



Implementing and Evaluating HHS Referral Networks

A Companion Guide to *Bridges to Resolution*

Network for Nonprofit and Social Impact
Northwestern University

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Project Investigator:

Michelle Shumate, Northwestern University

Contributing Authors:

Kate Albrecht, University of Illinois, Chicago

Emmeline Chuang, University of California, Berkeley

Caroline Fichtenberg, Social Interventions Research and Evaluation Network, UCSF

Leslie Hausmann, University of Pittsburgh & VA Pittsburgh Healthcare System

Matthew Kreuter, Washington University

Joshua-Paul Miles, University of Illinois at Urbana-Champaign

Jennifer Mosley, University of Chicago

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About Northwestern University

Northwestern University is a premier research institution based in Evanston and Chicago, Illinois, renowned for its academic excellence and ground-breaking research. Across 12 prestigious schools, the university fosters an interdisciplinary environment dedicated to driving innovation and developing global leaders. By tackling complex societal challenges, Northwestern's researchers and institutes produce high-impact insights that shape policy and advance community well-being.

About NNSI

The Network for Nonprofit and Social Impact (NNSI) at Northwestern University is dedicated to answering the question: How can nonprofit networks be rewired for maximum social impact? Since its establishment in 2012, NNSI has collaborated with organizations to produce rigorously studied results, actionable metrics, and practical applications for the social impact sector. To learn more about NNSI, visit <https://nnsi.northwestern.edu>.

About This Report

Bridging the divide between high-level health policy and the messy reality of front-line service delivery is the ultimate hurdle for modern social care, where design often fails to meet execution. This companion report to Bridges to Resolution serves as a practical manual for state, municipal, and nonprofit leaders, moving past theoretical concepts to provide concrete strategies for managing the day-to-day operations and rigorous performance assessment of health and human services (HHS) referral networks. By detailing how to navigate the complex inter-organizational dynamics required for these systems to function, the guide empowers leaders to move from simply designing networks to successfully sustaining them.

Drawn from decades of research on managing and evaluating interorganizational networks, this report suggests that operational success requires a fundamental shift in managing the friction between regimented clinical workflows and the flexible, holistic practices of community-based organizations (CBOs). Rather than relying on technology alone, the report emphasizes that robust human infrastructure — such as designated boundary spanners, shared governance, and intentional resource collaboration — is essential to overcome deep-seated power imbalances and resource strain. Furthermore, the evaluation framework encourages shifting metrics away from simple activity tracking toward patient-centered outcomes, such as true service receipt and needs resolution. It concludes that long-term resilience depends on embedding equity analysis and continuous learning feedback loops into the network's core, ensuring that improvements in care are measured, visible, and equitably distributed.

About NNSI at Northwestern University

NNSI is a research lab at Northwestern University dedicated to understanding how networks can have a greater social impact. We thrive on projects that produce rigorously studied results and practical applications for the social impact sector. Our work has been funded by the National Science Foundation, the Bill & Melinda Gates Foundation, and the Army Research Office. Our research is featured in academic journals and in venues such as *Stanford Social Innovation Review* and *Nonprofit Quarterly*. The lab has developed metrics to evaluate client outcomes over time based on clients' requests. In addition, it has worked with dozens of HHS referral networks to assess their impact.

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Executive Summary

The Health and Human Services (HHS) field is at a critical juncture, as states utilize Centers for Medicare and Medicaid Services Section 1115 waivers and pilot initiatives — such as North Carolina’s Healthy Opportunities Pilots and California’s Whole Person Care Pilots — to fundamentally shift the U.S. system toward integrated community care. This report outlines the strategies required to implement these initiatives and measure their ultimate value.

HHS referral networks are formal inter-organizational partnerships where independent providers use standardized protocols to assess client needs and manage the resulting service connections. These systems move beyond resource directories, relying on integrated infrastructure and established organizational bonds to oversee the full referral process. By relieving individuals of the burden of navigating a fragmented landscape themselves, these networks serve as a cornerstone for building a more unified community care model in the U.S.

Introduction and the scope of review

This report serves as a guide for state, municipal, and nonprofit leaders tasked with the practical execution and assessment of integrated care systems. While the primary report, *Bridges to Resolution: The State of the Evidence on HHS Referral Network Design and Outcomes*, establishes the evidence base and foundational design of these systems, this companion report focuses on the operational implementation; it moves from theoretical design to successful implementation and rigorous evaluation. This report offers strategies for day-to-day management, overcoming operational roadblocks, and detailed methodologies for performance monitoring.

The report has two key sections. The first section focuses on how state, municipal, and nonprofit leaders can overcome common barriers to effective implementation. The second section outlines strategies to assess the effectiveness of the network in connecting clients to services and addressing their needs.

Overcoming barriers to effective implementation

The shift toward integrated community care is often hindered by deep-seated structural and cultural divisions between sectors. Building a referral network is an active management strategy that demands significant investment in human infrastructure and typically takes much longer than leaders anticipate. The critical role of implementation is best illustrated by the WE CARE program in Boston; while the initial phase saw striking successes in employment and housing for mothers, the second stage failed to replicate these results. Implementation challenges at the clinic level led to lower screening rates and a reversal of infant health outcomes. Even a well-designed intervention can fail if the operational phase is not rigorously managed.

The most frequent implementation roadblocks stem from the resource and operational disparities between healthcare systems and CBOs (TABLE 1). While healthcare systems operate with established funding and regimented protocols, CBOs often function on thinner financial margins and flexible, holistic workflows. When healthcare partners increase screening and referral volumes, they risk overwhelming CBO partners who lack the staffing or technology to absorb the influx.

Furthermore, information decay represents a constant threat to network integrity. When resource directories are not continuously validated, clients may receive inaccurate information on hours or eligibility requirements, leading to service failures and client frustration.

TABLE 1 Primary Barriers to Network Success

Barrier	Explanation
CBO capacity strain	CBOs may be overwhelmed by the number of referrals. CBOs operate on thin margins and lack the staffing or technology to absorb sudden increases in referral volume from healthcare partners.
Power imbalances	Healthcare systems often become the dominant agencies in HHS referral networks due to greater financial resources, leading to the marginalization of social service priorities.
Information decay	Referrals fail and trust erodes when directory information regarding service availability, hours, or eligibility is inaccurate or outdated.
Cultural friction	There may be misalignment between more regimented clinical workflows (requiring strict documentation) and more flexible social service norms (prioritizing immediate aid).

Strategic recommendations for implementation

1 Bridge the healthcare-CBO divide through shared governance

To ensure the network is a true partnership rather than a compliance-driven mandate, organizations must establish a shared mission that reflects community-wide goals.

- **Define realistic constraints:** Healthcare systems should clearly communicate clinical and regulatory limitations at the early stages of the partnership.
Example: A healthcare system can explicitly outline HIPAA and data-sharing constraints to prevent CBOs from expecting levels of data access that are legally prohibited.
- **Elevate client and community barriers:** CBOs must help healthcare partners understand practical barriers to service.
Example: CBOs can point out that a standard 48-hour clinical follow-up window is unrealistic for clients who lack reliable transportation or stable housing.
- **Use Memorandums of Understanding (MOU) as collaboration tools:** Treat formal agreements as field guides for staff rather than just legal formalities.
Example: CBOs and healthcare systems can use an MOU to establish clear escalation pathways for disputes, reassuring frontline staff that there is a process for handling protocol exceptions.

2 Invest in human infrastructure and clear workflows

Technology is only an enabler; successful referral lifecycles require dedicated personnel to manage relationships and bridge silos.

- **Designate a single point of contact:** Healthcare systems should assign specific staff to manage the flow of network referrals.

Example: A hospital might designate one or more **Enrollment Specialists** to oversee all incoming social service requests, ensuring clients are routed to the correct department instead of getting lost in a general phone tree.

- **Deploy boundary spanners:** Hire personnel who can translate between clinical and community “languages.”

Example: Hiring **Community Health Workers (CHWs)** or peers with lived experience — such as those who were formerly unhoused — helps build client trust and provides “interpreters” who can simplify medical jargon for both clients and human service partners.

- **Directly fund CBO participation:** Move beyond short-term grants toward stable financing for social care.

Example: Healthcare partners can fund CBO navigator salaries through Medicaid waivers and value-based contracts.

Evaluating HHS networks

As referral networks mature, simple activity tracking is insufficient. Rigorous evaluation is required to assess impact, cost-effectiveness, and whether these results are experienced equally across subgroups.

The logic model framework

The logic model for HHS referral networks serves as a strategic roadmap that traces the causal pathway from initial investments to long-term community impact. It organizes the network’s lifecycle by differentiating between **Network** actions and **Client** experiences across five distinct stages:

- **Inputs:** the foundational resources, such as a referral network’s design, an accurate resource directory, and existing provider capacity
- **Activities:** the core work of the network, including network management, social needs screening, navigation, and enrollment support
- **Outputs:** the immediate results for both the system and the individual, such as increased referral efficiency and clients experiencing less stress.
- **Immediate outcomes:** short-term changes such as better relationships among member organizations and the initial resolution of identified social risks.
- **Long-term outcomes:** the ultimate goals of the system, including more consistent care through organizational learning, lower demand for emergency services, and better health and social well-being for client.

By using this framework for evaluation, leaders can move beyond simple activity tracking to see exactly how specific inter-organizational management choices — like governance and staffing — drive outcomes.

Evaluation must align with how networks actually function, tracing the causal pathway from inputs to outcomes.

- **Process and activity evaluation:** Measures include screening completion rates, outreach conversion, and the timeliness of status updates.
- **Output evaluation** focuses on the accuracy of matching clients with needs to providers that address those needs and enrollment success.
- **Outcome evaluation** assesses immediate changes in client stress (“cognitive bandwidth”) and long-term impacts on health and healthcare utilization.

Recommendations for rigorous evaluation

1 Prioritize patient-centered metrics over process completion

To accurately measure the impact of a network, leaders must distinguish between simple administrative closure and actual client benefit.

- **Adopt service receipt rate:** Shift the primary focus from the **closed loop rate** — which may only reflect that a file was closed — to the **service receipt rate**, which measures the percentage of cases in which the client actually received the service.
- **Identify the “success gap”:** Use both closed loop rate and service receipt rate in tandem to reveal operational failures; for instance, high closure rates can often mask low service receipt, signaling a breakdown between client match and service receipt. For instance, in a recent study, the closure rate was 85% but only in 27% of these cases did the client receive help.
- **Track needs resolution:** Go beyond service receipt to measure needs resolution, identifying if the intervention provided a sufficient “dose” to truly alleviate the client’s problem.

2 Use data to identify systemic disparities

Aggregate data often hides systemic disparities; therefore, evaluation must be designed to identify who is being left behind.

- **Conduct routine subgroup analysis:** Disaggregate outcomes by race, ethnicity, and geography to uncover barriers. Certain demographics may report significantly lower problem-resolution rates despite similar referral volumes.
- **Utilize geospatial mapping:** Overlay client “hotspots” with the **Social Vulnerability Index** to visually identify service deserts where high-need areas lack adequate provider coverage.

③ Establish continuous learning feedback loops

Evaluation should function as an ongoing management tool rather than a retrospective report card.

- **Create data feedback loops:** Monitor screening and enrollment funnels in real-time to identify exactly where clients drop out of the process.
- **Deploy mixed-method assessments:** Combine quantitative data (referral volume) with qualitative interviews to understand the “how and why” behind successful or failed connections.



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Introduction

Health and Human Services referral networks (HHS referral networks hereafter) have been a staple of U.S. policy for decades, from the Housing and Urban Development's Continuums of Care to Area Agencies on Aging. It's no wonder. Health and social needs are inextricably linked, but the agencies that address these needs operate as a fragmented system. In an effort to address this fragmentation, HHS referral networks offer promise as a way to enhance coordination and align stakeholders.

For organizations that are tasked with implementing and evaluating HHS referral networks, several key questions immediately arise.

- How can organizations with different missions, budgetary models, and capacities effectively work together?
- How can HHS referral networks determine if what they are doing is working?
- How can HHS referral networks be financially sustained?

The goal of this review is to present current knowledge of HHS referral network implementation and evaluation. This review identifies the common roadblocks that leaders face when implementing these networks and proven management strategies to address these issues. The report offers guidance on how to use the logic model presented in *Bridges to Resolution: The State of the Evidence on HHS Referral Network Design and Outcomes* to evaluate HHS referral network progress.

In order to write this report, we took a comprehensive review approach, drawing on research from medicine, public administration, and social work to learn about best-in-practice implementation designs. As such, this report does not just focus on studies of HHS referral networks, but draws more broadly on research on effective inter-organizational network implementation and evaluation.

Defining HHS referral networks

An HHS referral network is a collaborative arrangement of autonomous health and human service organizations that use agreed-upon processes to identify client needs and facilitate connections to services. Unlike a simple resource list, these networks involve formal inter-organizational relationships and shared infrastructure designed to manage the lifecycle of a referral.

The critical role of implementation

Implementation plays a key role in determining intervention success. For example, in Boston, MA, the WE CARE program targeting mothers of healthy infants had striking successes in the first phase of the program, including higher employment rates and lower rates of homelessness. But in a second stage, implementation challenges in clinics meant the intervention could not replicate the results of the early intervention. Fewer clients were screened and referred; in addition, health outcomes for infants in the study were reversed. This example demonstrates that a great design isn't enough to ensure HHS referral network effectiveness; implementation can influence these results dramatically.

Bridges to Resolution Reports

1. **Bridges to Resolution:** The state-of-the-evidence on HHS referral network focuses on the evidence-base and foundation design of these networks.
2. **Implementing and Evaluating HHS referral networks:** A companion guide to Bridges to Resolution focuses on common challenges when implementing and evaluating HHS referral networks.

Part I: Strategies for successful HHS referral network implementation

This section analyzes what it takes to move the network from the design stage to successful implementation. An important factor that affects the impact of any HHS network is the full participation and buy-in of CBOs and healthcare systems serving members of the same community. Having integrated networks that include both CBOs and health care organizations is one factor that distinguishes high- and low-performing hospital service areas, with performance being defined as avoidable healthcare use and spending on Medicare beneficiaries.¹ Having the participation of a prominent healthcare system can also add credibility to emerging networks, and it can influence the ability to attract other organizations into the network.² Similarly, CBO buy-in is essential for addressing social needs and ensuring high service receipt rates. Healthcare systems have struggled to onboard CBOs into HHS referral networks.³

Healthcare systems and CBOs have very different organizational structures, funding models, and cultures that affect willingness and ability to collaborate effectively. Healthcare organizations' primary purpose is the clinical management of disorders and illnesses, with an emphasis on diagnosis, medications, and prevention. Access to healthcare services is generally based on medical need, as determined by healthcare providers and insurance companies. Patients usually seek care when needed or on scheduled timelines (e.g., annual checkups), and services rendered are shaped by clinical practice guidelines, provider recommendations, patient preferences, and cost. Healthcare funding models are well-established and offer reliable and predictable resources to support operations. The ability and

motivation for healthcare systems to collaborate with other institutions that support the same community is often hindered by real or perceived competition, concerns about patient privacy and data sharing, need for legal approvals, and other bureaucratic hurdles.

In contrast, human services, community-based, or social care organizations (CBOs hereafter) focus on supporting communities by addressing social needs. These organizations aim to support clients by providing services such as housing assistance, income support, and food. Client management tends to be comprehensive and holistic, with an emphasis on building connections with clients to identify and prioritize co-occurring needs, motivating clients to access social support to address immediate needs, and laying the groundwork to address long-term needs. Eligibility requirements for various services are often established by funders, and clients are assessed for eligibility by social workers, case managers, or public workers at health centers and safety-net hospitals.

Compared with healthcare systems, practices within human services organizations tend to be less regimented, more flexible, and more customizable. For example, when a hospital coordinates discharge with a housing provider, the hospital typically requires standardized referral forms, documentation of those forms, and confirmation that services comply with liability standards before releasing a patient. In contrast, the housing provider may be accustomed to focusing on providing assistance first when individuals arrive and completing documentation later, or informally. Friction between healthcare systems

1 Amanda L. Brewster et al., "Collaboration in Health Care and Social Service Networks for Older Adults: Association With Health Care Utilization Measures," *Medical Care* 57, no. 5 (2019): 327–33, <https://doi.org/10.1097/MLR.0000000000001097>.

2 Leslie R. M. Hausmann et al., "Participation of Veterans Affairs Medical Centers in Veteran-Centric Community-Based Service Navigation Networks: A Mixed Methods Study," *Health Services Research* 59, no. 3 (2024): e14286, <https://doi.org/10.1111/1475-6773.14286>.

3 Caroline Fichtenberg et al., "If You Build It, They May Not Come: Understanding Factors Influencing Use of a Community Resource Referral Technology," *Health Services Research* 59, no. S1 (2024): e14234, <https://doi.org/10.1111/1475-6773.14234>.

and human service providers can arise when these norms conflict; after clinical needs have been met, the hospital may delay collaboration due to missing paperwork from the housing provider, whereas the housing provider perceives the delay as unnecessary and harmful to the client.

The success of any cross-sector referral network is heavily dependent on the capacity and active engagement of its CBO partners. Likewise, the viability of any health and social care referral strategy is contingent upon the capacity of CBOs to absorb the increased referral volume. If healthcare organizations ramp up screening for social needs, they risk overwhelming the CBOs tasked with meeting these needs. The CBOs may change the ways that they offer services to their clients.⁴ Without sufficient and sustainable capacity in the social services sector, these well-intentioned efforts can lead to service bottlenecks, unmet client needs, and ultimately, the

failure of the entire collaborative model.⁵ Synthesizing findings from multiple studies, CBOs face a distinct set of systemic challenges when engaging in formal partnerships with the healthcare sector, which is often vastly better resourced.

- **Financial instability and resource disparity:** The CBO sector typically operates with thin financial margins. CBOs are frequently underresourced and understaffed, operating on tight budgets that leave little room for adopting new technologies or altering workflows. A study of two communities found that the majority of CBOs relied on short-term funding. Just over 50% reported grants and donations as their primary funding source, and less than 40% relied on more stable fees-for-service or tax dollars.⁶ This creates a fundamental resource imbalance when partnering with healthcare organizations, which have significantly larger budgets and greater political and financial power, affecting a CBO's ability to scale services and negotiate contracts.⁷

4 Lauren A. Taylor and Elena Byhoff, "Money Moves the Mare: The Response of Community-Based Organizations to Health Care's Embrace of Social Determinants," *The Milbank Quarterly* 99, no. 1 (2021): 171–208, <https://doi.org/10.1111/1468-0009.12491>.

5 Rachel Hogg-Graham et al., "Exploring the Capacity of Community-Based Organisations to Absorb Health System Patient Referrals for Unmet Social Needs," *Health & Social Care in the Community* 29, no. 2 (2021): 487–95, <https://doi.org/10.1111/hsc.13109>; Matthew W. Kreuter et al., "Addressing Social Needs in Health Care Settings: Evidence, Challenges, and Opportunities for Public Health," *Annual Review of Public Health* 42, no. Volume 42, 2021 (2021): 329–44, <https://doi.org/10.1146/annurev-publhealth-090419-102204>.

6 Hogg-Graham et al., "Exploring the Capacity of Community-Based Organisations to Absorb Health System Patient Referrals for Unmet Social Needs."

7 Charlotte Pearson and Nick Watson, "Implementing Health and Social Care Integration in Scotland: Renegotiating New Partnerships in Changing Cultures of Care," *Health & Social Care in the Community* 26, no. 3 (2018): e396–403, <https://doi.org/10.1111/hsc.12537>; Heather Nelson et al., *Developing Healthcare and Human Services Collaborations: Current Case Studies* (Health Resources in Action and Northeastern University, 2018), https://humanservicesandhealthcare.org/wp-content/uploads/2019/12/RWJF-NU_HRiA-Case-Studies_Final-10.6.18.pdf.



- **Infrastructure and technology deficits.** Many CBOs lack robust information technology, data analytics, and administrative infrastructure, which hinders their ability to meet partner expectations for sophisticated performance reporting, secure data sharing, and complex billing for services.⁸ Integrating a new referral platform into existing CBO processes can be difficult and disruptive. This challenge is compounded when CBOs are asked by different healthcare partners to use multiple, non-interoperable platforms, creating significant administrative inefficiency.⁹ Furthermore, the cost of participating in shared technology platforms, such as Community Resource Referral Platforms, can be a significant barrier for smaller, lesser-resourced CBOs, potentially perpetuating existing inequalities.¹⁰ Without dedicated funding or a clear financial return on investment, the cost and staff time required to use a new platform can be prohibitive.¹¹
- **Workforce strain and administrative burden.** CBOs face significant challenges in recruiting, training, and retaining essential frontline staff, such as case managers and CHWs. These difficulties are often driven by insecure employment tied to short-term funding cycles, leading to high rates of stress and burnout.¹² The inability to maintain a stable, well-supported workforce directly limits a CBO's capacity to absorb an increased volume of referrals from healthcare partners. Additionally, the staff time required to maintain up-to-date resource

information, respond to incoming electronic referrals, and document outcomes represents a significant, and often unfunded, administrative burden for CBOs.¹³

Together, these differences in working models and CBO-specific challenges create significant barriers to collaborative alignment, including misaligned financial incentives, communication and information sharing challenges, and structural and relational tensions.

Despite the cultural, structural, and financial differences, there are strategies for setting up HHS networks to encourage full participation of healthcare systems and CBOs alike. The recommendations below are aimed at those who are seeking to establish or support high-functioning HHS networks. These strategies will help bridge the gaps between healthcare systems and CBOs so that both are motivated and participate fully in the network.

Common CBO Challenges

1. CBOs rely on short-term funding and are often under-resourced.
2. Many CBOs lack technological and evaluation capacity to meet healthcare partner expectations.
3. CBOs face challenges recruiting and retraining front-line staff because of resources and high rates of burnout.

⁸ Nelson et al., *Developing Healthcare and Human Services Collaborations: Current Case Studies*; Frank J. Thompson et al., "Medicaid Waivers and Tenancy Supports for Individuals Experiencing Homelessness: Implementation Challenges in Four States," *The Milbank Quarterly* 99, no. 3 (2021): 648–92, <https://doi.org/10.1111/1468-0009.12514>.

⁹ Laura B. Beidler et al., "More than Just Giving Them a Piece of Paper": Interviews with Primary Care on Social Needs Referrals to Community-Based Organizations," *Journal of General Internal Medicine* 37, no. 16 (2022): 4160–67, <https://doi.org/10.1007/s11606-022-07531-3>; Yuri Cartier et al., "Implementing Community Resource Referral Technology: Facilitators and Barriers Described by Early Adopters," *Health Affairs* 39, no. 4 (2020): 4, <https://doi.org/10.1377/hlthaff.2019.01588>.

¹⁰ Bradley Iott and Denise Anthony, "Provision of Social Care Services by US Hospitals," *The Milbank Quarterly* 101, no. 2 (2023): 601–35.

¹¹ Yuri Cartier et al., *Community Resource Referral Platforms: A Guide for Health Care Organizations* (Social interventions research and evaluation network, 2019), 98, https://childrenshealthwatch.org/wp-content/uploads/SIREN-webinar-for-HVS-NCOP-2019_05.pdf; Julia Browne et al., "Addressing Social Determinants of Health Identified by Systematic Screening in a Medicaid Accountable Care Organization: A Qualitative Study," *Journal of Primary Care & Community Health* 12 (January 2021): 2150132721993651, <https://doi.org/10.1177/2150132721993651>; Jenny Harlock et al., "Challenges in Integrating Health and Social Care: The Better Care Fund in England," *Journal of Health Services Research & Policy* 25, no. 2 (2020): 86–93, <https://doi.org/10.1177/1355819619869745>.

¹² Thompson et al., "Medicaid Waivers and Tenancy Supports for Individuals Experiencing Homelessness"; Michael J. Yedidia and Joel C. Cantor, "Providing Health Care to People Experiencing Homelessness: Strategies and Challenges for Cross-Sector Initiatives," *The Milbank Quarterly* 00, no. 0 (2025), <https://doi.org/10.1111/1468-0009.70056>.

¹³ Beidler et al., "More than Just Giving Them a Piece of Paper"; Browne et al., "Addressing Social Determinants of Health Identified by Systematic Screening in a Medicaid Accountable Care Organization."

Recommendations to bridge the healthcare and CBO gap

Recommendation 1

Establish shared purpose and trust

To ensure network viability, the participating organizations need a shared understanding of the network’s goals. The network’s mission should reflect big-picture goals that are shared across healthcare and human service organizations that serve the community. Establishing a shared purpose not only builds buy-in and commitment from participating organizations; it also helps guide network-level decisions about funding models, governance structures, and other design and implementation choices. Shared purpose can be developed by engaging organizational leaders (from both healthcare systems and CBOs), personnel, and, ideally, the communities they serve in deliberate network-building activities throughout the collaboration’s

lifecycle, so that all partners understand and agree on the desired impact. This creates a sense of connection across partners and community members, allowing for more trust and buy-in.

Continuing to foster opportunities for meaningful engagement after a network is established is essential to maintain buy-in, trust, and shared purpose. Engagement may take many forms. It can include opportunities to learn about services offered by partner organizations, highlighting successes in the community and within the network, and workshops or communities of practice where participants develop skills to support their organizations.

TABLE 2 Practice Points for Establishing Shared Purpose and Trust

Role of Healthcare Systems	Role of CBOs	Shared Role
- Clearly communicate the clinical, regulatory, and funding limitations to community-based partners to set realistic expectations - Clearly define what healthcare organizations are able and unable to do within the network when working toward shared goals - Use the shared mission as a way to invite collaboration, not as a compliance requirement for partners	- Assist healthcare partners in understanding community priorities, lived experiences, and service barriers in practice, while accounting for their regulatory constraints - Provide examples of how network goals manifest in clients’ daily lives to make the mission tangible - Highlight when network activities diverge from community needs and propose course corrections	- Develop the network’s mission through joint activities rather than one-time planning sessions - Build in regular opportunities to revisit the shared purpose as circumstances, funding, or membership evolve - Use shared learning spaces (e.g., workshops or communities of practice) to strengthen trust, alignment, and commitment across sectors

Recommendation 2

Establish governance and leadership protocols

Clear decision-making structures, accountability mechanisms, and conflict resolution processes are essential to improve trust and reduce confusion. For example, networks should establish shared protocols for routing service requests from one member to the next and for handling protocol exceptions. More concretely, agencies should create formal agreements that describe decision-making criteria and network roles that establish escalation pathways for disputes or emergencies. Protocols need to be feasible for participating organizations, ideally striking a balance between having clear, regimented processes while allowing for modifications to accommodate existing workflows within each provider organization.

For healthcare systems, formal agreements may be required to ensure data sharing is HIPAA-compliant and that the healthcare system's involvement meets relevant laws and regulations. In some cases, the presence of a formal agreement, even if not legally required, can assuage reservations of healthcare staff who may not be accustomed to working with outside organizations to meet patients' needs.¹⁴ Having an influential but neutral third-party, such as a local United Way chapter or Area Agency on Aging, drive network development and recruit organizations may help overcome resistance, perceived competition, and other reservations to joining the network.¹⁵

TABLE 3 Practice Points for Establishing Governance and Leadership Protocols

Role of Healthcare Systems	Role of CBOs	Shared Role
- Clearly outline legal, regulatory, and data-sharing requirements (such as HIPAA, consent, and documentation) so community partners are aware of constraints from the beginning - Collaborate with community-based organizations to develop protocols for referrals, exceptions, and escalation instead of simply imposing clinical workflows - Utilize formal agreements as tools for collaboration, not merely compliance, to demonstrate commitment and reassure staff who might be reluctant to work across organizational boundaries	- Help healthcare partners understand how governance decisions influence service access, timeliness, and client trust - Identify where inflexible protocols create barriers for community members and suggest practical alternatives - Actively participate in drafting agreements to ensure roles, responsibilities, and escalation pathways accurately reflect how work is actually carried out	- Establish shared governance structures with a clearly defined decision-making matrix and conflict resolution pathways - Engage a neutral organization (such as United Way or Area Agency on Aging) to coordinate governance, manage tensions, and recruit members - Include community representatives in governance roles to ensure decisions reflect lived experiences and maintain legitimacy among all partners

¹⁴ Hausmann et al., "Participation of Veterans Affairs Medical Centers in Veteran-Centric Community-Based Service Navigation Networks."

¹⁵ Amanda L. Brewster et al., "Patterns of Collaboration among Health Care and Social Services Providers in Communities with Lower Health Care Utilization and Costs," *Health Services Research* 53, no. S1 (2018): 2892–909, <https://doi.org/10.1111/1475-6773.12775>.

Recommendation 3

Explore resource collaboration and value-based models

To address power dynamics and imbalances stemming from different financial arrangements, network designers and implementers should consider models that prioritize social and clinical needs. Value-based models that incentivize quality and cost savings over volume of services provide financial motivation for healthcare systems to partner with human services providers. Coordinating with human service providers to address upstream needs of patients may reduce the need for high-cost healthcare services, such as emergency department visits and preventable hospitalizations. Value-based models that use capitation, that is, the allocation of a set amount of

funds per patient, aim to support the health of large populations and offer greater flexibility in spending funds. Healthcare partners can justify increased collaboration with human services providers if it results in more effective and cost-efficient management of health issues. This also encourages shared governance by reframing human services partners as key contributors to achieving outcomes, not just referral destinations. When considering payment models, it is important to ensure that human service organizations are adequately compensated for their contributions, especially when they support the overall health of the population they serve.

TABLE 4 Practice Points for Exploring Resource Collaboration and Value-Based Models

Role of Healthcare Systems	Role of CBOs	Shared Role
• Collaborate with human service partners to understand how social services impact clinical outcomes and reduce costs, such as by decreasing ER visits and enhancing care continuity • Implement value-based or capitated funding models to establish flexible arrangements that support non-clinical services that address upstream needs • View human service organizations as active partners who generate outcomes when developing payment and accountability systems, rather than just referral points	• Clearly explain how services (e.g., housing support, transportation, food access) promote population health goals valued by healthcare partners • Work with healthcare organizations to document impacts that matter in value-based models, even if results are indirect or take longer to appear • Support compensation structures that account for workload, expertise, and ongoing engagement, not just volume of referrals	• Design funding models collaboratively to balance clinical and social priorities and reduce power imbalances between partners • Implement shared governance structures to decide how resources are allocated, adjusted, and evaluated across the network • Regularly review payment and resource-sharing arrangements to ensure they remain fair, flexible, and aligned with community needs

Recommendation 4

Foster clear and transparent communication channels

For a network to function effectively, people need to communicate across multiple levels. Leaders should have regular dialogue with other leaders, frontline staff need clear channels to connect with their counterparts in partner organizations, and leaders must maintain close contact with their own teams to explain processes and gather feedback on what’s working or not. If any of these communication channels break down, coordination and trust can quickly decline. Having dedicated network staff to facilitate connections between organizations and promote ongoing internal communication is essential to keep the collaboration on track.

Collaboration may occur through both asynchronous and synchronous communication channels, including regular network meetings, idea-generation labs, and informal discussions about network processes and practices. Shared communication tools should also be used, as described in other sections, to support asynchronous communication and learning and to enhance collaboration and collective problem-solving. Partners should also develop shared terminology, data standards, and metrics to ease

cross-sector information exchange and reduce the administrative burden on less-resourced partners. This reduces friction, allowing organizations from different sectors to exchange information efficiently, align expectations, and participate meaningfully without being overwhelmed by duplicative reporting or incompatible systems. Opportunities for continuous learning through joint training sessions and evaluations of network processes, outputs, and outcomes will help maintain an open communication environment, thereby mitigating perceptions of hierarchy and relational tensions.

One strategy for fostering communication across organizations is to establish **boundary-spanning roles**, that is, personnel who enable communication across organizational boundaries and silos. CHWs, social workers, and navigators can help bridge health and social care needs, especially when these roles are filled by members of the community. These roles can build trust with clients by reducing barriers related to terminology, cultural differences, and communication issues, such as language barriers, which can hinder connection and ongoing access to care.

TABLE 5 Practice Points for Fostering Clear and Transparent Communication Channels

Role of Healthcare Systems	Role of CBOs	Shared Role
• Establish clear and dependable communication channels for frontline staff to connect directly with their counterparts in community-based organizations • Support boundary-spanning roles, such as social workers, navigators, and CHWs, who interpret clinical processes and terminology for human service partners • Share data standards, metrics, and reporting expectations in ways that reduce administrative burden on less-resourced partners	• Ensure that staff are available to communicate with frontline healthcare staff when necessary. Assist healthcare partners in understanding community context, service realities, and client communication needs • Utilize boundary-spanners to convey community experiences into actionable information for healthcare systems • Use shared communication tools and learning spaces to align terminology, expectations, and workflows	• Establish consistent cross-level communication routines, such as leader forums, peer exchanges at the frontline, and network-wide meetings • Use shared platforms and tools to support asynchronous communication, learning, and problem-solving • Invest in joint training, shared metrics, and collective evaluations to reduce friction, catch tensions early, and build trust across sectors

Recommendation 5

Develop clear relational and operational workflows

Joining a network requires staff from participating organizations to change and adapt their existing workflows, which may be a strong point of resistance for highly protocolized and understaffed healthcare systems. Clear relational and operational workflows allow staff to successfully send and receive network referrals. One successful strategy for managing network referrals flowing into healthcare systems is

to have a single point of contact manage all incoming referrals, such as a social worker or enrollment specialist.¹⁶ This ensures that clients are routed to the appropriate healthcare team, department, or program. Alternatively, training multiple social workers or other staff within the healthcare system to refer patients to other organizations in the network will increase the number of patients referred to CBOs.

TABLE 6 Practice Points for Developing Clear Relational and Operational Workflows

Role of Healthcare Systems	Role of CBOs	Shared Role
• Designate a single point of contact (e.g., social worker, care coordinator, enrollment specialist) to manage incoming referrals from network partners • Clearly communicate referral pathways, response times, and decision rules to human service organizations to align expectations • Train multiple staff members on network workflows and referral tools to reduce bottlenecks and enhance follow-through when patient needs extend beyond clinical care	• Coordinate referral details and documentation to match healthcare partners' intake and triage procedures • Clearly indicate when referrals are urgent, incomplete, or require exceptions to usual workflows • Keep in touch with designated healthcare contacts to swiftly address routing problems and avoid referral failures	• Collaboratively develop and document relational and operational workflows during onboarding, revisiting them as staffing, tools, or needs evolve • Use shared training sessions or walkthroughs to foster mutual understanding of each partner's workflow constraints • Regularly analyze referral flow data and frontline feedback to identify friction points and collaboratively refine processes

¹⁶ Hausmann et al., “Participation of Veterans Affairs Medical Centers in Veteran-Centric Community-Based Service Navigation Networks.”



Recommendation 6
Allow for local flexibility

Communities considering creating an HHS network should always begin by evaluating how network processes can be adapted to local strengths, contexts, and needs. For example, if the network aims to build trust with communities that are suspicious of it, it should hire boundary spanners from those communities. These boundary spanners can provide

a sense of familiarity within the care-seeking process, may speak the same language as clients, and may have social ties that lend reputational support to the network, thereby reducing fears of engagement. As noted in other sections, communities should approach this endeavor with strategies that work for their community, rather than a one-size-fits-all approach.

TABLE 7 Practice Points for Allowing for Local Flexibility

Role of Healthcare Systems	Role of CBOs	Shared Role
- Collaborate with community partners to understand local histories, trust levels, and barriers to care before implementing standardized network procedures - Hire or integrate boundary spanners from the communities served to bridge cultural, linguistic, and relational gaps - Allow flexibility in protocols and workflows when strict standardization reduces trust or limits access for local populations	- Share insights on community norms, expectations, and trusted messengers to inform network design and implementation - Assist healthcare partners in identifying approaches that build trust versus those that may face resistance - Promote locally tailored adaptations to network processes instead of one-size-fits-all solutions	- Establish network processes that define shared objectives while permitting local adaptations - Engage boundary spanners, community representatives, or trusted intermediaries to guide continuous network decision-making - Regularly review integration strategies to ensure they are aligned with changing community needs and circumstances

Recommendations to bridge the healthcare and CBO gap

1 Establish shared purpose and trust

4 Foster clear and transparent communication channels

2 Establish governance and leadership protocols

5 Develop clear relational and operational workflows

3 Explore resource collaboration and value-based models

6 Allow for local flexibility

Part II: Evaluating HHS referral networks

Social service referral networks require a robust evaluative framework to assess their structure, processes, and outcomes. Selecting an appropriate evaluation methodology is a fundamental prerequisite for building effective, equitable, and resilient social service systems. As these integrated networks mature, a rigorous understanding of their impact, cost-effectiveness, and overall value is essential, demanding an evolution in evaluation methodologies from simple activity tracking to comprehensive impact assessment.

When choosing an evaluation design, we recommend a multi-method approach impact assessment. Such an assessment includes different types of questions.

- **Process questions** examine how services are delivered and experienced. These questions explore the mechanisms, barriers, and facilitators that shape referral pathways. For example, how do service users experience the referral process? What organizational factors enable or hinder successful connections?

- **Output questions** measure the immediate products of network activity, such as the volume of referrals made, the percentage of referrals completed, or patterns of service utilization over time. For example, how many referrals were completed within 30 days? What percentage of clients successfully connected with services?
- **Outcome questions** assess whether the referral network caused meaningful changes in client well-being or system performance. These questions require establishing causal relationships. For example, did the new referral platform improve client health outcomes? Did increased funding lead to better connection rates?

TABLE 8 presents some of the primary questions, resources, and constraints associated with recommended designs.

TABLE 8 Exemplar Evaluation Designs Driven by Research Questions

Primary Question Type	Recommended Design	Resources Required	Key Advantages
Process (How and why do referrals work?)	Qualitative design with semi-structured interviews and thematic analysis ¹⁷	Moderate (15–25 interviews, transcription, analysis time)	Captures lived experience, reveals barriers and facilitators, and explains mechanisms
Output (What is the volume and pattern of activity?)	Longitudinal or retrospective cohort study ¹⁸	Low to Moderate (if using existing platform data) to High (with prospective data collection)	Tracks patterns over time, measures completion rates, and identifies trends
Outcome (Does the intervention cause change?)	Randomized controlled trial ¹⁹ or quasi-experimental design	High (requires careful design, control group, outcome measurement)	Establishes causation, provides strongest evidence for impact
Network structure (How is the network organized and accessible?)	Cross-sectional network analysis ²⁰ or geospatial analysis ²¹	Moderate (requires specialized software and analytical expertise)	Maps relationships, identifies gaps in coverage, and helps visualize system structure
Complex (What is happening and why?)	Sequential explanatory mixed-method design ²²	High (combines quantitative and qualitative phases)	Provides both measurement and explanation, creates comprehensive understanding

¹⁷ Emma B. Black et al., “Homeless Youth: Barriers and Facilitators for Service Referrals,” *Evaluation and Program Planning* 68 (June 2018): 7–12, <https://doi.org/10.1016/j.evalprogplan.2018.02.009>.

¹⁸ Sonia Boyum et al., “Getting Help from 2-1-1: A Statewide Study of Referral Outcomes,” *Journal of Social Service Research* 42, no. 3 (2016): 402–11, <https://doi.org/10.1080/01488376.2015.1109576>; Fred S. Johnson et al., “Measures of Referral vs Receipt of Social Services Among Patients With Health-Related Social Needs,” *JAMA Network Open* 7, no. 4 (2024): e247021, <https://doi.org/10.1001/jamanetworkopen.2024.7021>.

¹⁹ Tess Thompson et al., “Promoting Health by Addressing Basic Needs: Effect of Problem Resolution on Contacting Health Referrals,” *Health Education & Behavior* 43, no. 2 (2016): 201–7, <https://doi.org/10.1177/1090198115599396>.

²⁰ H. Brinton Milward and Keith G. Provan, “Measuring Network Structure,” *Public Administration* 76, no. 2 (1998): 387–407, <https://doi.org/10.1111/1467-9299.00106>.

²¹ Stephanie L. Fitzpatrick et al., “Establishing a Regional Health System and Community-Based Organization Social Care Coordination Network: An Application of Geospatial Analysis,” *The Permanente Journal* 28, no. 3 (2024): 157–62, <https://doi.org/10.7812/TPP/24.052>.

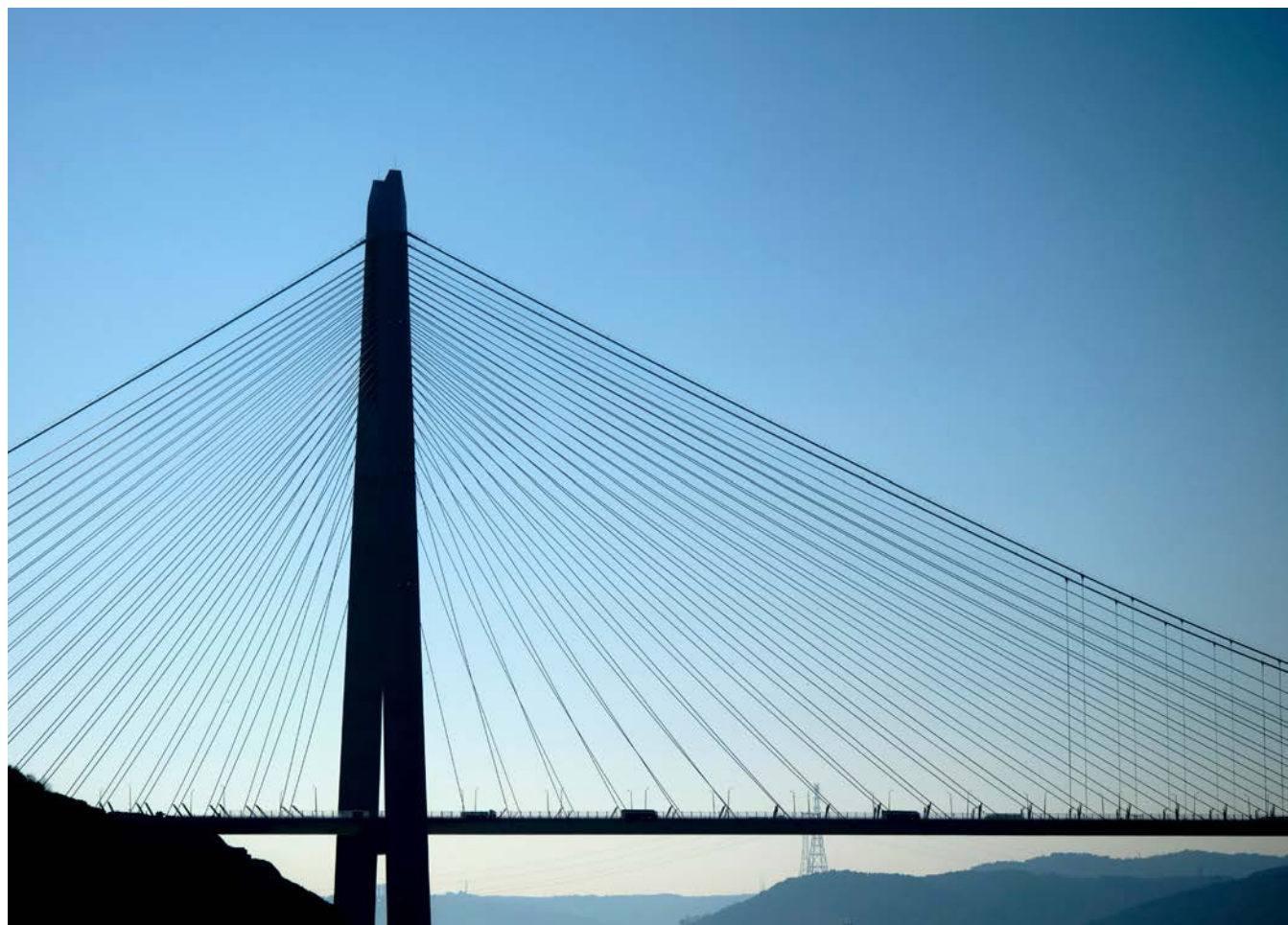
²² Joshua-Paul Miles et al., *Maintaining Systems of Care in the Midst of Shock*, under review.

The remainder of this evaluation framework is organized according to the logic model introduced in *Bridges to Resolution: The State of Evidence on HHS Referral Networks Design and Outcomes* that maps the pathway from network inputs through activities, outputs, and outcomes. This structure reflects how referral networks function in practice: they begin with resources (inputs), use those resources to conduct specific work (activities), generate direct products and services (outputs), and ultimately produce changes at the individual and network levels (outcomes). By aligning evaluation strategies with this logic model, assessment approaches capture the full complexity

of how these networks create value. This section provides an overview of the types of evaluation that are needed. It ends with key equity concerns that should be taken into account in any evaluation plan. For a more detailed playbook for evaluation associated with referral processes, see *The Health and Human Services Referral Systems' Measurement and Evaluation Playbook*²³ and the *Community Action and Analysis Plan*.²⁴

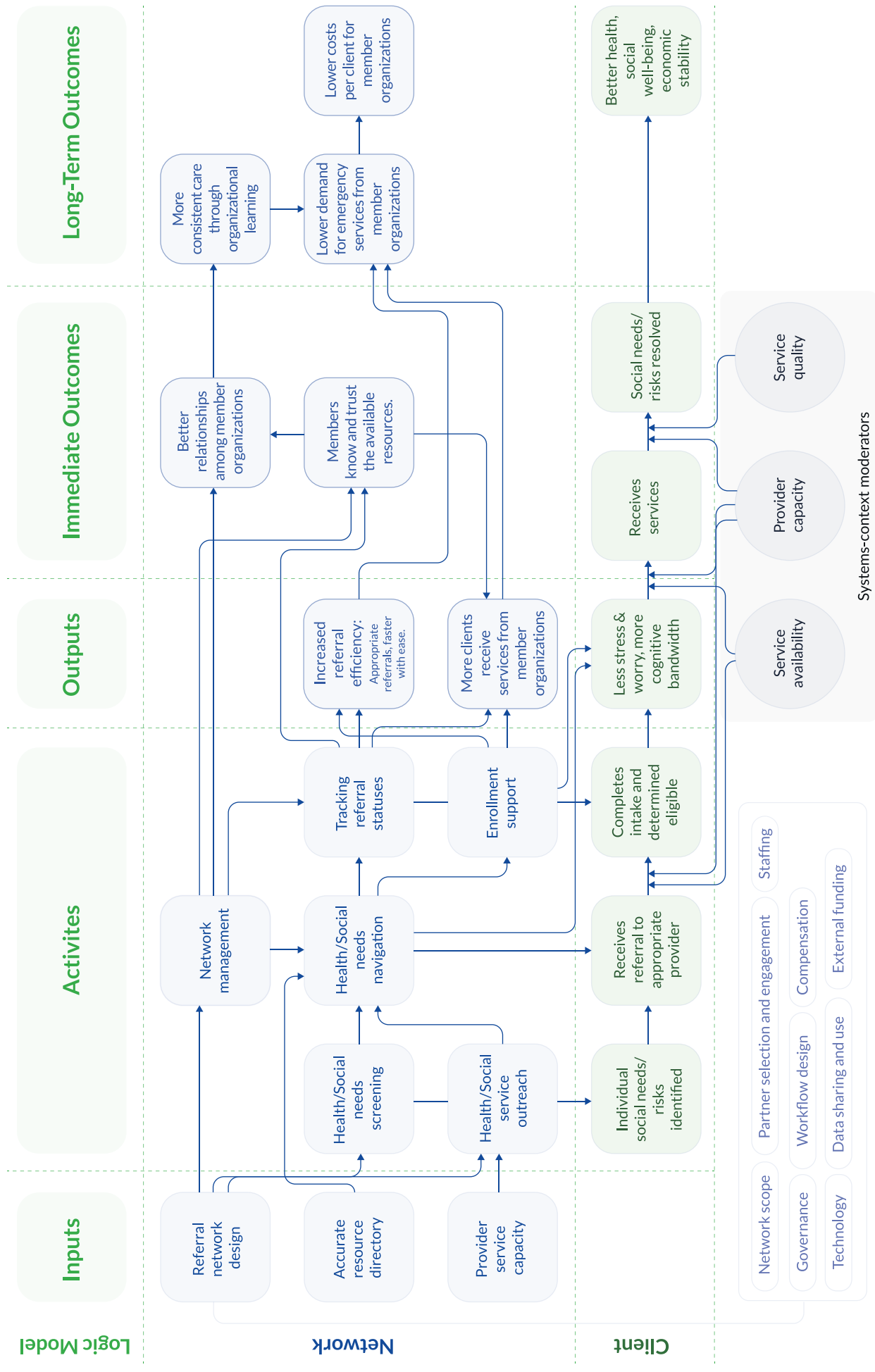
²³ Michelle Shumate and Qiwen Zhang, *The Health and Human Services Referral Systems' Measurement and Evaluation Playbook* (Network for Nonprofit and Social Impact at Northwestern University, 2026), <https://nnsi.northwestern.edu/introducing-the-health-and-human-services-referral-systems-measurement-and-evaluation-playbook/>.

²⁴ Katie Huber et al., *Community Action and Analysis Plan: Guidance and Resources for Community Care Hubs to Address Health-Related Social Needs Based on Lessons from North Carolina* (Duke-Margolis Institute for Health Policy, 2024), https://healthpolicy.duke.edu/sites/default/files/2024-08/Community%20Action%20and%20Analysis%20Plan_8.27.24.pdf.



A Logic Model for Health and Human Service Referral Networks

This logic model depicts how health and human service networks may influence long-term outcomes. However, not all health and human service networks perform the activities listed. We expect those that do will produce better outcomes.



Evaluating processes and activities

Activities represent the core work that a referral network conducts to connect individuals with services. These activities transform inputs into tangible services and connections. The logic model identifies six key activity domains: social needs screening, social service outreach, referral tracking, navigation services, enrollment support, and network management. Evaluating these activities requires assessing both the volume and quality of the work. This section examines methodological approaches to activity evaluation, with particular attention to understanding not just whether activities occur, but how well they are executed.

Evaluations need to analyze the conceptual pathway from screening to outcomes. The OASIS (Outcomes from Addressing SDoH in Systems) framework provides a clear conceptual model for this process.²⁵ It hypothesizes a pathway for screening to identify unmet social needs, leading to referrals and connections with community resources. The successful reduction of these needs is then theorized to improve patient adherence to medical advice and, consequently, lead to better clinical outcomes.²⁶ This model posits that addressing fundamental life challenges is a prerequisite for effective healthcare engagement.

One practical method for assessing the real-world validity of a screening and referral program is to systematically track a patient's journey from the moment a need is identified to its potential resolution. This approach measures the operational effectiveness of the system in moving a person through the necessary stages of receiving help. A study of The MetroHealth System in Cleveland, Ohio identifies a clear, six-step process that can be used as

an evaluation framework.²⁷ By tracking the number of patients who complete each step, evaluators can create a “funnel” that visualizes progress and attrition throughout the system.

Evaluating screening and outreach

Screening and outreach are the entry points for referral networks, identifying which individuals have unmet needs and what type of assistance they require. Effective screening is both comprehensive (detecting the full range of needs) and efficient (not overburdening staff or clients). Evaluation should address two fundamental aspects of outreach: penetration and conversion.

Screening and outreach penetration

Outreach penetration describes the percentage of the eligible population that is reached by outreach efforts. There are many reasons why individuals do not enroll in programs and benefits that they are eligible to receive. These include learning costs, or the effort required to find and understand available services; compliance costs, such as the time and effort needed to apply for benefits; and psychological costs, including stigma, which deters individuals from seeking help due to shame or frustration associated with navigating complex bureaucracies.²⁸ These are the key barriers that effective outreach can address.

To assess outreach penetration, evaluators should use population-level statistics on incidence rates of health and social needs to determine the number of eligible individuals. They should then compare the number of individuals reached by outreach efforts against the number of individuals in the population that have those needs and are eligible to receive services.²⁹

²⁵ Deborah Gurewich et al., “Addressing Social Determinants of Health Within Healthcare Delivery Systems: A Framework to Ground and Inform Health Outcomes,” *Journal of General Internal Medicine* 35, no. 5 (2020): 1571–75, <https://doi.org/10.1007/s11606-020-05720-6>.

²⁶ Gurewich et al., “Addressing Social Determinants of Health Within Healthcare Delivery Systems.”

²⁷ Kevin Chagin et al., “A Framework for Evaluating Social Determinants of Health Screening and Referrals for Assistance,” *Journal of Primary Care & Community Health* 12 (January 2021): 21501327211052204, <https://doi.org/10.1177/21501327211052204>.

²⁸ Dafna F. Bearson and Cass R. Sunstein, “Take Up,” *Behavioural Public Policy*, October 4, 2023, 1–16, <https://doi.org/10.1017/bpp.2023.21>.

²⁹ Shumate and Zhang, *The Health and Human Services Referral Systems' Measurement and Evaluation Playbook*.

Screening and outreach conversion

Outreach conversion serves as a diagnostic tool for understanding the initial friction in the referral system, which is the point where client motivation, system accessibility, and communication effectiveness first intersect. This metric assesses the success of initial engagement efforts by measuring the proportion of individuals who, after being contacted or referred, take a concrete next step. It provides a direct measure of whether the initial outreach was compelling and accessible enough to motivate action, such as seeking a referral.

Second, action-oriented conversion metrics measure whether a referral prompted the client to take an independent next step. For example, one study found that 24% of 2-1-1 callers contacted a health referral they received.³⁰ This metric assesses the effectiveness of the referral in motivating client action outside of the initial interaction.

Finally, the end-to-end programmatic metric provides a high-level indicator of overall program success. The Washington State Community Care Hub (CCH) framework proposes the “referral to enrollment rate” as a key programmatic measure.³¹ This metric directly quantifies the conversion from an initial referral to successful enrollment, serving as a comprehensive benchmark of system effectiveness.

Program evaluators can use several specific metrics to directly measure the success rate of outreach and referral efforts. Organizing these metrics from micro-conversions to macro-outcomes provides a clear analytical progression. First, stage-specific conversion metrics measure success at discrete points in the referral process. The multi-step data from one study illustrates this approach.³² In this study of patients screened for food insecurity, 86% of patients with identified needs consented to a referral, and of

those who consented, only 42% had a referral placed on their behalf. These metrics pinpoint exactly where initial engagement succeeds or fails.

Tracking referral and enrollment activities

Referral tracking systems are the operational backbone of coordinated care networks, creating visibility into referral flow and enabling performance monitoring. Evaluating tracking activities focuses on system utilization, data quality, and the timeliness of status updates. Below is a table of suggested activities to track, associated metrics, and evidence-based benchmarks to measure success.

The core distinction is between metrics that track whether a client received a service and those that track whether receiving a service resolved an individual's needs.³³ *Service receipt rate is frequently much higher than that of needs resolution.* This difference is driven by the sufficiency of the “dose” of the intervention to alleviate needs. For example, although receiving a food box provides for some individuals' needs, it may be insufficient to resolve food insecurity for their family in the long run.

The type of referral and enrollment activity differs depending on the HHS referral network design, especially the workflow model. **TABLE 9** provides several example activities that apply to some of these workflow models. These metrics can be calculated for the network as a whole or within specific subgroups, as shown in the last column. However, the metrics a HHS referral network uses should be aligned with its workflow design.

³⁰ Thompson et al., “Promoting Health by Addressing Basic Needs.”

³¹ Washington State Dept. of Health, “Community Care Hub Measurement Approach,” n.d.

³² Chagin et al., “A Framework for Evaluating Social Determinants of Health Screening and Referrals for Assistance.”

³³ Johnson et al., “Measures of Referral vs Receipt of Social Services Among Patients With Health-Related Social Needs.”

TABLE 9 Examples of Potential Referral and Enrollment Activities, Metrics, and Benchmarks for Success

Activity	Tracking Metrics	Example Benchmarks for Success	Examples of Subgroup Comparison ³⁴
Managing and tracking referrals ³⁵	# of referrals; service receipt rate; needs resolution rate	Referral outcomes documented for 80% of cases; connection to service within 7 days of referral; 27% service receipt	Clients in rural counties have service receipt of 20%; clients in urban counties have service receipt of 45%
Enrolling referred individuals into care coordination or navigation services ³⁶	# of enrolled clients; referral to enrollment rate	80% of clients enrolled with consent/ authorization; clients enrolled within 7 calendar days	70% of women veterans enrolled with consent; 40% men veterans enrolled with consent
Providing outreach and engagement to referred individuals who have not yet enrolled ³⁷	% of individuals who have received at least 3 outreach attempts	80% of non-enrolled individuals receive at least 3 outreach attempts	90% of individuals age 18-30 receive at least 3 outreach attempts; 60% of individuals over 65 receive 3 outreach attempts
Developing and documenting comprehensive care plans for clients ³⁸	# of clients served with documentation of a completed care plan	100% documentation of a completed care plan as a standard for all enrolled individuals	75% of pregnant clients have a documented and completed care plan; 50% of clients who are not pregnant have a documented care plan
Supported referrals, in which existing providers introduce clients to new providers through joint sessions or phone calls ³⁹	# of supported referrals; % of successful transitions	Service receipt generally completed within 30 days of initial screening	On average, service received in 45 days for Medicaid clients and 25 days for Medicare Advantage clients
Information and referral helpline that connects callers with local health and social service agencies ⁴⁰	% of referrals reached; % of callers receiving assistance; % problem resolution	82% reach rate for referrals; 36% assistance receipt rate	48% assistance receipt rate for non-Hispanic white callers; 25% assistance receipt rate for Latino callers
Network efficiency and effectiveness in connecting clients to care and resolving referral cases ⁴¹	Average time to accept requests (i.e., client wait times); # of requests per service type; % of cases resolved vs unresolved; # of service requests per client	Improvement or maintenance of efficiency compared to pre-process change baseline; 70% of network performance changes show improvement	6 of 10 regional networks managed by community hubs showed improvement in the percentage of cases resolved
Coordination and case load management across health and social care services ⁴²	# of contacts (clinicians/ case managers); # of appointments; missed appointment rates	80% documentation completion	70% of documentation completed by CHWs in Federally Qualified Health Centers; 90% of documentation completed by CHWs in other settings

³⁴ Examples for subgroup comparison are hypothetical for illustration purposes. These do not reflect the resources cited in the first column.

³⁵ ChaginChagin et al., "A Framework for Evaluating Social Determinants of Health Screening and Referrals for Assistance"; Washington State Dept. of Health, "Community Care Hub Measurement Approach"; Johnson et al., "Measures of Referral vs Receipt of Social Services Among Patients With Health-Related Social Needs."

³⁶ Washington State Dept. of Health, "Community Care Hub Measurement Approach."

³⁷ Washington State Dept. of Health, "Community Care Hub Measurement Approach."

³⁸ Washington State Dept. of Health, "Community Care Hub Measurement Approach."

³⁹ Chagin et al., "A Framework for Evaluating Social Determinants of Health Screening and Referrals for Assistance"; Black et al., "Homeless Youth."

⁴⁰ Boyum et al., "Getting Help from 2-1-1."

⁴¹ Miles et al., *Maintaining Systems of Care in the Midst of Shock*.

⁴² Laura Kelly et al., "Measures for the Integration of Health and Social Care Services for Long-Term Health Conditions: A Systematic Review of Reviews," *BMC Health Services Research* 20, no. 1 (2020): 358, <https://doi.org/10.1186/s12913-020-05206-5>.

Network management

Network management refers to how HHS referral networks manage the relationships among member organizations. This can happen through collaborative peer-to-peer designs, such as communities of practice, or top-down methods, such as providing technical assistance.

Measuring these activities can provide evaluators with insights into how to improve partner engagement, help know which providers offer which services, and help understand relationships among members. At a minimum, evaluators should document the frequency of engagement with and among partner organizations.⁴³

In addition, evaluators may wish to pay attention to the ways that these activities are related to referral activity in the network. For instance, they can assess the degree to which participation in communities of practice is associated with sending or receiving referrals.

Collecting this data may be useful in refining network management processes over time. Evaluators may consider using an action-research model to refine implementation and promote continuous improvement of the network. The action research model uses a repeating cycle — diagnosing, planning action, taking action, and evaluating action — to support real-world problem-solving and continuous adaptation.⁴⁴

Evaluating outputs

The core argument of this section is that successful outcomes in the final stages of a logic model are dependent on the quality and equity of the preceding stages. At the client level, the logic model argues that reduced stress and increased cognitive bandwidth are the key outputs. At the network level, improved referrals are the key outcome.

Less stress and increased cognitive bandwidth

The expectation that resolving social needs will yield psychological benefits is grounded in well-established theoretical models. A primary concept is scarcity, which posits that the state of having an unmet need can “capture the mind,” diminishing the cognitive bandwidth available for focusing on long-term goals, including health behaviors.⁴⁵ The OASIS framework synthesizes these ideas, proposing that reducing unmet social needs can lead to decreased stress, less life chaos, and improved well-being, thereby reducing the cumulative physiological “allostatic load” that chronic stress places on the body.⁴⁶

To objectively assess the psychological benefits of social need resolution, evaluators must employ quantitative methods that utilize validated instruments and follow a clear measurement timeline. The use of standardized and validated tools is necessary to ensure the reliability of psychological measurement. For instance, the World Health Organization’s 5-Item Well-Being Index (WHO-5) is a brief, validated instrument that has been effectively used in social service network evaluations. Research employing this tool has demonstrated high concurrent validity, showing that clients with unresolved basic

⁴³ Black et al., “Homeless Youth”; Vincent Lorant et al., “Effectiveness of Health and Social Service Networks for Severely Mentally Ill Patients’ Outcomes: A Case-Control Study,” *Administration and Policy in Mental Health and Mental Health Services Research* 46, no. 3 (2019): 288–97, <https://doi.org/10.1007/s10488-018-0910-x>.

⁴⁴ Teresa S. Waring and David W. Wainwright, “Integrating Health and Social Care Systems in England - A Case of Better Care?,” 2015, <https://api.semanticscholar.org/CorpusID:55131604>.

⁴⁵ Thompson et al., “Promoting Health by Addressing Basic Needs.”

⁴⁶ Gurewich et al., “Addressing Social Determinants of Health Within Healthcare Delivery Systems.”

needs report significantly lower WHO-5 scores than clients whose needs are met, confirming the link between need resolution and subjective well-being.⁴⁷ For a more focused assessment of psychological distress, single-item stress measures adapted from validated surveys offer a concise method for tracking change. They often include the question, “How often do you feel stressed these days (e.g., tense, restless, nervous, anxious, or trouble sleeping)?”⁴⁸

Improved referrals

A successful referral is not just one that is accepted by a provider, but one that is accurate and appropriate for the client.

Referral accuracy can be measured quantitatively by tracking the efficiency of the matching process. An inaccurate referral often results in a client being rejected by a provider due to ineligibility or a mismatch of services, leading to wasted time and frustration. A key metric for referral accuracy is the proportion of clients who receive one or more rejections before successfully enrolling in services. A complementary metric, proposed by Tahoub and colleagues,⁴⁹ measures accuracy as the percentage of referrals accepted by the first provider. This directly assesses the system’s ability to make a correct initial match.

Efficiency is the time required for a client to be connected to care. A shorter time usually suggests effective screening and well-managed service request routing. Conversely, a longer time might indicate bottlenecks or uneven distribution of requests. However, processing requests quickly does not necessarily mean everything is fine. Clients could be connected swiftly but routed to incorrect

or incomplete services, making the network seem efficient while causing downstream failures and unnecessary demand.⁵⁰

Referral appropriateness involves qualitative factors that go beyond eligibility criteria. A referral may be technically accurate but inappropriate if it fails to consider the client’s holistic needs and preferences. Drawing on findings from studies with vulnerable populations, key factors for appropriateness include:⁵¹

- Client preferences: aligning the service with the individual’s stated goals, values, and comfort level
- Geographic accessibility: ensuring the service location is accessible via available transportation and does not create an undue burden on the client
- Cultural and linguistic congruence: matching the client with providers who can communicate effectively and offer culturally-sensitive care

Evaluating immediate outcomes

Immediate outcomes represent the direct changes that occur as a result of successful outputs. While outputs measure what the network produces, immediate outcomes measure how those outputs begin to change conditions for individuals and within the system itself. The logic model identifies immediate outcomes at two levels: client-level outcomes and network-level outcomes. These outcomes typically emerge within weeks to months of service delivery and represent necessary preconditions for longer-term impacts.

⁴⁷ Marwa Tahboub et al., “Trajectories of Care and Associated Patterns,” paper presented at SIREN National Research Meeting, February 2025.

⁴⁸ Anna-Liisa Elo et al., “Validity of a Single-Item Measure of Stress Symptoms,” *Scandinavian Journal of Work, Environment & Health* 29, no. 6 (2003): 444–51, <https://doi.org/10.5271/sjweh.752>.

⁴⁹ Tahboub et al., “Trajectories of Care and Associated Patterns.”

⁵⁰ Jeannie L. Haggerty et al., “Continuity of Care: A Multidisciplinary Review,” *BMJ* 327, no. 7425 (2003): 1219–21, <https://doi.org/10.1136/bmj.327.7425.1219>.

⁵¹ Black et al., “Homeless Youth.”

Client-level immediate outcomes

There are two metrics for client-level immediate outcomes: receiving services and resolving social needs or risks. Receiving services logically precedes needs or risk resolution. However, provider capacity and service quality can moderate the expected relationship.

Receives services: Service receipt can be measured by tracking whether clients received the services for which they were referred. Best-in-practice measurement does not include client self-resolution of referrals as service receipt. Closed-loop referral systems make measuring referral receipt much easier than most traditional case management technologies. Not only can providers indicate if they have accepted the referrals, but they can also indicate the outcome of the referral (e.g., receives services, self-resolved need or found help elsewhere, client failed to respond).⁵²

Social needs or risks resolved: Needs resolution rates differ from service receipt rates. **Needs resolution rates** describe the rate at which a referral addresses the need completely.⁵³ Logically, effective referrals should completely address a client's needs. However, the sufficiency and quality of services are contextual factors that attenuate this link. The field is only now beginning to grapple with how to optimize referrals for needs resolution instead of service receipt.⁵⁴ Evaluators can capture needs resolution through structured telephone surveys and self-reported ratings.⁵⁵

Network-level immediate outcomes

Beyond individual client outcomes, referral networks generate immediate outcomes at the network level. These include changes in how organizations work together, how efficiently the network operates, and

how effectively organizations learn and adapt. These network-level outcomes are important because they create the conditions for sustained, scalable impact.

Better relationships among member organizations

The quality of relationships among network organizations affects how well the network functions. Better relationships enable smoother referrals, more effective problem-solving, and greater willingness to collaborate on complex cases. Partnership quality itself functions as a performance mechanism. More extensive forms of collaboration are associated with higher referral resolution rates.⁵⁶ Strong partnerships, clear communication channels, and mutual understanding among service providers are often prerequisites for successful referrals and collaborative care.

Social network analysis provides a formal methodology for quantitatively mapping and measuring the structural relationships between organizations in a service network. This approach involves surveying key informants at each agency to map the specific types of service links that connect them. This method also offers a high degree of methodological rigor. For instance, a linkage between two organizations is typically validated only when it is confirmed by respondents from both organizations. The resulting network map provides a powerful visual and analytical tool for assessing the overall pattern and integration of service linkages within the system. However, these structural maps only reveal the architecture of the network; they do not capture the quality or functional effectiveness of the ties, which requires assessing the participants' perceptions.

Alongside structural analysis, it is vital to assess the quality of relationships by examining the experiential and relational dynamics within the network. Perceptual measures capture the degree

⁵² Shumate and Zhang, *The Health and Human Services Referral Systems' Measurement and Evaluation Playbook*.

⁵³ Boyum et al., "Getting Help from 2-1-1."

⁵⁴ Tahboub et al., "Trajectories of Care and Associated Patterns."

⁵⁵ Boyum et al., "Getting Help from 2-1-1"; Jane Gibbons, "Children in Need and Their Families: Outcomes of Referral to Social Services," *The British Journal of Social Work* 21, no. 3 (1991): 217-27, <https://doi.org/10.1093/oxfordjournals.bjsw.a055754>.

⁵⁶ Hausmann et al., "Participation of Veterans Affairs Medical Centers in Veteran-Centric Community-Based Service Navigation Networks."

of trust, satisfaction, and mutual understanding that defines the day-to-day experience of inter-agency collaboration. Surveys are an effective tool for systematically capturing partner perceptions of network functioning. Strategic measures can be designed to assess key aspects of collaboration and administrative efficiency. Examples of such metrics include the percentage of network partners who feel that the administrative burden of participating in the network is reduced, the percentage who are satisfied with the administrative support provided by a central hub, and the percentage who report the presence of shared decision-making in network governance.⁵⁷

Member organizations know and trust available resources

A second key intermediate outcome of HHS referral networks is that member organizations have better knowledge of and trust in available resources. A high-quality resource directory, strong network management activities, and experiences with successful referrals should work together to improve both knowledge and trust in resources.

Qualitative research can illuminate gaps that hinder effective referrals. For instance, a study involving providers from homelessness and mental health services found that a significant barrier was that staff in each sector simply did not know what services were available in the other. As one mental health provider stated, “We don’t know, we actually don’t know which services are around. With homelessness, there is no clear [service].”⁵⁸ This lack of basic, cross-sectoral knowledge directly impedes the ability to make appropriate and successful referrals.

More clients receive services from member organizations

Finally, an effective HHS referral network should result in a greater number of clients seeking and receiving help from participating member organizations. This relationship, again, is logical. If more unreached individuals are engaged through outreach and screening, and referrals and enrollment effectively match clients to services, then, in aggregate, more clients will be referred and served by member organizations. Evaluation measures should account for both “baseline” client throughput and trends in client throughput for member organizations.

Evaluating long-term outcomes

Long-term outcomes represent the ultimate impacts that HHS referral networks aim to achieve: improvements in health, social well-being, and economic stability, alongside system-level changes, such as more consistent care through organizational learning, lower emergency service utilization, and lower per-client costs for member organizations. These outcomes typically appear after months or years and reflect the cumulative effect of successful outputs and immediate outcomes. Evaluating long-term outcomes presents distinct methodological challenges, including longer time horizons, attribution complexity (i.e., many factors influence these outcomes beyond the referral network), and data access limitations. This section examines approaches to measuring long-term outcomes while acknowledging these constraints. These interrelated outcomes represent the most distal endpoints in the logic model. **TABLE 10** summarizes key long-term outcomes, key methods for evaluation, and examples from academic and practitioner publications.

⁵⁷ Washington State Dept. of Health, “Community Care Hub Measurement Approach.”

⁵⁸ Black et al., “Homeless Youth.”

TABLE 10 Rationales for Measuring Outcomes, Examples, and Key Challenges

Outcome	Rationale for Measurement	Key Methodologies and Metrics
Better health, social well-being, and economic stability	Demonstrates the full, holistic value of interventions beyond single clinical markers; captures comprehensive effect of resolving multiple needs	• Trajectory of Care (TOC) metric⁵⁹ • Standardized scales (WHO-5)⁶⁰ • Qualitative interviews • Clinical indicators (e.g., systolic blood pressure), behavioral adherence (e.g., colposcopy attendance), and self-reported reductions in unmet needs⁶¹ • Clients' social functioning and well-being indicators (e.g., housing stability, lower recidivism rates, and improved employment outcomes)⁶²
Enhanced social functioning and well-being	Provides earlier indicators of program success; captures human experience of care before clinical/economic outcomes appear	• Validated scales (SIX Index for social integration)⁶³ • Client satisfaction surveys • Qualitative interviews
More consistent care through organizational learning	Over time, better relationships among member organizations allow for the development of effective care coordination routines. Networks can identify bottlenecks, refine service criteria, and standardize effective procedures, while remaining flexible in other areas. ⁶⁴	• Referrals between organizations become standardized and complete • Complex cases are resolved through more in-depth organizational coordination • Networks demonstrate resilience in the face of changing service environments⁶⁵
Lower demand for emergency services and healthcare utilization	Core component of value proposition for payers and health systems; demonstrates improved resource allocation and cost savings	• Administrative claims data analysis (preventable hospitalizations, urgent care use) • Pre-post intervention analysis
Lower costs and higher return on investment (ROI)	Ultimate financial justification for investing in social care infrastructure; ensures long-term sustainability and scalability	• Cost-effectiveness analysis (intervention costs vs. costs averted)⁶⁶ • Funder satisfaction tracking⁶⁷ • Revenue tracking⁶⁸ • Healthcare expenses⁶⁹

⁵⁹ Tahboub et al., "Trajectories of Care and Associated Patterns."

⁶⁰ Christian Winther Topp et al., "The WHO-5 Well-Being Index: A Systematic Review of the Literature," *Psychotherapy and Psychosomatics* 84, no. 3 (2015): 167–76, <https://doi.org/10.1159/000376585>.

⁶¹ Christa Mayfield et al., "Development of a Statewide Network Hub for Screening, Referral, and Enrollment into Food as Medicine Programs across Kentucky," *Frontiers in Public Health* 12 (January 2025), <https://doi.org/10.3389/fpubh.2024.1502858>; Lindsay Kuroki et al., "Addressing Unmet Basic Needs to Improve Colposcopy Adherence Among Women With Abnormal Cervical Cancer Screening," *Journal of Lower Genital Tract Disease* 25, no. 2 (2021): 106, <https://doi.org/10.1097/LGT.0000000000000593>; Luke Mueller et al., "A Novel Intervention for Medicaid Beneficiaries with Complex Needs," *Journal of General Internal Medicine*, ahead of print, September 25, 2025, <https://doi.org/10.1007/s11606-025-09839-2>.

⁶² Hugh Alderwick et al., "The Impacts of Collaboration between Local Health Care and Non-Health Care Organizations and Factors Shaping How They Work: A Systematic Review of Reviews," *BMC Public Health* 21, no. 1 (2021): 1–16, 149880379, <https://doi.org/10.1186/s12889-021-10630-1>; Harvey Whiteford et al., "System-Level Intersectoral Linkages between the Mental Health and Non-Clinical Support Sectors: A Qualitative Systematic Review," *Australian & New Zealand Journal of Psychiatry* 48, no. 10 (2014): 895–906, <https://doi.org/10.1177/0004867414541683>.

⁶³ S. Priebe et al., "Objective Social Outcomes Index (SIX): A Method to Summarise Objective Indicators of Social Outcomes in Mental Health Care," *Acta Psychiatrica Scandinavica* 118, no. 1 (2008): 57–63, <https://doi.org/10.1111/j.1600-0447.2008.01217.x>.

⁶⁴ Julia Carboni et al., *Collaborative Networks: The next Frontier in Data Driven Management*, 2022.

⁶⁵ Miles et al., *Maintaining Systems of Care in the Midst of Shock*.

⁶⁶ Deborah Gurewich et al., "Screening and Referral for Social Needs Among Veterans: A Randomized Controlled Trial," *Journal of General Internal Medicine*, ahead of print, January 23, 2025, <https://doi.org/10.1007/s11606-024-09105-x>; Gurewich et al., "Addressing Social Determinants of Health Within Healthcare Delivery Systems."

⁶⁷ Washington State Dept. of Health, "Community Care Hub Measurement Approach."

⁶⁸ Washington State Dept. of Health, "Community Care Hub Measurement Approach."

⁶⁹ RTI International, *Accountable Health Communities (AHC) Model Evaluation Third Evaluation Report* (Centers for Medicare and Medicaid, 2024), <https://www.cms.gov/priorities/innovation/data-and-reports/2024/ahc-3rd-eval-report>; Seth A. Berkowitz et al., "Medicaid Spending and Health-Related Social Needs in the North Carolina Healthy Opportunities Pilots Program," *JAMA*, ahead of print, February 27, 2025, <https://doi.org/10.1001/jama.2025.1042>.

Equity in evaluation

Effective evaluations must move beyond aggregate results to understand how interventions and service systems impact different subgroups and communities. This requires a deliberate focus on analyzing the heterogeneity of effects across populations and explicitly considering equity. The goal is to ensure that services both reach and tangibly benefit those with the greatest needs.

Equity in this context refers to the fair distribution of resources and outcomes, ensuring that all individuals can achieve their full potential for health and well-being. The reviewed literature demonstrates an evolution in how equity is measured, moving from retrospective analysis to the intentional design of equity-focused metrics.

Several studies have conducted subgroup analyses to investigate how outcomes differ across demographic and social lines, revealing important disparities and differential impacts. Some evaluations have assessed equity by disaggregating outcomes by key demographic variables. Key examples include:

- **Racial disparities in service receipt:** An analysis of the Connect Oregon network provides a clear example. The data revealed a slightly lower referral acceptance rate for Latino clients.⁷⁰ Such findings allow network leaders to investigate the root causes of disparities and implement corrective actions.
- **Racial disparities in needs resolution:** A study of 2-1-1 callers in Missouri found that African Americans were significantly less likely than White callers to report that their problem had been resolved at a 1-month follow-up. This disparity persisted even after controlling for a range of other sociodemographic variables, suggesting systemic barriers to problem resolution.⁷¹

- **Demographic differences across conversion steps:** The evaluation of an SDoH screening program found that completion of referral process steps differed significantly by patient demographics; older patients were more likely to have referrals placed and resolved, while Black patients were less likely than White patients to consent to a referral in the first place, though their referrals were resolved at similar rates if they did consent.⁷²
- **Equity-focused network management and design:** Modern evaluation frameworks now propose explicit, forward-looking metrics to hold systems accountable for equitable practices. The measurement approach for CCHs in Washington state, for example, includes strategic measures such as “percent of funding from CCH to small, grassroots, and/or impacted organizations.” This metric moves beyond simply tracking outcomes by demographic to assessing whether the system’s resources are being distributed equitably to the community organizations best positioned to serve marginalized populations.

Assessing system capacity

A sophisticated evaluation must look beyond immediate outputs and outcomes to assess a network’s underlying health and capacity. System capacity refers to the resources, infrastructure, and ability of a network to meet the volume and complexity of community needs. Capacity is both an input to be evaluated and a moderating factor that affects performance across all components of the logic model.

Assessing capacity helps understand systemic-level variance and determine whether a network is building a resilient system of care. Qualitative studies have effectively identified capacity constraints through the perspectives of providers and clients. These analyses highlight systemic barriers such as

⁷⁰ Bradley Iott and Caroline Fichtenberg, *A First Look at Connect Oregon Implementation - Analysis of Connect Oregon Platform Data from 2023* (2024), https://ohlc.org/wp-content/uploads/2024/10/COSIE_FinalReport_9.30-1.pdf.

⁷¹ Boyum et al., “Getting Help from 2-1-1.”

⁷² Chagin et al., “A Framework for Evaluating Social Determinants of Health Screening and Referrals for Assistance.”

“resource shortages” that limit the availability of safe housing and funding for homeless youth.⁷³ Similarly, quantitative follow-up studies have found that a primary reason for not receiving assistance from a referral was that the agency simply did “not have funds” available.⁷⁴

The emerging focus on system capacity marks a significant maturation in the field, representing a direct response to the limitations of earlier evaluation models. While previous methods could demonstrate that a referral was made (an output) or even that a problem was resolved (an outcome), they often failed to explain why some networks had worse outcomes or why some systems buckled under pressure. Capacity assessment provides this explanatory power and should be integrated into evaluations at all levels of the logic model.

This evaluation section has organized assessment strategies according to the logic model pathway that referral networks follow, from inputs through activities and outputs to immediate and long-term outcomes. This organization reflects a fundamental principle: effective evaluation must align with how programs actually function, tracing the causal pathway from resources invested to changes achieved.

Several key themes emerge across this framework. First, *no single evaluation method is sufficient to capture the complexity of referral networks*. Qualitative methods are essential for understanding process and experience; quantitative methods provide the rigor needed to measure outcomes and test causal relationships; network and geospatial analyses reveal structural properties that other methods miss. The most sophisticated evaluations intentionally combine methods to answer questions that no single approach could address alone.

Second, equity must be embedded throughout the evaluation process, not treated as an add-on consideration. Every level of the logic model — from

input assessment through long-term outcome measurement — should incorporate equity analysis. This means disaggregating results by demographic characteristics, assessing geographic disparities in coverage, and examining whether resources and services reach those with the greatest needs. It also means involving diverse stakeholders in defining what outcomes matter and how success should be measured.

Third, evaluation and implementation must evolve together. The most useful evaluations don’t simply document what happened; they generate actionable insights that drive improvement. This requires designing data systems that enable real-time monitoring, creating feedback loops between evaluation findings and practice changes, and building capacity for continuous learning within networks.

Finally, the field continues to mature in its evaluation approaches. Early evaluations focused primarily on whether referrals were made and services delivered, but this is insufficient for demonstrating value. Newer evaluation methods increasingly examine system capacity, partnership quality, and resilience under stress. The emerging focus on patient-centered metrics (e.g., service connection rate) and equity-focused measures (e.g., resource distribution to grassroots organizations) reflects this maturation.

As referral networks proliferate and mature, the evaluation strategies outlined in this framework provide a roadmap for rigorous, comprehensive, and useful assessment. By aligning evaluation with the logic model, employing appropriate methods at each level, and focusing on equity and continuous improvement, we can build the evidence base needed to strengthen these critical systems and demonstrate their value to the individuals and communities they serve.

⁷³ Black et al., “Homeless Youth.”

⁷⁴ Boyum et al., “Getting Help from 2-1-1.”

Evaluation recommendations

Recommendation ①

Implement comprehensive logic model-based evaluation systems.

Move beyond simple activity tracking to evaluate referral networks across all components of the logic model: inputs, activities, outputs, and outcomes. Establish evaluation systems that assess network infrastructure, provider capacity, process quality, and client outcomes using mixed methods combining quantitative metrics, qualitative approaches, and network analysis. Create a centralized CCH responsible for maintaining evaluation infrastructure and use bilateral confirmation protocols to validate service linkages between agencies. Set up geospatial analysis systems overlaying client need hotspots with the Social Vulnerability Index to identify coverage gaps in high-need areas.

Recommendation ②

Embed equity analysis throughout all evaluation levels.

Make equity assessment a core component of every stage of the evaluation rather than an afterthought. Disparities can emerge at multiple points, from who gets screened and referred, to who accepts referrals, to whose problems ultimately get resolved. Without systematic equity analysis, networks risk perpetuating existing inequalities. Require comprehensive demographic data collection across all network touchpoints to enable disaggregated analysis by race, ethnicity, gender, language, and disability status. Conduct subgroup analyses to examine how referral acceptance, service completion, and problem resolution differ by demographic characteristics, and use geospatial analysis to identify whether high-need, high-vulnerability areas have adequate provider coverage.

Recommendation ③

Evaluation should inform both initial implementation design and continuous improvement.

Move beyond evaluation as a retrospective accountability exercise and embrace it as an ongoing learning system that drives real-time improvement. Build data infrastructures that enable continuous monitoring and establish feedback loops where evaluation findings directly inform operational adjustments, using shared referral data to identify patterns requiring community-level intervention. Implement quality improvement processes that combine discovery, systems mapping, and redesign and testing. Create regular opportunities for collaborative reflection through network-strengthening meetings where partners develop joint action plans based on evaluation insights.

The most valuable evaluations generate actionable insights that inform mid-course corrections and iterative refinement of network operations.

Conclusion

While the fragmentation of health and human services has long been a challenge in the United States, the strategic implementation of integrated referral networks offers a promising pathway toward cross-sector alignment. As this report outlines, HHS referral network operational success demands an active management strategy that addresses cultural friction, power imbalances, and the capacity strain of CBOs. By establishing a shared purpose, formal governance protocols, and clear relational workflows, these networks can effectively bridge the gap between highly protocolized clinical environments and the flexible, holistic nature of social service providers. Prioritizing “human infrastructure” — including navigators and boundary spanners — ensures that the system is built on trust and community reality rather than just technological capability.

The long-term viability of these collaborations depends on linking implementation with a rigorous evaluative framework that evolves beyond simple activity tracking toward comprehensive impact assessment. By aligning evaluation with a logic model, leaders can trace the causal pathway from initial screening to patient-centered outcomes. This creates a continuous learning system where data informs real-time implementation adjustments, allowing networks to identify bottlenecks and address systemic demographic disparities. Ultimately, strong implementation practices and evaluation can enable state, municipal, and nonprofit leaders to move HHS referral system outcomes from promise to reality.



Abbreviations

CBO	Community-Based Organizations
CCH	Community Care Hub
CHW	Community Health Workers
HHS	Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
HUD	U.S. Department of Housing and Urban Development
MOU	Memorandum of Understanding
NNSI	Network for Nonprofit and Social Impact
OASIS	Outcomes from Addressing SDoH in Systems
RCT	Randomized Controlled Trial
ROI	Return on Investment
SDoH	Social Determinants of Health
SIREN	Social Interventions Research and Evaluation Network
SIX	Social Outcomes Index
TOC	Trajectory of Care
VA	Veterans Affairs
WHO-5	World Health Organization's 5-Item Well-Being Index

