The Community-Centered Health Homes Model: Bridging patient-centered health and communities

Prevention Institute
Prevention and equity | at the center of community well-being

What is a CCHH?

In 2011, Prevention Institute released its groundbreaking report on the Community-Centered Health Home (CCHH) model based on an environmental scan of community-based clinical practices and activities across the country. The CCHH model provides a concrete framework for institutionalizing practices that help advance population health by addressing community conditions that impact health outcomes. A CCHH not only ***acknowledges*** that factors outside the healthcare system affect patient health outcomes, it ***actively*** participates in improving them to achieve health equity.

Why should healthcare consider a CCHH?

Health systems and providers have acknowledged that a broad range of community factors—such as quality affordable housing, public transportation, and meaningful social connections—influence health outcomes outside the exam room or emergency department. Many health systems have established programs and are leveraging community benefit initiatives to establish programs linking patients to basic needs such as housing, transportation, and healthy food. The CCHH model enables healthcare to expand its influence on health outcomes, complementing its clinical expertise with effective strategies. As the healthcare industry continues to introduce value-based payment models and population health metrics, addressing social, economic, and physical environmental factors can help in meeting goals of improving patient and population health.

CCHH in Action

A CCHH applies critical thinking skills to the underlying factors that shape patterns of illness and injury.[i] The CCHH model represents a set of core practices that serve as a menu for healthcare organizations interested in pursuing activities that prioritize prevention, health, and well-being alongside quality clinical services.

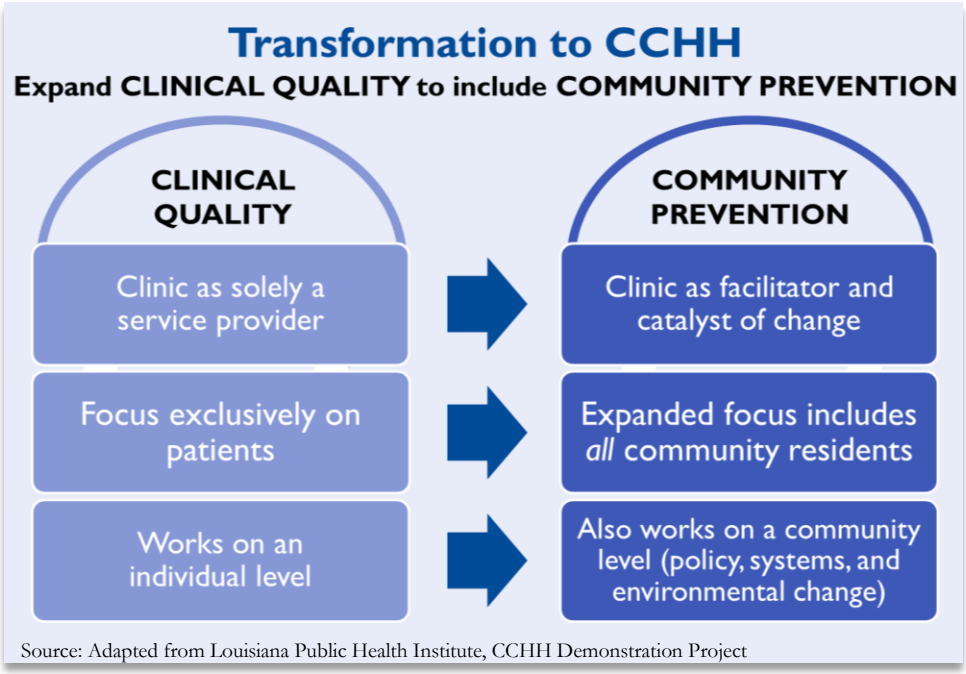
Operationally, the CCHH model is closely aligned with the problem-solving skills providers currently employ to address individual health—such as collecting patient data, diagnosing the problem, and undertaking a treatment plan—yet applies them to community health through *inquiry, analysis,* and *action.* The skills and capacity needed to engage in a CCHH expand upon continuous quality improvement approaches, such as Plan-Do-Check-Act, to include activities that also strengthen community environments. A CCHH can amplify a patient-centered medical home by formalizing active community partnerships to address health conditions (e.g. diabetes, asthma, etc.) external to the immediate influence of healthcare providers.

There are several CCHH initiatives emerging across the country. The Episcopal Health Foundation, which serves a 57-county region of East and South Texas, is working with Prevention Institute to establish a CCHH initiative to complement its current grant funding to clinics to address systemic problems that cause and perpetuate gaps in

CCHH Core Practices
Inquiry: Identify leading health issues using internal and external sources of data
Review health and safety trends among patient population; identify the links between health concerns and community conditions
Collect and analyze data on social, economic, and community conditions
Analysis: Examine data internally, and with external partners, to determine underlying community conditions
Share data with community partners to assist process of agreeing upon priority health conditions and community conditions
Identify strategies with community partners and coordinate action
Action: Decide on and implement policy, systems, or environmental change strategies
Advocate for improvements to community conditions that are impacting patients' health (i.e. access to fresh foods, safe streets, etc.)
Mobilize patient populations to improve community conditions
Build and strengthen authentic community partnerships
Establish model organizational practices

social safety-net services. In North Carolina, the Blue Cross and Blue Shield of North Carolina Foundation funded short-term "Action Learning" grants to support the field testing of the CCHH model. Three communities in North Carolina have been funded for an 18-month planning process.

A partnership between Prevention Institute and the Louisiana Public Health Institute has established the first-ever CCHH demonstration project. The aim of this demonstration project is "to advance health equity and community resiliency by enhancing the capacity of selected health center sites to take the next step beyond the patient-centered health home model and serve as trusted, effective partners in community prevention." Five clinics in Louisiana, Florida, Alabama, and Mississippi are testing strategic implementation of the CCHH model. One example of a CCHH in action is the Escambia Community Clinic (ECC) in Pensacola, Florida. ECC worked with healthcare organizations, local governments, and the local UnitedWay to raise $106,000 in impact grant funds to build a Weis Community School Family Playground.[ii]



Source: Adapted from Louisiana Public Health Institute, CCHH Demonstration Project

Interests and activities in clinical-community linkages to improve population health are growing rapidly and will continue to grow as healthcare pursues the Triple Aim of lower costs, improved quality, and improved population health.[iii] Healthcare is positioned to take an active stance and invest in practices that promote health equity by participating in comprehensive strategies to address the socio-cultural, physical/built, and economic environments; and partnering with community residents and key sectors such as public health, education, housing, transportation, planning and economic development, and regional food systems. The CCHH model highlights the value of healthcare partnering with the surrounding community to not only link patients with social services and support, but also to influence community conditions and behaviors that affect health outcomes. The resources listed below can support healthcare institutions interested in exploring the CCHH model to support population health improvement.

For more information about this model, please contact us at prevent@preventioninstitute.org or 510-444-7738.

Resources

- Community Centered Health Homes: Bridging the Gap between Health Services and Community Prevention
- Introducing Community-Centered Health Homes (Video)
- The Community-Centered Health Homes Model: Updates & Learnings

These resources can be found on our website: www.preventioninstitute.org/focus-areas/reforming-our-health-system.html.

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References

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