniques and screening and escalation protocols.
- Provide education and resources on blood pressure control.
- Designate at least one staff member as the primary point of contact for the health care organization.
- Maintain an up-to-date directory of clinical and community resources.
- Develop a system for tracking referrals and follow-ups.

Recommendations for Health Care Organizations (HCOs)

- Health care organizations play a critical role in identifying people with hypertension and connecting them to community resources and support. To effectively participate in community-clinic linkages, HCOs should:
- Designate at least one staff member as the primary point of contact for the CBO.
- Use only validated blood pressure measurement devices.
- Train staff in proper blood pressure measurement techniques and screening protocols.
- Maintain an up-to-date directory of clinical and community resources.
- Develop a system for tracking referrals and follow-ups.
- Ensure staff readiness to receive referrals from CBO and provide timely medical care.
- Consider launching a **Self-Measured Blood Pressure program**[11] and providing blood pressure devices with right sized cuffs to patients with hypertension.
- Refer patients with hypertension to community resources, SMBP programs, and lifestyle or health education classes.

Recommendations for Public Health Stakeholders

Public health stakeholders and American Heart Association staff can offer technical assistance to support CBOs in these efforts. They can help:

- Serve as liaisons between CBOs and HCOs.
- Educate on best practices for community-clinical linkages.
- Provide the most current science-based community, patient, and clinical resources.

Formalizing Relationships

Once a shared interest in collaboration is established between an HCO and a CBO, formalizing the relationship helps ensure accountability and sustainability. The following section offers guidance on establishing shared goals and using formal accountability tools such as Memoranda of Understanding (MOUs) and Data Sharing Agreements (DSAs).

Recommendations for Community and Health Care Organizations

- Co-develop a referral system pathway that supports both community-to-clinic and clinic-to-community.
- Collaborate to leverage existing and potential community programs that promote healthy living (e.g., lifestyle prescription programs, walking groups).
- Establish a regular communication cadence between designated points of contact, for example, one in-person check-in per month.
- Provide orientation and training for staff on how to connect people to medical care or community resources.
- Ensure timely guideline adherent follow-ups for all people referred due to high blood pressure readings.

Tools for Formalization

- Example MOU Template
- Data Sharing Framework – The DASH (Data Across Sectors for Health) Framework offers a guide for building equitable data ecosystems to foster community health.

Visit **DASH Framework**[12]

Section 3: Design Screening Process

This section offers practical guidance on:

- **Setting up a Blood Pressure Self-Management Station**
- **Blood Pressure and Non-Medical Screenings**
- **Staff Training**

Blood Pressure Readings in Community Settings

Community-based organizations play a key role in helping people monitor their blood pressure. They should determine the most effective and accessible method for people to check their readings. A stationary self-monitoring station is ideal, as it allows the greatest number of people to participate. Alternatively, organizations may choose to host regular screening onsite or mobile events with volunteer medical health care professionals or partner with a local health care organization. It is important to note that staff or volunteers must be trained in the basics of teaching someone how to take their blood pressure, understanding what the numbers mean, and being familiar with the process identified for referrals.

Setting Up a Blood Pressure Self-Management Station

Setting up a blood pressure self-management station that is accessible, comfortable, and easy to use is critical for community-based organizations engaged in community-clinical linkages. Below are key considerations to guide setup and maintenance:

Setting Up a Blood Pressure Self-Management Station

Consideration	Rationale / description
Client comfort	Select comfortable, adjustable chairs with back support if using home monitoring devices. (Note: Tabletop devices can be used with an adjustable stool since the person leans in with their arm rather than sitting upright.) Position the blood pressure device in a quiet or moderately quiet area to reduce distractions and support getting accurate readings.
Functional layout	Place the device in a location that is easily accessible to both clients and staff. Ensure there is adequate space and good lighting for interaction and mobility. For tabletop devices, use a sturdy table near an electrical outlet. The station should accommodate wheelchairs and walking aids.
Device type	Choose a validated blood pressure device[13] that best suits your client population. Freestanding tabletop devices are ideal for high-traffic public settings but may require additional supplies, such as printer paper. Individual monitors are better suited for home, clinic, or small workplace use and often offer a wider range of cuff sizes. Make sure that there's signage or that staff understand how to direct users to the appropriate cuff size for an accurate reading.
Educational materials	Display a large-print "Blood Pressure Measurement Instructions" poster[14] at eye level near the device to support ongoing education. Provide culturally appropriate materials in multiple languages. Select a few key fact sheets to display, focusing on essential information to avoid overwhelming users. Consider signage for visual cues (e.g. no talking). Poster in other languages;[15] Best blood pressure infographics and resources for community members and patients.[16]

Success Story

The American Heart Association launched a large project in three cities to work with 14 community based organizations that had self measured blood pressure stations and the ability to link community members to local HCOs for blood pressure control care. The Blood Pressure Kiosk Stations are welcomed because they provide access for monitoring and follow up and are easy to use. A printout of the reading makes it easy to keep and share the readings with their health care professionals.

How to Select a Blood Pressure Device

1. Clinical Validation

Refer to ValidateBP.org (VDL) for list of eligible devices.

2. Upper-Arm, Automatic Operation

One-button start or similarly simple interface.

3. Easy to Use

Big buttons and high-contrast display are helpful.

4. Offer Both Standard & XL Cuffs

For accommodating a wide range of arm sizes.

5. Durable for High Daily Volume

Consider models with AC power option and replacement cuffs/hoses.

6. Optional Export Capability

Tracking readings (without identifying information) can support evaluation.

7. Simple Maintenance

Look for units that are easy to clean and disinfect and have a battery indicator.

Non-Medical Screenings in Health Care Organizations

Health care organizations conducting non-medical screenings, sometimes referred to as screenings for non-medical drivers of health (NMDoH), play a crucial role in improving patient outcomes and strengthening community-clinical linkages. These screenings help uncover challenges such as housing instability, food insecurity, transportation issues, and financial hardship. These are non-medical factors that significantly affect health but can go unnoticed in traditional medical assessments. Screening enables health care professionals to refer patients to local community-based organizations, such as food banks, housing support, or transportation assistance — helping address factors that get in the way of best health.

Case Example

Buffalo, N.Y.: A health care organization expanded beyond the clinic walls by hosting and attending community events to provide community blood pressure screenings. People identified with elevated readings were immediately connected to primary care at the health care organization, and when appropriate, enrolled into one of two blood pressure self-monitoring (SMBP) programs designed to meet patients where they are: a traditional SMBP pathway or a Remote Patient Monitoring (RPM) program. Offering two flexible models allowed patients to engage in hypertension management in a way that best fit their needs, resources, and readiness, ensuring individualized care while maintaining evidence-based standards. This proactive, patient centered, community-based approach not only closed gaps in access but also enhanced early identification, strengthened care coordination, and created a seamless entry point into high quality hypertension management.

Blood Pressure Screening Events

In addition to a blood pressure station, organizations may choose to host regular screening events with volunteer medical providers or partner with a local health care organization. MOUs (Memorandum of Understanding) or other legal agreements may need to be in place to meet HIPAA compliance or other organizational requirements. Screening partners could include universities that provide health care programs, such as nursing, pharmacy, nutrition and dietary, or other health care disciplines.

Training for Community-Based Organization Staff

It is important that staff and volunteers at community-based organizations with a blood pressure self-measurement station are adequately trained. The American Heart Association provides several comprehensive resources for staff and volunteers including:

- **Community-Based Blood Pressure Screening Decision-Making Guide.**[17] This resource provides guidance to community-based organizations for blood pressure screening and events. It addresses blood pressure cuff procurement, maintenance, CBO screener training, and proper blood pressure measurement and technique. It also provides recommendations for screeners to make during a blood pressure reading.
- **DIY Health Lesson Blood Pressure**[16]
- **How to take your blood pressure**[18] (video)

Training for Clinical and Support Staff

Hypertension care requires both clinical expertise and supportive patient engagement strategies. Ongoing training and support ensure that health care professionals, nurses, community health workers, and care team members are well-prepared to deliver evidence-based care and address the full spectrum of patient needs. American Heart Association resources include:

- **Target: Blood Pressure (BP) Quality Improvement Tools:**[19] This resource provides best practices, standardized processes, and useful tools designed for clinical staff and patients to work together to control high blood pressure. The quick start guides12 were created as an outline of the core tools and resources available.
- **BP Measurement Policy and Procedure Template:**[20] This template document addresses BP device procurement and maintenance, health care team training and skills testing, and BP measurement processes and workflow.
- **2025 AHA/ACC Guideline Hypertension Guideline:**[21] Newly released guideline provides updated recommendations for hypertension diagnosis and management, with a strong emphasis on team-based care and patient-centered strategies.
- **The American Heart Association PREVENT™ Online Calculator:**[22] The Predicting Risk of Cardiovascular Disease EVENTs (PREVENT) equations estimate 10-year and 30-year risk for total cardiovascular disease (CVD), including atherosclerotic CVD (ASCVD) and heart failure (HF). It is the first risk tool to combine cardiovascular, kidney, and metabolic health measures to guide primary prevention-focused treatment decisions.

By combining guideline-driven care with patient-centered training and communication strategies, clinical and support staff can create an environment where every patient receives high-quality, personalized hypertension care.

Case Example

Columbus, Ohio: A health care organization recognized that inconsistent blood pressure measurement and variable staff knowledge of current hypertension guidelines were limiting progress toward improved control rates. To address this, the organization implemented a standardized approach to hypertension management across the entire care team.

A key element of their strategy was biannual staff training, provided to all members of the care team. These sessions included:

- Hands-on refreshers on accurate blood pressure measurement techniques, including proper cuff size, patient positioning, and repeat measurement protocols.
- Review of the latest hypertension guideline, ensuring that all health care professionals and champions were aligned in diagnosis, treatment thresholds, and follow-up care.
- Reinforcement of standard hypertension procedures so that every team member understood their role in supporting patient blood pressure control.
- Through this standardized training model, the organization built consistency across health care professionals, reduced variability in patient care, and created a culture of shared accountability for hypertension outcomes.

Section 4: Create the Referral Process and Feedback Loop

This section offers practical guidance on:

- **Referrals to Services**
- **Person-Centered Navigation Best Practices**

Referrals to Services

Both CBOs and HCOs should maintain accurate, up-to-date directories of local resources. While platforms such as **Unite Us** and **findhelp** might be more current than static resource sheets, they still rely on organizations to update their information. If an organization maintains its own directory, it should assign a staff member to review and update it at least quarterly to reflect changes in hours, services, and availability.

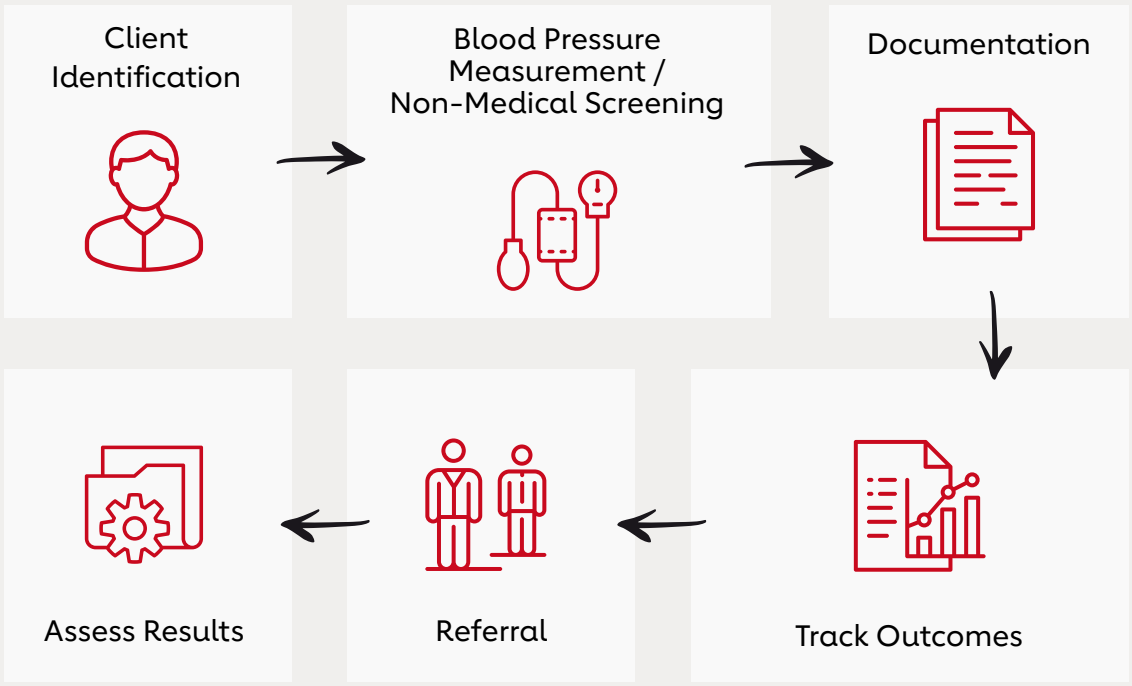
Referrals are most effective when they are warm handoffs, culturally and linguistically appropriate, and closed-loop referrals. A closed-loop referral is a process in which a health care professional refers a person to a service and then confirms that the person receives the service — either through the organization or person. This approach ensures accountability and continuity of care. Some examples of referrals and data exchange may include:

- Person-centered navigation using community health workers
- Technology-based platforms such as **Unite Us**, **findhelp**, or **Healthify**
- Hybrid approaches combining human and digital navigation

Research shows that community-clinical linkages supported by Community Health Workers can positively impact chronic disease outcomes.[23] Organizations that are successful in closed-loop referrals often have additional staff and resources dedicated to tracking referrals and referral tracking software.

For both community-based and health care organizations, one often-recommended referral process[24] is pictured below. The appendix provides two other recommended processes.

Recommended Referral Process



Person-Centered Navigation Best Practices

Client or patient navigation is essential for closing care gaps and improving outcomes, especially for people at high risk for high blood pressure or already diagnosed with hypertension. Effective navigation ensures patients are referred and supported throughout their care journey.

Client or patient navigation is essential for closing care gaps and improving outcomes, especially for people at high risk for high blood pressure or already diagnosed with hypertension. Effective navigation ensures patients are referred and supported throughout their care journey.

Warm Handoffs

A warm handoff is a personal, intentional transition of care where the current provider introduces the person to the next point of contact — whether clinical or community-based. A warm handoff builds trust, reduces confusion, provides continuity in real time, and improves client follow-through. This personal touch is more impactful than simply providing a person with a list of resources. Beside are best practices:

- Conduct real-time introductions (in-person, phone, or virtual) between the referring provider and the navigator or partner organization.
- Provide high blood pressure education and blood pressure device training, as needed.
- Use shared decision-making, reinforce the referral purpose, what to expect, and how it supports the person's health goals.
- Document the handoff in the Electronic Health Record (EHR) or shared communication system.
- Follow up within 24–72 hours to confirm connection and address any barriers.

Culturally and Linguistically Appropriate Support

- Navigation should reflect the cultural, linguistic, and lived experiences of the people served. Below are best practices:
- Employ navigators who reflect the diversity of the community.
- Use native speakers or professional interpreters and translated materials for medical or complex discussions.
- Incorporate cultural beliefs, dietary preferences, and health literacy into education and goal setting.
- Train navigators in trauma-informed care and implicit bias reduction.
- Refer patients to social navigation platforms when appropriate.
- Engage community health workers (known as promotores de salud in Spanish) or patient care navigators as co-navigators or frontline partners.

Case Example

1. **Houston:** A local CBO discovered the value of appointing a staff member as a blood pressure station "Champion." This person, whose primary role is nutrition education, has a warm and charismatic presence. Trained in accurate blood pressure measurement and kiosk operation, the Champion encourages clients to use the station and engages them in conversations about their health needs. This rapport enables the Champion to make informed clinical care recommendations and initiate warm referrals to health care professionals.
2. **Referral Challenges:** An American Heart Association initiative with 14 CBOs and 14 HCOs found that they had similar challenges in ensuring closed-loop referrals, including lack of resources, referral site issues, and individual patient preferences.

- **Lack of Resources:** Not having enough resources makes tracking and closed-loop referrals difficult. For some organizations, not having a referral tracking software or system makes it challenging to track where referrals are sent and if they seek care. For other organizations, their resources are strained by not having staff responsible for tracking referrals.
- **Referral Site Issues:** Some organizations work with health care sites that have long waitlists, which make tracking referrals difficult due to how long patients might have to wait to seek care.
- **Individual Patient Preferences:** Many organizations report that some community members have less available resources, citing potential struggles with finding transportation, affording additional care, etc. In addition, some organizations state that people may feel uncomfortable giving out personal information needed to track referrals.
- **Cultural Background and Practices:** Some organizations stated that some community members may seek care differently based on cultural backgrounds and traditions or citizenship status, which could potentially affect someone's willingness to seek health care or additional care if referred.

The appendix provides information on staff training and engagement related to patient engagement and communication skills.

Section 5: Evaluate and Share Outcomes

This section offers practical guidance on:

- **Why evaluation matters**
- **Key evaluation metrics for blood pressure linkages**
- **Formalizing relationships to support effective linkages**
- **Using data for program improvement and grant reporting**
- **Funding models and sustainability practices**

Why Evaluation Matters

Evaluation is a critical component of any public health initiative, and it is especially vital when implementing community-clinical linkages aimed at improving blood pressure outcomes. More specifically, evaluation:

- **Demonstrates Impact:** Shows whether interventions achieve intended outcomes such as increased screenings, referral completion, and improved hypertension control.
- **Drives Quality Improvement:** Tracks metrics and feedback to refine workflows, enhance communication, and improve care quality.
- **Ensures Accountability:** Promotes transparency across sectors, confirming roles are fulfilled and patients receive timely care.
- **Supports Funding and Sustainability:** Provides data to justify investment, advocate policy changes, and strengthen grant applications.
- **Addresses Contextual Factors:** Reveals access and engagement barriers by analyzing data by race, language, geography, and other non-medical factors.

It may be challenging for some blood pressure devices and organizations to track these metrics. Determining what you want to collect and what you can collect is important when starting a blood pressure station.

Recommended Metrics

Selecting the correct metrics for a community-clinical linkage is crucial because they define how success is measured and ensure that evaluation reflects the true impact of the intervention. Well-chosen metrics provide actionable insights, guide decision-making, and prevent wasted resources on irrelevant or misleading data. Below are recommended metrics to collect:

- Number of people screened in community settings
- Number of people screened with high blood pressure in community settings
- Number and type of referrals made to clinical care
- Referral completion rates and time to follow-up
- Changes in blood pressure readings over time
- Patient satisfaction and engagement

Approaches to Tracking Outcomes and Referrals

Effective tracking of outcomes and referrals is critical to ensuring patients receive timely, coordinated care while enabling organizations to identify gaps and improve performance. By integrating data-driven tools with feedback mechanisms, health care organizations (HCOs) and community-based organizations (CBOs) can close the loop on referrals, strengthen partnerships, and enhance patient outcomes.

Evaluation depends on practical tools and structured approaches that make progress visible and actionable. Technology solutions such as closed-loop referral systems and real-time dashboards provide transparency and accountability, while qualitative methods, including staff and patient interviews, offer deeper insights into barriers and successes. Standardized forms and feedback loops between CBOs and HCOs further promote consistency and collaboration, creating a strong foundation for data-informed decision-making.

Key Tools and Approaches

- Closed-loop referral tracking systems to monitor outcomes
- Qualitative interviews with staff and patients to gather insights
- Dashboards and data visualization for real-time monitoring
- Standardized screening and referral forms to ensure consistency
- Feedback loops between CBOs and HCOs to share learnings
- Dashboards and reports summarize referral completion rates, patient outcomes, and system-level performance. Continuous monitoring through dashboards enables organizations to quickly identify trends, address gaps, and act on emerging needs.

Using Data for Program Improvement and Grant Reporting

Data is a critical driver of both quality improvement and accountability. For HCOs, systematically collecting, analyzing, and reporting data ensures that programs are responsive to patient needs, demonstrate measurable outcomes, and remain sustainable through ongoing funding. For CBOs, tracking the number of community-based screenings, number with high blood pressure readings, and the number and type of referrals can help to understand if the stations are being used on a regular basis, and can help inform if the location of that station or other factors may need to be adjusted. It may be helpful to understand if patrons are using the device for a true screening or because they are concerned about potential high blood pressure. Tracking referrals can also help the CBOs understand where people are seeking care, which can help with establishing bi-directional referral relationships with HCOs through relationship-building and sharing information.

Recommendations for Health Care Organizations

HCOs should integrate both quantitative and qualitative data into their evaluation processes to capture a full picture of program performance. Quantitative measures such as blood pressure control rates, referral completion rates, and patient follow-up metrics provide clear indicators of impact, while qualitative data gathered through patient and staff interviews, focus groups, or open-ended surveys adds context by highlighting barriers, successes, and lived experiences. To support continuous improvement, organizations can administer surveys at multiple points in the program lifecycle: pre-implementation to assess baseline needs and readiness, midpoint to identify challenges and inform mid-course adjustments, and final surveys to evaluate effectiveness and lessons learned.

Aligning internal data collection with external reporting requirements (such as UDS, HEDIS, or CMS quality measures) also reduces duplication and ensures consistency with broader system-level metrics.

In addition, real-time dashboards and visualization tools can help teams monitor progress, spot trends, and prioritize areas for improvement. Finally, pairing hard data with patient and provider narratives strengthens grant reporting by demonstrating not only measurable outcomes but also the impact of the program.

Recommendations for Community-Based Organizations (CBOs)

Current interventions have demonstrated that CBOs are effective partners and essential for community-based blood pressure screening and clinical referrals. However, CBOs vary greatly (e.g. not-for-profit, schools/colleges, corporations) and therefore the capacity of each CBO needs to be understood prior to beginning this work. CBOs should ensure that they have enough space to set up the stations and adequate staff to monitor their use and collect and report data on a regular basis. A referral tracking system or mechanism should be established by all participating CBOs to deliver rapid referrals to people who express interest or require one (in cases where a person is having a hypertensive crisis). These referral systems or mechanisms can vary in sophistication, from electronic to paper-based; however, it is essential that referral information is collected and tracked, including the results of any referrals when possible. It is also recommended that CBOs enhance their relationships with HCOs as they establish referral networks for people requesting a referral to care. These referral networks with feedback loops can help to create a bidirectional referral relationship where patients can be referred to CBOs for their community-based needs, while the CBOs can assist patients with finding a health care professional for their health care needs.

Funding Models and Sustainability Strategies

The table below outlines various funding models, identifies potential funding sources, and highlights strategies for each, along with the rationale for why each approach is effective.

Funding model	Potential sources	Best-paired sustainability strategies	Why this works
Government & public health funding	CDC, HRSA, NIH, state health departments, Medicaid/Medicare reimbursement	• Integrate into existing clinical workflows • Embed screenings in other public health programs (WIC, immunizations) • Use data to demonstrate improved outcomes to policymakers	Embedding mandated or reimbursable services makes it easier to secure multi-year or recurring funding.
Private & philanthropic grants	Robert Wood Johnson Foundation, American Heart Association, hospital community benefit funds, CSR programs	• Build partnerships with community groups and nonprofits • Use grant funds to launch "train-the-trainer" models • Demonstrate ROI to transition to corporate or hospital sponsorship	Philanthropic funds are often short-term, so building local ownership and partnerships helps maintain services after grant periods end.
Earned revenue & fee-for-service	Worksite wellness contracts, gym/wellness center memberships, mobile health clinics	• Offer subscription packages for regular BP monitoring • Integrate screenings with broader wellness offerings • Leverage technology (apps, automated reminders) for low-cost delivery	Fee-for-service models are sustainable if services provide clear value and are easy to bundle with other wellness programs.
Hybrid / braided funding	Combination of grants, reimbursement, sponsorships	• Diversify income streams to reduce reliance on any single source • Use grants for start-up costs and insurance reimbursement for ongoing operations • Embed program in multiple partner settings	Spreading funding risk keeps the program running even if one funding source ends.
Policy & advocacy-driven funding	State mandates, employer wellness program requirements, insurance coverage expansions	• Engage in local policy advocacy • Use data to influence benefit design (e.g., coverage for community BP screenings) • Partner with public health coalitions	Policy changes can create long-term, systemic funding for BP initiatives, ensuring coverage across settings.

Case Example

Community-Based Organizations

The American Heart Association launched a large project in three cities to work with 14 community-based organizations. Qualitative evaluation results found that many organizations' biggest success is seeing community members use blood pressure readings to be proactive about their own health. These organizations report that their community members might not have access to BP cuffs at home, so these stations allow people to get proactive health care readings when they might not have had the resources to do so otherwise. Many patients reported tracking their BP and sharing their readings back with their primary care professionals, helping to inform care. One organization regularly had staff members measuring their blood pressure as well. All organizations reported that this program was incredibly beneficial and helpful to community members.

Case Example

Health Care Organizations

The American Heart Association launched a large project in three cities to work with 14 clinical organizations. Across the initiative, sites have strengthened accountability and engagement by establishing site-level objectives for hypertension management and reporting progress through the Target:BP program and site-level surveys (pre-implementation, midpoint, final). To complement system-level reporting, many organizations have adopted health care professional dashboards and scorecards that highlight panels of patients with uncontrolled hypertension. These tools allow care teams to monitor patients in real time, track follow-up, and ensure timely outreach.

In one example, a clinic in Buffalo used scorecards to identify patients with persistently high blood pressure, which helped health care professionals focus their efforts on those most in need of intervention. Having a clear view of patient panels not only improved care coordination but also served as a motivating tool for health care professionals.

Appendix

Below are templates and tools recommended, but this is not an exhaustive list. If your organization has an addition for a future iteration of this guide or you need assistance, please reach out to: communityimpact@heart.org

Templates and Documents

All of these need to be uploaded to the new AHA Community Impact external website [INTERNAL NOTE]

- Blood Pressure Referral Form Template.docx
- Sample Referral List Template.docx
- Partnership MOU template
- CBO Screen and Refer Policy & Procedure Template
- Three Referral Process Options (info pasted at end)

Links to Other Community-Clinical Playbooks

- Community-Clinical Linkages for the Prevention and Control of Chronic Diseases: A Practitioner's Guide[1]

Training for Community-Based Organization Staff

It is important that staff and volunteers at community-based organizations with a blood pressure self-measurement station are adequately trained. The American Heart Association provides several comprehensive resources for staff and volunteers.

- Community-Based Blood Pressure Screening Decision-Making Guide.[17] This resource provides guidance to community-based organizations for blood pressure screening and events. It addresses blood pressure cuff procurement, maintenance, CBO screener training, and proper blood pressure measurement and technique. It also provides recommendations for screeners to make during a blood pressure reading.
- DIY Health Lesson Blood Pressure[16]
- How to take your blood pressure[18] (video)
- Self-Measured Blood Pressure Training slides (SMBP Training CI.pptx)

Training for Clinical and Support Staff

Hypertension care requires both clinical expertise and supportive patient engagement strategies. Ongoing training and support ensure that health care professionals, nurses, community health workers, and care team members are well-prepared to deliver evidence-based care and address the full spectrum of patient needs.

- Target: Blood Pressure (BP) Quality Improvement Tools: [19] This resource provides best practices, standardized processes, and useful tools designed for clinical staff and patients to work together to control high blood pressure. The quick start guides12 were created as an outline of the core tools and resources available.
- BP Measurement Policy and Procedure Template:[20] This template document addresses BP device procurement and maintenance, health care team training and skills testing, and BP measurement processes and workflow.
- 2025 AHA/ACC Guideline Hypertension Guideline:[21] Newly released guideline provides updated recommendations for hypertension diagnosis and management, with a strong emphasis on team-based care and patient-centered strategies.
- The American Heart Association PREVENT™ Online Calculator:[22] The Predicting Risk of Cardiovascular Disease EVENTs (PREVENT) equations estimate 10-year and 30-year risk for total cardiovascular disease (CVD), including atherosclerotic CVD (ASCVD) and heart failure (HF). It is the first risk tool to combine cardiovascular, kidney, and metabolic health measures to guide primary prevention-focused treatment decisions.
- Validate BP: A resource for people and health care organizations to find validated blood pressure devices.

Patient Engagement and Communication Skills

Non-Medical Determinants of Health Training: *The AHA's Health Equity Learning for Healthcare Professionals* series equips teams with knowledge and tools to identify and address non-medical drivers of health that affect hypertension management and long-term outcomes.

- Health Equity Learning For Healthcare Professionals | American Heart Association | American Heart Association[25]

Motivational interviewing (MI): A proven counseling approach that enhances patient engagement and medication adherence and supports sustained behavior change. MI helps staff meet patients where they are and tailor care plans to individual goals and readiness for change.

- *Center for Evidence-Based Practices (Case Western Reserve University):* Practical resources and toolkits to strengthen MI skills[26]
- *AHA Digital Health Professional Training Program: Motivational Interviewing:*[27] Provides tailored MI training modules specifically designed for cardiovascular disease and hypertension management, empowering staff to integrate MI techniques into daily patient interactions.

Three Referral Process Options

(need this uploaded so it can be linked to) Here are three referral process options between Community-Based Organizations (CBOs) and Community Health Centers (CHCs):

1. Electronic Health Record (EHR) Integration

Process:

- Implement EHR systems at both the CBO and CHC.
- Integrate the EHRs to allow for seamless sharing of patient information and referral data.
- When a CBO identifies a patient in need of clinical care or social services, they initiate a referral through the EHR.
- The CHC receives the referral electronically and reviews the patient's information.
- If clinical care is needed, the CHC schedules an appointment and updates the patient's EHR with the referral details.
- If social services are required, the CHC can refer the patient to the appropriate CBO, and this information is documented in the EHR.
- Both organizations can track the progress and outcomes of referrals through the EHR system.

Advantages:

- Real-time data sharing
- Reduced administrative burden
- Enhanced care coordination

2. Social Navigation Platform (e.g., UniteUs)

Process:

- Implement a social navigation platform, such as Unite Us, that facilitates referrals and collaboration between health care professionals and CBOs.
- CBOs and CHCs register on the platform and establish profiles.
- When a CBO identifies a patient in need, they enter referral information into the platform.

- The CHC receives the referral notification through the platform and reviews the details.
- The CHC can accept the referral and communicate with the CBO through the platform.
- Progress updates, communication, and documentation of services are recorded within the platform.
- The platform offers analytics and reporting tools to monitor referral outcomes.

Advantages:

- Specialized platforms designed for health care-community collaboration
- Streamlined referral processes
- Enhanced communication and reporting capabilities

3. Hybrid Approach (EHR Integration + Social Navigation Platform)

Process:

- Implement both an EHR integration and a social navigation platform.
- Use EHR integration for clinical data sharing between CBOs and CHCs, ensuring seamless access to patient health records.
- Use the social navigation platform for referrals, communication, and tracking of social service needs.
- When a referral is initiated, the platform notifies the relevant parties while maintaining the connection to the EHR for clinical data.
- Organizations can leverage both systems for comprehensive care coordination.

Advantages:

- Combines the strengths of EHR integration and specialized referral platforms
- Comprehensive data sharing and referral tracking
- Flexibility to adapt to varying referral needs

The choice between these options depends on the specific needs, resources, and infrastructure of the CBO and CHC. EHR integration offers seamless clinical data sharing, while social navigation platforms are tailored for community health care collaborations. A hybrid approach combines the best of both worlds, ensuring comprehensive and efficient referrals and care coordination. Organizations should assess their requirements and select the approach that aligns with their goals and capabilities.

Example MOU

[Your Organization's Letterhead]

Memorandum of Understanding (MOU)

Between [Community-Based Organization Name]

And [Community Health Center Name]

Effective Date: [Date]

1. Purpose and Scope

This Memorandum of Understanding (MOU) outlines the collaboration and partnership between [Community-Based Organization Name] (hereinafter referred to as "CBO") and [Community Health Center Name] (hereinafter referred to as "CHC") to enhance community-clinical linkages aimed at improving blood pressure management and addressing social determinants of health within our community.

2. Responsibilities of the Community-Based Organization (CBO)

a) CBO will conduct community outreach efforts to identify people at risk of hypertension and non-medical drivers of health.

b) CBO will provide health education sessions to increase awareness of blood pressure management and address social drivers of health.

c) CBO will perform blood pressure screenings within the community.

d) CBO will offer referrals to social services for people in need.

e) CBO will facilitate referrals to CHC for clinical care as appropriate.

3. Responsibilities of the Community Health Center (CHC)

a) CHC will provide clinical care, including official diagnosis and treatment of hypertension.

b) CHC will identify patients who may benefit from CBO's blood pressure education and engagement programs.

c) CHC will make referrals to CBO for patients who would benefit from community-based interventions.

d) CHC will collaborate with CBO to ensure seamless care coordination for referred patients.

4. Referral Process and Social Navigation Platform

Both organizations will work together to establish a clear and efficient referral process, including the use of a social navigation platform. Details of this process will be documented in an addendum to this MOU, to be developed jointly by both parties.

5. Best Practice Activities for Strengthening Community-Clinical Linkages

Both parties commit to implementing best practices to strengthen community-clinical linkages. These may include regular meetings to review referrals, joint training for staff, and data sharing to assess program effectiveness.

6. Data Sharing and Reporting

Both parties agree to share relevant data as needed to monitor and evaluate the effectiveness of the community-clinical linkages program. Data sharing protocols will be developed and agreed upon separately.

7. Term and Termination

This MOU will be in effect from [Effective Date] and will automatically renew annually unless terminated by either party with 90 days' advance written notice. Either party may terminate this agreement immediately upon notice if there is a material breach of the terms outlined herein.

This MOU signifies the commitment of both parties to work collaboratively in improving the health and well-being of our community members.

For [Community-Based Organization Name]:

Name: [Your Name]

Title: [Your Title]

Date: [Date]

For [Community Health Center Name]:

Name: [CHC Representative's Name]

Title: [CHC Representative's Title]

Date: [Date]

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