



Community-Centered Health Homes

Bridging Healthcare Services
and Community Prevention



FUNDING AND AUTHORSHIP

PREVENTION INSTITUTE

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Prevention Institute (PI) is a national nonprofit with offices in Oakland, Los Angeles, Houston, and Washington, D.C. Our mission is to build prevention and health equity into key policies and actions at the federal, state, local, and organizational levels to ensure that the places where all people live, work, play and learn foster health, safety and wellbeing. Since 1997, we have partnered with communities, local government entities, foundations, multiple sectors, and public health agencies to bring cutting-edge research, practice, strategy, and analysis to the pressing health and safety concerns of the day. We have applied our approach to injury and violence prevention, healthy eating and active living, land use, health systems transformation, and mental health and wellbeing, among other issues.

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a. Jessica Riccardo is no longer with the Louisiana Public Health Institute, but was on staff when drafting portions of this report.

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Introduction



Photo credit: California Healthy Nail Salon Collaborative

The Collaborative conducts a training a local nail salon.

Rashes on hands and arms. Headaches. Dizziness. Respiratory problems. In 2005, Asian Health Services (AHS), a federally qualified health center (FQHC) located in Oakland, California, began noticing a pattern of these and other acute complaints among patients who were predominantly younger and female.¹ The common factor among these patients? They were all nail salon workers.

AHS became aware of this pattern of complaints because the health center was already deeply engaged with Oakland’s Asian-American community. In the process of conducting diabetes education in nail salons, AHS community health workers heard from nail salon employees about their chemical-related health issues.² Trained to listen for issues impacting the community, the community health workers brought these concerns back to their supervisor and to Julia Liou, a chief deputy of administration, whose responsibilities include advocacy and program planning. She checked in with clinical providers and learned that they were seeing patients with these employment-related health concerns.³ In response, AHS established the California Healthy Nail Salon Collaborative with a mission to “improve the health, safety, and rights of the nail and beauty care workforce.” The collaborative now consists of over 25 community-based organizations, and AHS sits on its steering committee. Together, collaborative members educate salon workers and owners about reducing workers’ exposure to occupational hazards, conduct community-based participatory research studies focused on worker health and safety, and advocate for local and state policies that protect nail salon workers.^{4 5}

This type of effort was not new for AHS, which has a long history of working with and on behalf of the community to improve health and promote wellness. AHS was founded with the dual mission of service and advocacy. Its leadership works to integrate services and advocacy very closely and creates multiple spaces for staff and patients to elevate community health issues. Thus, Asian Health Services has become engaged in many pressing community concerns, including safe streets for pedestrians, resident-friendly economic development,⁶ identification and disruption of commercially exploited minors/ human trafficking, and organizing against harmful policies aimed

Asian Health Services has become engaged in many pressing community concerns, including safe streets for pedestrians, resident-friendly economic development, and others.

at immigrants. AHS's advocacy takes many forms such as activating partner organizations, supporting relevant research, conducting media interviews, hosting legislative briefings, and preparing issue-specific materials for patients. This level of community engagement is a great source of pride for Asian Health Services staff and is considered by leadership as part of AHS's DNA—that is, integral to its mission and vision.

To galvanize the clinic's action within new arenas, AHS leadership encourages staff to share their observations about community conditions that may affect patient health in order to better inform services, programming, and potential partnerships to address those conditions. While community services staff seek grants to support community-centered activities, AHS jumps in right away when there is a critical community need; they find a way to make it work regardless of funding support.⁷

Asian Health Services exemplifies the spirit of a Community-Centered Health Home. The Community-Centered Health Home (CCHH) model was first presented by Prevention Institute in a 2011 publication.⁸ The model was based on analysis of case studies⁹ and interviews with health system key informants about the practices of healthcare organizations, such as Asian Health Services, that advance quality healthcare along with quality community-level prevention.

This paper represents a second edition of the 2011 original. Since its publication, philanthropic partners inspired by the CCHH model have invested in three independent demonstration projects involving over 21 primary care organizations across the Gulf Coast Region, North Carolina, and Texas to further inform the model and the practices. This paper integrates lessons learned from these demonstration projects and insights we've gleaned from our involvement with national initiatives that have emerged since to engage healthcare organizations in upstream work. It offers practical strategies for implementing the CCHH model, drawing upon lessons and examples from participating sites, and describes the capacities needed for healthcare organizations interested in beginning their own journey toward becoming a CCHH.

What is a Community-Centered Health Home?

A CCHH is a healthcare organization that has institutionalized practices . . . to improve community conditions. A CCHH not only *acknowledges* that factors outside the clinic walls affect patient health outcomes, it *actively participates* in improving them.

A CCHH is a healthcare organization that has institutionalized practices to address community-identified health priorities through collaborative activity to improve community conditions. A CCHH not only *acknowledges* that factors outside the clinic walls affect patient health outcomes, it *actively participates* in improving them. These factors include community conditions, such as the availability of parks and open space, healthy food, affordable housing, clean air and water, and strong social networks.¹⁰ Being community-centered is a world-view, an organizational identity, and a mission for healthcare organizations seeking greater impact and effectiveness in health improvement – it is the core perspective and value that propels a CCHH.

The CCHH model (Figure 1) consists of three functional capacities in the outer ring and four foundational capacities in the inner circle. The functional capacities of **Inquiry, Analysis, and Action** enable a CCHH to assess and identify community determinants of health, engage in collaborative planning and priority-setting, and contribute to improvements in the community conditions that shape health. The four foundational capacities of **Leadership, Staffing, Knowledge & Skills, and Partnership** enable a healthcare organization to intentionally and strategically integrate a community-centered approach into the fabric of the organization.

Together, these capacities equip a CCHH to engage in a flexible and collaborative process to address and improve the community conditions that can either support—or hinder—the good work done every day by healthcare teams. While the model is comprehensive, uptake of the practices and activities is not necessarily a linear process, nor is it intended to introduce another set of prescriptive compliance standards. Rather, the model builds on the skills that healthcare organizations have developed through their quality improvement journeys and leverages those skills to impact health on a community-level. Although taking on community conditions might seem far afield from the exam room, the impact of those conditions on patients' health is ubiquitous during patient encounters.

Community-level prevention^b is aimed at preventing illness and injury in the first place, and strategies focus on addressing underlying community conditions that influence health, safety, and wellbeing.¹¹ Effective initiatives recognize the leadership and experiences of community members; implement comprehensive multi-sector strategies; leverage policy, systems, and organizational practice changes; and conduct evaluation alongside community members to recalibrate strategies.^{12 13 14 15}

Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health, such as poverty, discrimination, and their consequences, including powerlessness, lack of access to good jobs with fair pay, quality education and housing, safe environments, and healthcare.¹⁶

Figure 1: Community-Centered Health Home Model



The CCHH model is grounded in the tenets of community-level prevention and health equity (see definitions in sidebar). A CCHH learns from patients and community members about the community conditions that contribute to illness and injury, interfere with treatment plans, or present obstacles to improving health. It also listens for opportunities to enhance community assets. With this knowledge, and taking stock internally, a CCHH identifies how to work in partnership with allies like community-based organizations, local public health departments, residents, and others to foster communities that support health, safety, and wellbeing. Recognizing that community conditions are shaped by structural drivers including economic and social policies, a CCHH advocates for policy and systems change. The CCHH is a valued member of local coalitions because it brings its unique relationships and resources to the table. These include relationships with patients and insights into community conditions they face, the credibility of clinicians and institutions as health experts, and the organization’s role as a community institution. Ultimately, being a CCHH reflects an ongoing organizational commitment to advancing health equity by utilizing its influence, expertise, and partnerships to make improvements in health-impacting conditions within the community it serves.

b. This definition for community-level prevention has been developed by Prevention Institute through our synthesis of research and community practice.

Roots and Evolution of the CCHH Model

The CCHH model draws inspiration from and builds upon the pioneering work at the Delta Health Center in Mississippi, one of the first federally-funded health centers in the nation, opened in 1967 through the U.S. Office of Economic Opportunity.¹⁷ The Delta Health Center applied early lessons learned from community-oriented primary care (COPC) experiments abroad, and incorporated COPC principles into its operations by both expanding access to medical care and improving community environments. Dr. H. Jack Geiger built the medical team, while Dr. John Hatch, a social worker and community organizer, recruited community residents to join local health associations across Northern Bolivar County to identify the most urgent community needs and take action to improve them. Lack of employment opportunities, disease-causing vermin in housing, social isolation of seniors, the violence and trauma of living in the segregated South, and severe food insecurity were common issues facing residents.

The Delta Health Center staff took immediate actions to improve community conditions, such as making home repairs and improving access to clean drinking water. Further, it supported the health associations in longer-term community priorities to achieve structural changes in economic development, such as access to home mortgage loans, voter registration, and participation in local government. With a budget funded by the Office of Economic Opportunity that didn't require fee-for-service reimbursement, the early Delta Health Center leaders delivered high-quality healthcare and partnered with community members to address the social determinants of health, with their actions focusing on the

question: "What does it take to be healthy and stay healthy, not just get healthy?"¹⁸

More than 50 years later, this question still echoes in health system debates about how to improve population health and achieve health equity. Compared to other developed countries, the U.S. health system is something of a paradox: despite huge healthcare expenditures, the U.S. continues to have some of the worst population health outcomes among its peers.¹⁹ At the time the CCHH model was developed, a national consensus was emerging that access to quality healthcare and healthy community conditions are both critical elements of advancing population-level health improvement, hence the inclusion of Title IV (Prevention of Chronic Disease and Improving Public Health) in the Patient Protection and Affordable Care Act.^{20 21 22, 23} This national consensus rests upon a strong evidence base that illuminates the connection between physical and mental wellbeing and the social determinants of health—the conditions in which people are born, grow, live, work, and age.^{24 25} Further, strengthening community conditions is key to promoting health equity and eliminating health disparities among people of color and people experiencing poverty in the United States.^{26 27}

Healthcare providers are well aware that circumstances outside of clinic walls have an impact on the health status of their patients.²⁸^{29 30 31} Healthcare teams delivering evidence-based care to their patients with chronic conditions find that a portion of patients are unable to control their medical conditions due to challenges presented by physical, social, and economic environments.³² These community conditions impact mental and physical health

status in a myriad of ways, including by influencing health behaviors, diminishing the mental wellbeing required for successful self-care, and inducing stress-related physiological changes.³³ Tools like THRIVE, developed by Prevention Institute, support healthcare–community collaboratives in understanding non-medical community determinants of health (Figure 2) and taking action to improve them.^{34 35}

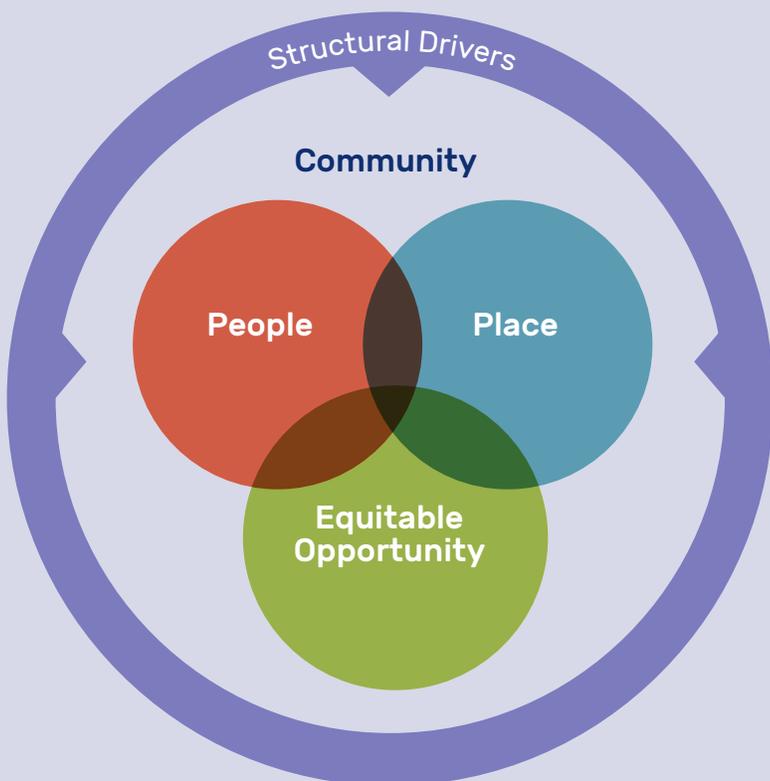
“It is unreasonable to expect that people will change their behavior easily when so many forces in the social, cultural, and physical environment conspire against such change.”³⁶

—Institute of Medicine, 2001

Alongside improvements in quality and access to healthcare services, healthcare leaders are elevating social determinants of health as a strategy to achieve better population health outcomes and reduce healthcare costs. An increasing number of healthcare organizations are providing services like prevention education and chronic disease self-management. They are also employing tools and programs to screen for social needs and connect patients to support services, including transportation vouchers, food bags, behavioral health services, legal assistance, and environmental assessments for asthma triggers in the home.^{37 38 39 40}

Yet these strategies alone do not reach everyone in a community, nor do they maximize opportunities to prevent illness, injury, and mental distress throughout the lifespan. In order to achieve population health and health

Figure 2: THRIVE Clusters and Factors



People

- Social networks & trust
- Participation & willingness to act for the common good
- Norms & culture

Place

- What’s sold & how it’s promoted
- Look, feel & safety
- Parks & open space
- Getting around
- Housing
- Air, water, & soil
- Arts & cultural expression

Equitable Opportunity

- Education
- Living wages & local wealth

equity goals, healthcare leaders are proposing that healthcare organizations complement healthcare access and patient management strategies with actions to ensure all community members experience conditions that promote health, safety, and wellbeing.^{41 42 43 44} This includes advocating for policies and systemic changes to address inequities between communities.^{45 46 47 48 49} Further, primary care leaders suggest that forging a “system of health” requires eliminating the silos between clinical care and public health and reimagining the interface between clinical care and community-level interventions.^{50 51 52} The CCHH model offers a cohesive approach to envisioning and building this connection.

The community centeredness that is at the heart of a CCHH adds a sixth attribute to the medical home model (patient-centered, coordinated, accessible, timely, and safe/high quality).^{53 54 55 56} This attribute provides a conceptual as well as practical opening for healthcare organizations to pursue bolder and more impactful efforts to improve the health of their patients. It enables healthcare organizations to think through the relationship between quality healthcare and patients’ non-medical needs while growing the internal and external capacities to engage in systemic, community-level work. Being community-centered embeds community considerations into the health home and offers a set of capacities and practices to envision and actualize this growth (Figure 3).

Figure 3: An Evolving Approach to Health



CCHH Capacities

A Framework for Implementation

The CCHH model describes a healthcare organization that deliberately develops the culture, staff, systems, and initiatives needed to be effective in meaningful, community-aligned action.

The CCHH model describes a healthcare organization that deliberately develops the culture, staff, systems, and initiatives needed to be effective in meaningful, community-aligned action. Prevention Institute conducted interviews with healthcare organizations across the country known for having a strong sense of community centeredness at the core of their identity and programming to learn more about how they approach their work and the capacities they bring to it. This data was enhanced through conversations with demonstration sites and our co-authors from the Gulf Coast CCHH demonstration project and the University of New Mexico Health Sciences Center Health Extension Rural Offices.

We organized themes and activities into a framework that describes the capacities for a fully evolved CCHH and provides examples of practices from the field. These capacities were laid out in the 2011 paper that first introduced the CCHH model and are updated here to reflect subsequent observations and conversations from those participating in the demonstration projects. The practices were gleaned from community-centered healthcare organizations as examples of strategies and activities that support organizational development in the direction of the capacity.

Foundational Capacities

The four foundational capacities of **Leadership, Staffing, Knowledge & Skills**, and **Partnership** enable a healthcare organization to intentionally and strategically integrate a community-centered approach into the fabric of the organization (Figure 4).

Figure 4: Foundational Capacities



Adaptive & Engaged Leadership

Executive leadership, senior management, providers, and board members prioritize community-level prevention and health equity as part of the organization’s ongoing vision, mission, and goals, and set the strategic direction for building their CCHH. Structures, systems, and processes are built to support CCHH implementation. Organizational leaders are effective in stewarding strategic change internally as well as engaging community leaders and stakeholders around common aims.

Practices:

- Establish a shared organizational vision and commitment to becoming a CCHH
- Understand and communicate the CCHH model, key concepts, and grounding frameworks, and align these with the organization’s mission and vision
- Establish an infrastructure for supporting and sustaining CCHH aims, initiatives, and evaluation
- Cultivate an organizational culture that values and promotes community prevention and health equity

- Utilize adaptive leadership skills in managing change both within the organization and with external partners to support CCHH implementation
- Identify and leverage opportunities to integrate CCHH practices into the organization’s programming and operations
- Incorporate CCHH aims and practices into the organization’s strategic plan



Photo credit: Annabelle Rose Photography

Community Health Northwest Florida helped create a playground at C.A. Weis Elementary School.

CCHH in Action:

Chandra Smiley, executive director of Community Health Northwest Florida (CHNF), saw the organization’s CCHH initiative as an opportunity to revitalize its mission as a community health center. She incorporated the core value of community centeredness into her work to improve CHNF’s strategic direction and culture. Smiley developed strategies to communicate her vision and to make both the CCHH business case and value proposition to her senior staff, employees across 12 clinic sites, and the board of directors. She also incorporated leadership for community engagement into an executive role. CCHH activities are now a standing agenda item at weekly senior team meetings, with a focus on connecting those efforts to the health center’s core mission of providing “quality, compassionate care to the most vulnerable community members.” This garnered support from fellow executives, and two years after the start of the initiative, all senior staff are able to give an elevator pitch on CHNF’s CCHH work. This health center has also integrated CCHH aims into its long-term strategic plan as well as into its new employee orientation.⁵⁷



Dedicated and Diverse Staffing

Leadership of the organization identifies internal assets and staff capacities for implementing the CCHH model. Leaders, staff, and clinicians across departments and disciplines understand how community conditions outside the clinical setting shape health and apply that knowledge to their role. Designated CCHH staff—proficient in community-level prevention and community engagement—coordinate and implement CCHH initiatives and serve as a bridge between the health-care organization and community partners.

Practices:

- Develop and designate CCHH team roles, responsibilities, and functions across the organization, from leadership to frontline staff

- Assess human resources, staff capacity, competencies, and inclinations toward roles and relationships to advance CCHH
- Establish the internal structures and communications practices to assure a continuously aligned, competent, and learning CCHH team
- Provide the CCHH team with the leadership and support needed to be authentic and effective partners in the community
- Query the organization’s employees, board members, advisory committee members, and patients to learn who is involved in activities to improve community conditions

CCHH in Action:

Across CCHH demonstration projects, all take different approaches to hiring or designating a dedicated staff person to lead and implement the CCHH work in a manager or coordinator-level position. Common responsibilities include serving as a liaison between clinic staff and the community, building relationships and facilitating ongoing communication with partner organizations and advocates in the community, and day-to-day coordination of both the internal and external operations of the CCHH work. In Texas, sites also identified a core CCHH team comprised of both clinical and non-clinical staff with responsibility for operationalizing the CCHH work. Staff involvement varies from site to site, but typically includes the executive director or CEO, a CCHH manager/coordinator, the chief clinical officer, and development staff.

El Centro de Corazón in Houston, Texas, instituted a “champions team,” whose role is distinct from a core CCHH team. The champions team is made up of individuals from different departments within the organization who share a common vision of community prevention. The team’s charge is to assist the organization in internalizing prevention efforts and inform executive staff about upstream concepts and programming ideas. Team members meet monthly and include a registered dietitian, physical activity coordinator, wellness program coordinator, outreach coordinator, and front desk staff.⁵⁸



Knowledge & Skills for Advancing Community-level Prevention

The designated CCHH team is proficient in the models, tools, and competencies needed to advance health equity through community prevention. Care teams and frontline staff receive continuing education, tools, and support to identify and address the community context of their patients, and support the CCHH team by lending their knowledge and credibility to CCHH initiatives.

Practices:

- Assess CCHH team knowledge and experience with the principles, models, and practices of community prevention, and implement comprehensive training and development plans for the team
- Develop communication pathways and tools for care teams and frontline staff to be informed of and contribute their perspectives and energies to the CCHH team and related initiatives



Photo credit: Palak Jalan

AccessHealth staff participate in a training that explores the root causes of poor health.

CCHH in Action:

Community centeredness expands the worldview of a clinical organization from a focus on individual patients to include the community conditions that impact patient health. To support staff in embracing this expanded view and integrating it into their work, AccessHealth in Richmond, Texas, incorporated training about its CCHH initiative and its link to their mission into new employee orientation. The training provides details on how staff can get involved, and the CCHH manager is available to answer questions. Recently, the health center's billing clerks, front desk staff, and patient service representatives participated in a training called "Roots and Fruits," which explores the root causes of poor health and solutions for addressing them. As a follow-up, the health center plans to engage all employees in "The Life-Course Game"⁵⁹ during staff town hall and departmental meetings. This interactive activity increases awareness of social and community determinants of health by demonstrating how social and biological factors impact health and development.⁶⁰



Authentic Community Partnerships

The healthcare organization is a credible and trusted partner in the community. It effectively collaborates with stakeholders from other sectors (e.g. schools, housing organizations, and local government) to leverage collective strengths and enable community-level action to

improve conditions impacting health and health equity. It invites and enables patients, community members, and community-based organizations to participate in inquiry, discovery, invention, design, and decision-making related to community prevention strategies.

Practices:

- Establish community engagement principles and practices to inform and guide the healthcare organization's interface with and activity in community
- Assess the community landscape to learn about community efforts underway to improve community conditions
- Establish formal or informal partnerships with other organizations/ coalitions that are already active or are interested in taking action to improve conditions
- Assess and leverage complementary assets and strengths of partners
- Co-develop structures and agreements for collaboration, communication, and accountability

CCHH in Action:

For Highland Health Center in Gastonia, North Carolina, the CCHH model's emphasis on authentic community partnerships provided an opportunity to build the center's connection to the surrounding community. When the Blue Cross and Blue Shield of North Carolina Foundation awarded one of three implementation grants under its Community-Centered Health Initiative to the clinic, project leadership quickly recognized that an element was missing from its community work. While the clinic had established relationships with the local public health department, a local hospital, and some community organizations, it wanted to strengthen its relationship with community residents, a longstanding and predominantly African-American population. The health center hired a local resident to serve as its coordinator, which has helped build authentic engagement with her fellow residents. Implementing the model would require someone who was capable of understanding the community, rallying them, and engaging with them. The center also needed someone who could discuss and educate residents about the social determinants of health and their connection to the health issues residents were facing. When the project began, the coordinator spent her time on the phone and in the homes of people she had known all her life, explaining the initiative and the model, and asking them to come on board.⁶¹



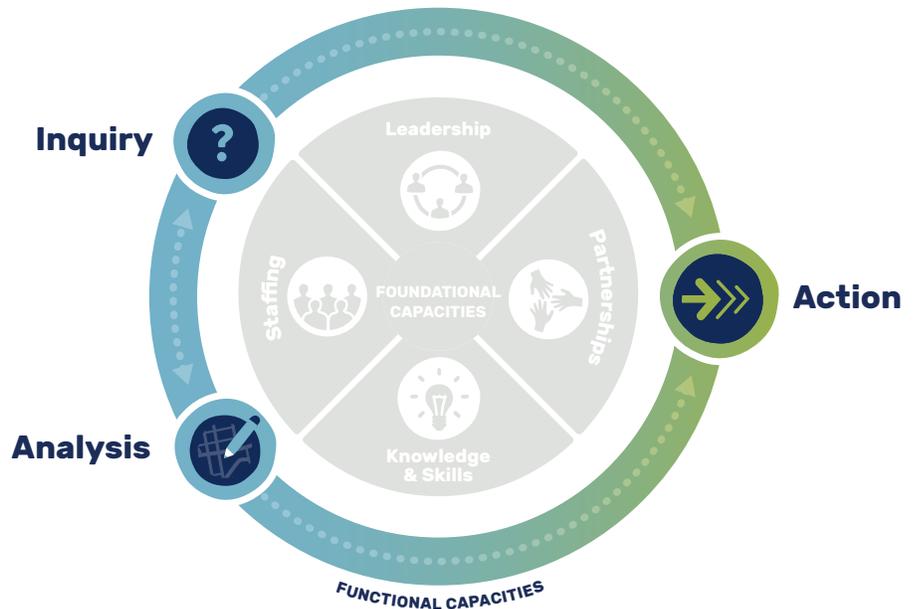
Photo credit: Donyel Barber

Highland Health Center initiated a collaborative that advocated for park and infrastructure improvements, a priority of community residents.

Functional Capacities

The functional capacities of **Inquiry, Analysis, and Action** enable a CCHH to assess and identify community determinants of health, engage in collaborative planning and priority-setting, and contribute to improvements in the community conditions that shape health (Figure 5).

Figure 5: Functional Capacities



Inquiry: Assess & Identify Community Determinants of Health

The healthcare organization supports the CCHH team to identify, compile, and share internal knowledge and data useful for understanding community health conditions and determinants. It also encourages the team to gather and utilize external knowledge and data sources that are indicative of the community health conditions. Staff and clinicians have opportunities and venues to contribute their insights about community-level issues, factors, and causation that may be underlying the prevalence of injuries and illnesses in both the clinical and community settings. Patients, community members, and partners participate in the production of knowledge and data regarding community conditions.

The process of **Inquiry** involves harnessing a healthcare organization's available data for community planning and action.

Practices:

- Develop, identify, and analyze internal data (quantitative and qualitative) that explain how community determinants impact the health and health outcomes of patients
- Identify and utilize community-level data sources (and/or work with partners that have this capacity) to understand and describe the community context, trends, and patterns (such as inequitable conditions among communities) that are linked to health indicators and outcomes
- Develop opportunities for patients, staff, care teams, communities, and partners to come together to share information and knowledge regarding community conditions

CCHH in Action:

The process of inquiry involves harnessing a healthcare organization's available data for community planning and action. That could mean sharing health-related data with community groups or coming up with creative ways to compile information about a problem that clinicians are seeing. This was the case for Hope Clinic in Houston, Texas, which took inspiration from Asian Health Services to address nail salon worker health after noticing that a number of young, Asian female patients were presenting with skin and eye irritation, allergies, and neurological issues, as well as neck, shoulder, wrist, and back problems due to poor ergonomics and repetitive movements.

After making this connection, clinicians wanted to validate their observations with community-based research, and hired nail salon workers to be community researchers. These investigators visited nail salons across the Houston area and interviewed almost 400 nail salon workers about their physical and mental health, exposure to chemicals, access to healthcare, workplace protections, and more. They then used this data to collaborate with community organizations and nail salon workers to set priorities for action.⁶² As the practices above reflect, inquiry doesn't have to include an extensive survey – having conversations with community members about what supports health and what diminishes health in their community is an excellent jumping off point for identifying community determinants of health.



Analysis: Collaborate with the Community on Planning and Priority Setting

The healthcare organization shares knowledge and data with relevant community partners to support the identification and prioritization of issues, and develop comprehensive intervention strategies. The CCHH team is proficient in presenting and communicating data trends and implications, designing and facilitating collaborative planning processes, and developing action plans in concert with community members and community-based partners.

Practices:

- Share and interpret relevant knowledge and data internally, and with community partners, to inform planning, priority-setting, and action
- Engage in collaborative planning and priority-setting with external partners and community members
- Engage in collaborative strategy development to address identified priorities

CCHH in Action:

Inquiry and analysis go hand-in-hand. When Daughters of Charity Services of New Orleans (DCSNO) began its CCHH work, the health center wanted to focus on diabetes, a major health concern in the community. Clinical data from one of its sites showed rising hemoglobin A1C levels in patients. DCSNO also had data from a community assessment conducted by a university partner that identified diabetes as a major health condition. Because the health center wanted to establish its own relationship with the community, staff began attending community meetings, where they learned the community was aware of the diabetes issue but had other concerns and “did not want another community garden.” Those concerns included food insecurity and the lack of safe places for physical activity. Using the CCHH model led the team to think further upstream to understand the community’s underlying needs. In response, they integrated questions related to food resources, physical activity, and safety into their patient registration and adult history forms—questions they never thought to ask before. To institutionalize this new focus on community engagement and hear directly from the community, the health center established a council made up of patients and other community members to advise them on an ongoing basis.⁶³



Action: Contribute to Improvements in Community Conditions

The healthcare organization embraces model organizational practices that contribute to community-level prevention. It also participates with partners to improve the community conditions that shape health outcomes and health equity. To achieve this, healthcare organizations and their partners advocate for community-level changes in policies, systems, practices, and environments.

Practices:

- Adopt and implement policies and practices in the healthcare facility that support health, equity, and wellbeing
- Advocate for community improvements and policies with elected officials and decision makers
- Activate and mobilize patients through information-sharing practices, patient advisory boards, and broader community engagement activities
- Generate data and stories to make the case for community-level changes
- Communicate with the media and serve as a resource on the health impacts of broader policies, systems, and environmental conditions
- Influence peers in the healthcare sector to be advocates of community-level prevention



Photo credit: People's Community Clinic

A clinician at People's Community Clinic speaks on the issue of paid sick leave, which became a mandatory requirement for all non-government employers in Austin.

CCHH in Action:

People's Community Clinic (PCC) in Austin, Texas, is using its clinical expertise to advance health-affirming public policies. When community organizations needed a healthcare advocate to work with them on the issue of paid sick leave, the health center stepped up to the plate – the only healthcare organization involved in the campaign from start to finish. They saw how the issue affected the health of their patients, many of whom work in industries that do not provide paid sick leave. The health impacts were clear: increased disease transmission, longer hospital stays for children, and increased job-related injuries, to name a few. The health center also recognized that the lack of paid sick leave intersected with food insecurity, an issue they had been working on for some time. Families without paid sick leave had to choose between putting food on the table and taking care of sick family members. As a result of the clinic's advocacy

“Clinical interventions alone can’t get us to the health outcomes we want without complementary community interventions.”

– Pritesh Gandhi, M.D., M.P.H., Acting Director,
Adult Health, People’s Community Clinic⁶⁵

in collaboration with community partners, Austin became the first city in Texas to make paid sick leave a mandatory requirement for all non-government employers.⁶⁴

The CCHH capacities and example practices are intended to be a flexible guide to spark, inspire, and support healthcare organizations in having a greater impact on shaping the health of the communities they serve. While the capacities and practices may build upon existing quality improvement activities, they are not meant to initiate a rigorous certification or accreditation process. Moreover, the uptake of the capacities is not linear, but rather can be a fluid process that builds off of an organization’s existing assets. In other words, it is possible to engage in action in the absence of fully developed capacities in either inquiry or analysis, and organizations should not feel stymied as they simultaneously work to build those capacities.

We’ve translated the CCHH capacities into a tool that can be used to determine the organization’s baseline as well as to periodically assess organizational assets, practices, and activities. These assessments can guide the healthcare organization’s planning to strengthen its impact on community health and wellbeing (Appendix). Healthcare organizations using this tool may discover they are already engaging in many of the practices but may not have sustained these activities through changes in staff or available resources. Others may find that it allows them to take stock and prioritize working in one area versus another based on internal or external factors. Still others may find that the tool offers a way of looking at the organization’s non-clinical programming as a coherent whole that supports its clinical mission. How a healthcare organization grows and finds opportunities may vary depending on its existing activities and abilities, as well as existing resources and partnerships in the community.

Sites participating in CCHH demonstration projects have used various iterations of this tool to both test the model and guide their initiatives. While resources were invested to start up, support, and study the demonstrations, many grantees found that working with the CCHH model and focusing on these seven capacities allowed them to harness existing strengths, resources, and initiatives in a more synergistic, impactful way.

CCHH Demonstration Projects

Several organizations were inspired by the 2011 CCHH publication to invest in CCHH demonstration projects in their regions. As described below, the Gulf Coast pilot project is completed, while initiatives are still underway in North Carolina and Texas. Each initiative is aimed at encouraging healthcare organizations to partner in community efforts to improve community conditions impacting health outcomes. All were also focused on advancing health equity by taking actions that would benefit communities and community residents facing social and economic disadvantage. Prevention Institute has supported all three demonstration projects in some capacity.

The goal of the CCHH demonstration project in the Gulf States region was to enhance the capacity of community health centers to become active participants in improving upstream determinants of health.

In the Gulf States region, the Louisiana Public Health Institute (LPHI) conducted its CCHH demonstration project from March 2015 to April 2017. The two-year pilot was part of the Primary Care Capacity Project (PCCP), which was funded by the Gulf Region Health Outreach Program established by the Deepwater Horizon Medical Benefits Class Action Settlement in 2013.^c Five community health centers participating in the PCCP were awarded supplemental two-year grants to participate in the CCHH initiative: two sites in Louisiana, and one each in Florida, Mississippi, and Alabama.

The overarching goal of the CCHH demonstration project was to enhance the capacity of community health centers to become active participants in improving upstream determinants of health in their communities.⁶⁶ The project also sought to generate learnings about how CCHH could be operationalized in practice and what support community health centers require to do this work.⁶⁷ LPHI used the functions and capacities in the 2011 paper to guide project implementation. Based on a review of applications, LPHI instituted an intensive period of training and coaching to support awardees in identifying

c. The Gulf Region Health Outreach Program (GRHOP) is a series of integrated, five-year projects designed to strengthen health care in Gulf Coast communities. The program is funded by the Deepwater Horizon Medical Benefits Class Action Settlement which was approved by the U.S. District Court in New Orleans on January 11, 2013. The target beneficiaries of the GRHOP are residents, especially the uninsured and medically underserved, of 17 coastal counties and parishes in Alabama, Florida, Louisiana, and Mississippi.

The North Carolina initiative used the CCHH model as a conceptual framework . . . to advance health-impacting policy and environmental improvements.

implementation activities in alignment with the CCHH model. Health centers needed support in broadening from programmatic efforts aimed at a specific set of patients (e.g., cooking classes) to activities aimed at addressing community conditions (e.g., access to a grocery store) that affect the whole community. Important success factors in advancing their CCHH work included the commitment of senior leadership to integrating CCHH principles into their organizational culture and a designated staff member to keep CCHH activities moving.⁶⁸ LPHI concluded that the CCHH model held promise as a tool for supporting community health centers to respond to community conditions that affect the health of all residents.⁶⁹

In 2014, the Blue Cross and Blue Shield of North Carolina Foundation developed a strategic priority to increase the capacity of safety-net healthcare organizations and their communities to implement practices associated with the CCHH model. This was an opportunity to bridge the foundation's grant-making in its existing program areas that focused on shoring up the healthcare safety net and building healthy communities. The initiative used the CCHH model as a conceptual framework for bringing together healthcare providers, community-based organizations, and community members to advance health-impacting policy and environmental improvements. With the focus on connecting partners across these sectors, the initiative broadened the CCHH concept to a more global notion of "community-centered health."

The North Carolina approach employed three core components: developing clinical-community partnerships in which community members are deeply involved in decision-making; implementing changes in the healthcare organization to acknowledge and address non-medical drivers of health; and advocating for policy, systems, or environmental changes to improve health at the population level. Blue Cross and Blue Shield of North Carolina Foundation is currently supporting three community-clinical partnerships that are entering their fourth year of work and recently selected another six grantees for a planning grant period to be followed by four years of implementation funding. For this initiative, the grantee did not necessarily need to be a healthcare provider—in some cases it was the public health department or a community-based organization—but a healthcare organization was always a key partner.

“The CCHH model represents more than a one-time effort to improve community health . . . it’s a cultural shift of how clinics think about their role in improving their surrounding communities.”

– Andrea Caracostis, M.D., CEO, HOPE Clinic and Jo Carcedo, M.P.A, M.B.A, vice president for grants, Episcopal Health Foundation⁷⁰

Episcopal Health Foundation (EHF), which serves 57 counties in east and south Texas, established the Texas CCHH Initiative in 2016. The foundation is supporting a cohort of 13 community clinics with 18-month or 36-month grants. The goal of the Texas CCHH initiative is to support community clinics in improving the community conditions that contribute to poor health in Texas as a complement to the delivery of healthcare services.⁷¹ This goal is embedded in the foundation’s 2018-2022 strategic plan in order to support resource allocation and system reform in the health sector to promote health, not just healthcare.⁷² The 13 clinics are focused on a range of issues such as advocating for city paid sick leave policy, addressing food insecurity, and improving community spaces for physical activity.

Nail salon workers helped us turn the idea of community-centered health into reality

By Andrea Caracostis of HOPE Clinic and Jo Carcedo of Episcopal Health Foundation. *A longer version of this article appeared in Stat News on August 2, 2018*

One by one, the young nail salon workers came to the HOPE Clinic in Houston battling serious coughs, neck and arm pain, and fungal infections in their fingernails. Clinicians would help them with these ailments – but they kept coming back.

Health care practitioners routinely see how social, economic, and environmental factors affect their patients’ health. ... What’s not always clear, though, is what role health care practitioners can play in improving these conditions beyond the confines of an exam room. After seeing firsthand the repeated health problems faced by nail salon workers, our organizations tried to find out.

Nail salon workers are routinely exposed to toxic chemicals that can irritate the skin and eyes, trigger allergies, and cause neurological issues.

They also frequently experience neck, shoulder, wrist, and back problems because of poor ergonomics and repetitive movements.

With funding from Episcopal Health Foundation, HOPE Clinic hired nail salon workers to be community researchers. Based on the research results, clinic staff members were able to set priorities for action. But they didn’t want to decide on their own what steps were needed to address the working conditions in nail salons. Instead, they collaborated with community organizations and nail salon workers to listen to their ideas about what should be done.

When we put ourselves in our patients’ shoes, the call to action becomes crystal clear: In addition to creating a health system that ensures that all patients receive quality medical care, we need to ensure that the places in which they live and work also keep them healthy.⁷³

The Value of CCHH to Primary Care

Early Findings

Benefits described by some of the CCHH leadership include: enhanced achievement of the organization's mission, increased staff pride, elevated visibility of the healthcare organization, and increased trust by community members.

The healthcare organizations participating in the CCHH demonstration projects have begun to articulate a number of ways in which integrating CCHH aims, principles, and practices into their work brings value to their primary care organizations. This information is still emerging as two of the three demonstration projects are still underway, and evaluation data to date has primarily focused on the process of developing CCHH capacities. Thus far, benefits described by some of the CCHH leadership include: enhanced achievement of the organization's mission, increased staff pride, elevated visibility of the healthcare organization in the community, and increased trust by community members. These benefits are described further below and are important arenas for further exploration as more healthcare organizations implement CCHH practices.

The healthcare organizations participating in the CCHH demonstration projects tend to have organizational missions that include a commitment to improving the health of the whole community. A number of these organizations say that participating in the CCHH demonstration project equipped them to enhance their fulfillment of this mission by taking on a new role to impact conditions outside clinical walls. The CCHH approach provided tools and a pathway to actively prevent disease through action at the community level.^{74 75 76}

Some sites found that the work associated with the CCHH model fostered staff satisfaction and promoted an increased sense of purpose. Their staff members expressed pride that community organizations sought their organizations' support when they needed a healthcare ally.^{77 78} According to human resources research, meaning in the workplace and organizational pride may influence staff retention and quality of work, which would both be of benefit to primary care organizations.⁷⁹

Importantly, physicians are among the staff that are enthusiastically supporting their organizations' CCHH efforts.^{80 81} They are concerned that community circumstances faced by patients interfere with patient care. As described by Valerie Smith, M.D., a pediatrician at St. Paul Children's Foundation, "by focusing upstream on policies and practices, we hope to improve conditions not just for our patients, but for the entire community and reduce health disparities. It is by far the most challenging and rewarding undertaking of my career."⁸² This could be an important benefit of being a CCHH given the challenges of physician retention by safety net providers.⁸³ One health center reported that medical providers are more interested in being part of their organization because of their CCHH work.⁸⁴

In addition to fostering a positive internal climate, healthcare organizations that have embraced the CCHH worldview or model have seen positive impacts related to their organizations' relationships with community stakeholders and members directly. Actively engaging with community partners to address community members' priorities helped to raise the favorable profile of a practice and to establish trust. As one health center leader explains, "I don't have a marketing budget. Becoming a CCHH has elevated our status in the eyes of our community and enhanced the trust they have in us. Our volume has increased because people know who we are and that we are here for the long haul."⁸⁵ Particularly as Medicaid expansion increases the range of choices for patients when selecting a provider, a practice's profile and relationships within the community can be a positive distinguishing factor.

Conclusion

The CCHH model provides a unique contribution by offering a systematic approach to adding community centeredness to healthcare organizations' daily mission of delivering high-quality services.

From community organizing in the Mississippi Delta to community advocacy in the wake of recent Gulf Coast hurricanes, mission-driven healthcare providers and organizations have a proud history of partnering with the communities they serve to improve conditions in the places where their patients live, work, and play. Primary care providers recognize the impact of the social determinants of health on their patients and understand that having a strategy for addressing these community conditions can save lives, reduce illnesses and injuries, facilitate healing, and increase care team satisfaction and retention. Work and interest in healthcare-community partnerships to improve population health is growing exponentially and promises to intensify through increased efforts to transform the healthcare system. The CCHH model provides a unique contribution to this movement by offering a systematic approach to adding community centeredness to healthcare organizations' daily mission of delivering high-quality services.

Investments in CCHH pilots to date have surfaced early findings about the process of becoming a CCHH. Some of the lessons learned are that change is a developmental process, that it occurs on a gradient ranging from incremental improvement to transformation, that it requires adaptive leadership partnered with champions, and that assistive supports, such as coaching and peer learning communities, are valuable to facilitating change. Moreover, the CCHH pilots have demonstrated that engaging in the CCHH journey can invigorate mission-driven primary care systems and care teams with a renewed sense of purpose and possibility.

Across the various CCHH demonstration sites, primary care organizations have enthusiastically embraced the opportunity to push further into prevention, into the 'heart' of community. And while the availability of funding has supported their pursuit of community centeredness, CCHH pilot sites have found that having a comprehensive model for engagement in community-level prevention has allowed them to integrate isolated initiatives and relationships into a coherent, more effective whole. Utilizing the CCHH model, they've discovered that even a modest amount of funding to support staff engagement in community initiatives or devoting staff time to addressing community needs can

provide the stimulus for adopting CCHH practices that expand their impact further upstream. For example, some participants in the Gulf Coast CCHH Demonstration Project report that they have sustained integration of CCHH concepts and activities beyond the funding period that supported their initial culture change at the leadership level, increased staff capacity and new community partnerships. The inspiration, knowledge, skills, and commitment of these primary care innovators to sustain their reach into and impact on the community continues to drive movement, uptake, and institutionalization of the CCHH model.

Robust primary care promotes health, prevents illness and death, and saves resources; it is the foundation of a functional healthcare system.⁸⁶ Likewise, place-based, community-oriented healthcare organizations are not simply another service node in the healthcare marketplace. They are respected neighborhood institutions with histories and relationships as local stakeholders and thought leaders. The CCHH model leverages this role and provides a framework for understanding how healthcare can more intentionally impact the systems and structures that shape community health. As essential community assets, primary care organizations can utilize the CCHH model as their roadmap to catalyze, strengthen, and lead healthcare in the uptake of broader strategies to promote community-level prevention and improve population-wide health and wellbeing for all.

APPENDIX

BASELINE ASSESSMENT OF CCHH CAPACITIES

A Community-Centered Health Home (CCHH) is a healthcare organization that has institutionalized practices to address community-identified health priorities through collaborative activity to improve community conditions. A CCHH not only *acknowledges* that factors outside the clinic walls affect patient health outcomes, it *actively participates* in improving them. These factors include community conditions such as the availability of parks and open space, healthy food, affordable housing, clean air and water, and strong social networks.

A CCHH deliberately develops the culture, staff, systems, and initiatives needed to be effective in meaningful, community-aligned action. To support

healthcare organizations in their journey toward becoming a CCHH, Prevention Institute has developed the following tool that can be used to determine your organization’s baseline along the seven CCHH capacities, as well as to periodically assess progress. In this baseline assessment, your team will reflect on your healthcare organization’s existing assets, resources, activities, and experiences as a basis for guiding your journey towards becoming a Community-Centered Health Home. Being a CCHH is a journey, not a destination. There are no right or wrong answers to the assessment questions, but your responses should help you identify strengths and opportunities to position your organization to improve community health.





Adaptive and Engaged Leadership

Executive leadership, senior management, providers, and board members prioritize community-level prevention and health equity as part of the organization’s ongoing vision, mission, and goals, and set the strategic direction for building their CCHH. Structures, systems, and processes are built to support CCHH implementation. Organizational leaders are effective in stewarding strategic change internally as well as engaging community leaders and stakeholders around common aims.

As you review this **capacity** with your team, mark the statement that best reflects your organization’s needs relative to **adaptive and engaged leadership**.

- We will need focused support to grow in this area.
- We have some experience in this area, but could still use some support.
- We already excel in this area.

What activities and practices are you currently engaging in?

Please indicate which of the following practices that support adaptive and engaged leadership have been implemented by your healthcare organization, if any. For practices that have been implemented, please provide an example.

- Our healthcare organization has a shared organizational vision and commitment to becoming a CCHH.
- Our healthcare organization understands and communicates the CCHH model, key concepts, and grounding frameworks, and aligns them with our organization’s mission and vision.
- Our healthcare organization has an infrastructure for supporting and sustaining CCHH aims, initiatives, and evaluation.
- Our healthcare organization cultivates an organizational culture that values and promotes community prevention and health equity.
- Our healthcare organization uses adaptive leadership skills to manage change within the organization, and with external partners, to support CCHH implementation.
- Our healthcare organization identifies and leverages opportunities to integrate CCHH practices into our programming and operations.
- Our healthcare organization incorporates CCHH aims and practices into our strategic plan.

Examples:



Dedicated and Diverse Staffing to Lead and Implement CCHH

Leadership of the organization identifies internal assets and staff capacities for implementing the CCHH model. Leaders, staff, and clinicians across departments and disciplines understand how community conditions outside the clinical setting shape health and apply that knowledge to their role. Designated CCHH staff – proficient in community-level prevention and community engagement – coordinate and implement CCHH initiatives and serve as a bridge between the healthcare organization and community partners.

As you review this **capacity** with your team, mark the statement that best reflects your healthcare organization’s needs relative to dedicated **staffing** to lead and implement CCHH.

- We will need focused support to grow in this area.
- We have some experience in this area, but could still use some support.
- We already excel in this area.

What activities and practices are you currently engaging in?

Please indicate which of the below practices that support dedicated CCHH staffing have been implemented by your healthcare organization, if any. For practices that have been implemented, please provide an example.

- Our healthcare organization develops and designates CCHH team roles, responsibilities, and functions across the organization, from leadership to frontline staff.
- Our healthcare organization assesses human resources, staff capacity, competencies, and inclinations toward roles and relationships to advance our CCHH.
- Our healthcare organization establishes the internal structures and communications practices to assure a continuously aligned, competent, and learning CCHH team.
- Our healthcare organization provides the CCHH team with the leadership and support needed to be authentic and effective partners in community prevention.
- Our healthcare organization queries our employees, board members, advisory committee members, and patients to learn who is involved in community activities that improve health and wellbeing.

Examples:



Knowledge and Skills for Advancing Community-Level Prevention

The designated CCHH team is proficient in the models, tools, and competencies needed to advance community prevention. Care teams and frontline staff receive continuing education, tools, and support to identify and address the community context of their patients, and support the CCHH team by lending their knowledge and credibility to CCHH initiatives.

As you review this **capacity** with your team, mark the statement that best reflects your health-care organization’s capacity relative to **knowledge and skills** for advancing community-level prevention.

- We will need focused support to grow in this area.
 - We have some experience in this area, but could still use some support.
 - We already excel in this area.
-

What activities and practices are you currently engaging in?

Please indicate which of the below practices that support knowledge and skills for advancing community-level prevention have been implemented by your healthcare organization, if any. For practices that have been implemented, please provide an example.

- Our healthcare organization assesses the CCHH team’s knowledge and experience with the principles, models, and practices of community prevention, and implements comprehensive training and development plans for the team.
- Our healthcare organization develops communication pathways and tools for care teams and frontline staff to be informed of and contribute their perspective and energies to the CCHH team and related initiatives.

Examples:



Authentic Community Partnerships

The healthcare organization is a credible and trusted partner in the community. It effectively collaborates with multisector stakeholders to leverage collective strengths and enable community-level action to improve conditions impacting health and health equity. It invites and enables patients, community members, and community-based organizations to participate in inquiry, discovery, invention, design, and decision-making related to community prevention strategies.

As you review this **capacity** with your team, mark the statement that best reflects your healthcare organization's needs relative to authentic community **partnerships**.

- We will need focused support to grow in this area.
- We have some experience in this area, but could still use some support.
- We already excel in this area.

What activities and practices are you currently engaging in?

Please indicate which of the below practices that support authentic community partnerships have been implemented by your healthcare organization, if any. For practices that have been implemented, please provide an example.

- Our healthcare organization has community engagement principles and practices to guide our interface with and activity in the community.
- Our healthcare organization assesses the community landscape to learn about efforts underway to improve community conditions.
- Our healthcare organization has formal or informal partnerships with other organizations/coalitions that are already active or are interested in taking action to improve conditions.
- Our healthcare organization assesses and leverages the complementary assets and strengths of partners.
- Our healthcare organization co-develops processes and agreements for collaboration, communication, and accountability.

Examples:



Assess and Identify Community Determinants of Health through Inquiry

The healthcare organization supports the CCHH team to identify, compile, and share internal knowledge and data useful for understanding community health conditions and determinants. It also encourages the team to gather and utilize external knowledge and data sources that are indicative of the community health conditions. Staff and clinicians have opportunities and venues to contribute their insights about community-level issues, factors, and causation that may be underlying the prevalence of injuries and illnesses in both the clinical and community settings. Patients, community members, and partners participate in the production of knowledge and data regarding community conditions.

As you review this **capacity** with your team, mark the statement that best reflects your healthcare organization’s needs relative to assessing and identifying community determinants of health through **inquiry**.

- We will need focused support to grow in this area.
- We have some experience in this area, but could still use some support.
- We already excel in this area.

What activities and practices are you currently engaging in?

Please indicate which of the below practices that support inquiry have been implemented by your healthcare organization, if any. For practices that have been implemented, please provide an example.

- Our healthcare organization develops and analyzes internal data (quantitative and qualitative) that explain how community determinants impact the health and health outcomes of our patients.
- Our healthcare organization identifies and utilizes community-level data sources (and/or has worked with partners with this capacity) to understand and describe the community context, trends, and patterns linked to health outcomes.
- Our healthcare organization develops opportunities for patients, staff, care teams, communities, and partners to come together to share information and knowledge regarding community conditions

Examples:



Collaborate with the Community on Planning and Priority Setting through Analysis

The healthcare organization shares knowledge and data with relevant community partners to support the identification and prioritization of issues, and develop comprehensive intervention strategies. The CCHH team is proficient in presenting and communicating data trends and implications, designing, and facilitating collaborative planning processes, and developing action plans in concert with community members and community-based partners.

As you review this **capacity** with your team, mark the statement that best reflects your healthcare organization’s needs relative to collaborating with the community on planning and priority setting through **analysis**.

- We will need focused support to grow in this area.
 - We have some experience in this area, but could still use some support.
 - We already excel in this area.
-

What activities and practices are you currently engaging in?

Please indicate which of the below practices that support analysis have been implemented by your healthcare organization, if any. For practices that have been implemented, please provide an example.

- Our healthcare organization shares and interprets relevant knowledge and data internally, and with community partners, to inform planning, priority setting, and action.
- Our healthcare organization engages in collaborative planning and priority setting with external partners and community members.
- Our healthcare organization engages in collaborative strategy development to address identified priorities.

Examples:



Contribute to Improvements in Community Conditions through Action

The healthcare organization embraces model organizational practices that contribute to community-level prevention. It also participates with partners to improve the community conditions that shape health outcomes and health equity. To achieve this, healthcare organizations and their partners advocate for community-level changes in policies, systems, practices, and environments.

As you review this **capacity** with your team, mark the statement that best reflects your healthcare organization's needs relative to contributing to improvements in community conditions through **action**.

- We will need focused support to grow in this area.
- We have some experience in this area, but could still use some support.
- We already excel in this area.

What activities and practices are you currently engaging in?

Please indicate which of the below practices that support action have been implemented by your healthcare organization, if any. For practices that have been implemented, please provide an example.

- Our healthcare organization adopts and implements policies and practices in the healthcare facility that support health, equity, and wellbeing.
- Our healthcare organization advocates for community improvements and policies with elected officials and decision makers.
- Our healthcare organization activates and mobilizes patients through information sharing, patient advisory boards, and broader community engagement activities.
- Our healthcare organization generates data and stories to make the case for community-level changes.
- Our healthcare organization communicates with the media and serves as a resource on the health impacts of broader policies, systems, and environmental conditions in our community.
- Our healthcare organization influences peers in the healthcare sector to be advocates for community-level prevention.

Examples:

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