

# Appendix A: Clinical and Community Linkages Assessment (CCLA) questionnaire

PHII used the following questions to collect information from CODI participating organizations.

## General: Organizations, facilities and population reach

- So that we can understand the population that your organization serves, please tell us about your patients/clients.
- How many patients/clients/families do you serve?
  - What is the general age, racial and ethnic composition, and socioeconomic factors of your population?
- What services does your organization provide?
  - What are the most commonly utilized services?
- Please describe obesity, heart disease, and diabetes prevention and targeted treatment services/interventions (outside of the regular course of care).
  - Examples may include nutrition, physical activity, counseling, education, or targeted case management.
- Please describe other resources provided to patients/families (e.g., counseling, child welfare services, referral to other care, etc.)?
- Do you partner with other clinical or community organizations on chronic disease work such as schools, WIC, a health-center controlled network or a primary care association?
- Is your organization participating in value-based payment initiatives?
- Is your organization impacted by Medicaid transformation efforts? If so, how are you preparing and what changes do you expect?
- Are there certain populations your organization is having a difficult time reaching?
- How will partnership with CODI help the community organization meet goals, expand program offerings, improve reach into the community, participants in need or at disproportionate risk?
- How can we make CODI be most valuable to your organization?

## Technology and information systems

- What information system(s) are used by your organization? (e.g., EHR, population management, case management)
  - Does your organization host the system(s) internally, share the system with other organizations, or use an external cloud provider hosting service?
- What external information systems (current or future) are used by your organization? Which are integrated with your internal technology tools?
- Can you tell us about how you store your data? How is it managed?
- How does your organization partner with the HIE, NCCARE360, or Greenlight technologies to provide services to North Carolina families? Is there a diagram that displays this?
- Do you link child and parent/families' records? Is this done internally or by an external data team? Please explain this process.
- What information about other members of the household do you collect? Do you capture all the adults in a child's record? Do you capture household contact information?

## Social Determinants of Health (SDOH) Screening

The Centers for Disease Control and Prevention (CDC) defines social determinants of health (SDOH) as conditions in the places where people live, learn, work, and play that affect a wide range of health and quality-of-life risks and outcomes. Though all social determinants are important, the CODI project is particularly interested in food insecurity and housing.

- How do you screen patients/families for SDOH? What is the workflow?
  - How often does screening occur?
  - What does screening include? Who screens?
  - What questions are used?
  - How are responses documented?
  - What aspects of this process vary and why? Are there any patients or visits where SDOH screening does NOT OCCUR?
- What happens when a positive SDOH screening occurs? (e.g., documentation, referrals, follow up, communication with patient)
- Are screening results for a child associated with a household? Would a child's responses about food insecurity be associated with a parent's record?
- What challenges are involved in the SDOH screening processes?

## Referrals

Referrals represent an important topic closely related to SDOH screening that helps ensure a patient has the right clinical care regardless of institution. We recognize that there are clinical-to-clinical referrals, within and between institutions; clinical to community referrals, usually for social supports or community-based interventions; and community to community referrals to connect families to other community programs or services that could help.

- What essential services or interventions are provided in your organization (things that others might refer to)?
  - Examples can include transportation, food, help with medications, WIC or SNAP enrollment
- What services do you refer to?
  - What organizations provide these services?
- How are referrals sent?
  - What formats do the referrals take?
  - What technology?
  - Are clinical to clinical referrals different?
- Does your organization receive referrals?
  - From who?
  - What kind? (incoming and outgoing)
  - What information is shared in a referral?
  - How do you make the referral?
  - What additional tools/technologies are involved?
- What percentage of the time do you receive feedback about the outcome of a referral?
  - Progress note or fax?
  - If progress note, is that information making its way into the EHR?
  - Is any patient health information shared back to you?

## Governance and data sharing

- Do you currently share patient or client information with any external entities? If so, can you tell us a little bit about this project?
  - If yes, is there a data use agreement (DUA) in place?
  - How often are data shared?
- Are there any agreements or guidelines dictating data exchange with referral organizations?
  - Do you offer consent to patients?
- Have you previously established data use or sharing agreements with internal or external partners, including CDC?
  - If so, please describe the process and how long it took.
- Are there any regulations that restrict or constrain sharing data with other organizations (e.g., state laws, institutional regulations, federal regulations)? Please describe.
- Please describe any anticipated challenges in accessing or sharing data.