

Community-Centered Health Homes:

Bridging the gap between health services and community prevention

EXECUTIVE SUMMARY

There is newfound momentum and activity focused on delivery system reform and innovation in health care, due in large part to the vision and implementation of the Affordable Care Act (ACA). Leaders rightly acknowledge the need to change our current system from what is primarily a “sick care system” to one that truly promotes health. Efforts have largely focused on improving efficiency, quality, and patient outcomes, along with reducing costs. There is also growing recognition of the need to restructure health care institutions to be more patient-centered and to better meet the needs of patients and their families. These approaches target efforts once the patient accesses the medical care system, even though research shows the environment and other social factors have a bigger impact on health outcomes than medical care. An effective health system will foster both quality coordinated health care services and community conditions that support health and safety.

We present a new model for effectively bridging community prevention and health service delivery: the community-centered health home (CCHH). Some health care institutions, particularly community health centers, already address patients’ social conditions: in addition to providing quality treatment, they refer patients to support services such as public health insurance options, legal services, and food stamps. These strategies are critically important and move us closer to a health care system that promotes health and well-being. But in order to achieve lasting change, health care centers should explore incorporating community change and advocacy more systematically and comprehensively into their practices. The CCHH model provides concrete steps and a process for doing this.

Effectively integrating community prevention into health services delivery will be critical to health reform implementation and overall efforts to expand coverage, improve quality, and reduce costs. For example, having access to healthy community environments and social supports increases the ability of patients to follow through on recommended chronic disease management regimens such as engaging in regular physical activity or changing dietary habits. This in turn can improve health outcomes and decrease the need for drugs or other medical interventions. Community prevention complements medical care through actions to improve the physical and social environment in which people live, work and play; and by investing in policies and infrastructure that support safe, healthy communities.

What is a Community Centered Health Home?

The vision of a community-centered health home is not an entirely new idea, but rather builds upon existing models and practices, including community oriented primary care, as well as traditional and more recent models of the medical home. It takes these models a step further, however, by encouraging health care institutions to take an active role in strengthening their surrounding community, in addition to improving the health of individual patients.

The defining attribute of the CCHH is active involvement in community advocacy and systems change. A CCHH not only acknowledges that factors outside the health care system affect patient health outcomes, but actively participates in improving them.

Elements of the Community-Centered Health Home

The approach needed to engage in community change efforts is very similar to, and builds on, the problem solving skills clinicians currently employ to address individual health needs. It simply takes these skills and applies them to communities. With individuals, practitioners collect data (symptoms, vital signs, tests, etc.), diagnose the problem, and develop a treatment plan. The CCHH functions in a parallel manner by following a three-part process for addressing the health of the community, classified here as *inquiry, analysis, and action*.

Inquiry

Given the constant contact of health centers with patients in their surrounding community, they are uniquely positioned to maintain a “finger on the pulse” of their community’s health. To do this more effectively, they need to collect data that reflects community conditions, analyze medical records for community health trends, and capture clinician impressions and intuitions about underlying issues shaping the prevalence of injuries and illness.

- 1. Collect data on social, economic, and community conditions.**
- 2. Aggregate symptom and diagnosis prevalence data.**

CASE STUDY

St. John’s Well Child and Family Center

When clinicians noted a significant number of patients with conditions ranging from cockroaches in their ears to chronic lead poisoning, skin diseases, and insect and rodent bites, they inferred that many of the cases might be related to substandard housing conditions. The clinic incorporated a set of questions about patients’ housing conditions into office visits and was able to collect not only standard health condition data (e.g., allergies, bites, severe rashes, gastrointestinal symptoms) but also housing condition information (e.g., presence of cockroaches, rats or mice). St. John’s clinic partnered with a local housing agency, a human rights organizing agency, and a tenant rights organization to form a collaborative to address substandard and slum housing in Los Angeles. The data that St. John’s collected made them an asset in the collaborative and helped the collaborative to gain partners. The collaborative developed and pursued a strategic plan to improve housing conditions in the area. The plan included community engagement, research, medical care and case management, home assessments, health education, litigation, and advocacy. The collaborative passed local administrative policies and secured agreements from high level leadership at different government agencies (LA City Attorney’s Office and LA Department of Public Health) that led to improved landlord compliance with standard housing requirements. The clinic now serves a surveillance role, reporting landlords that perpetuate substandard housing, and the community now has the infrastructure in place to ensure that landlords not in compliance are dealt the proper financial and legal consequences. Evaluation results show that resident living conditions and health outcomes both improved as a result of the collaborative’s efforts.

Analysis

Once health and safety information is collected, health centers can play a key role in identifying underlying problems and prioritizing possible solutions. CCHH staff would analyze the collected data and share it with community partners to jointly identify the factors in the community environment that are influencing health and safety outcomes.

3. **Systematically review health and safety trends.**
4. **Identify priorities and strategies to improve community environments with community partners.**

Action

Given the credibility of medical professionals, clinical staff and health institutions can play critical roles in advancing broader systems change that improves community environments. *Actions* should be built on the evidence and partnerships that are developed in the *analysis* phase. Partners should include community residents and representatives from sectors outside of health that make decisions that impact, such as transportation, housing and agriculture.

5. **Implement a coordinated, comprehensive strategy.**
6. **Advocate for policies and organizational change to improve community environments.**
7. **Mobilize patient populations to engage in changing community environments.**
8. **Strengthen partnerships with local health care organizations.**
9. **Establish model organizational practices within health institutions.**

Capacities Needed for Effective Implementation

In order to fully engage in the three-step process of *inquiry*, *analysis*, and *action*, certain internal capacities and resources should be developed.

- **Staff Training and Continuing Education.** Staff will need a firm understanding of how factors outside of the clinical setting shape health as well as information and tools that enable them to play an active role in addressing those factors.

CASE STUDY

Ho’oulu ‘Aina: Kalihi Valley Nature Park, Kokua Kalihi Valley (KKV), a comprehensive community health center

“While it is unique for a present-day health center to be the caretakers for a large parcel of land, Hawaiian and Pacific Island cultures recognize land as an integral part of community health.” – Ho’oulu ‘Aina website

Kalihi Valley is a densely populated, low-income community in Honolulu, Hawaii. The valley lacks sufficient sidewalks, bike lanes and public green space to support regular physical activity for its residents. Kokua Kalihi Valley Comprehensive Family Services (KKV), a community health center, obtained a 20 year lease on a 100 acre parcel in Kalihi Valley. In partnership with local organizations and agencies including the City of Honolulu, a local bike shop, leaders from a public housing development, and other community-based organizations, KKV is transforming the parcel of land into a nature park with hiking trails, walking and biking paths, community food production, and a cultural learning center. Eventually, the park will have up to 10 acres of community gardens, which will provide space for people to be physically active and grow healthy foods. The opportunities for safe physical activity and healthy food access that the park provides will support the health of those living in the KKV community.

- **A Dedicated and Diverse Team.** Because community prevention is based on a multi-sector approach to health, health centers would benefit from diverse staffing that takes into account the right mix of staff capacities and skills to meet the needs of their communities.
- **Innovative Leadership.** A fully functioning CCHH may require a shift in activities, culture, norms, and values within the institution, as it currently exists. Effective and innovative leadership is necessary to implement and sustain these changes over time.

Overarching Systems-Change Recommendations

Community health centers are part of an integrated, complex health care system. Regulatory, funding, and training mechanisms can all be used to incentivize and support change within health institutions. The five key areas for innovation at a systems level are:

- **Structure health care payment systems to support CCHHs.**
- **Leverage current opportunities for government, philanthropy, and community benefits to support CCHHs.**
- **Establish consistent metrics for evaluation and continuous quality improvement.**
- **Strengthen and utilize health provider networks.**
- **Build a cadre of health professionals prepared to work in CCHHs.**

Conclusion

Many clinicians know that by the time a patient reaches their office, the patient's health has already been irrevocably compromised by factors that they are ill-equipped to address. The nation's health institutions are left to contend with a growing burden of complex, but preventable, illness and injury. This highlights the pressing need for a new approach to health care. The concept of the community-centered health home, built on years of work and innovative thinking, is intended to catalyze discussion about how to create a health care system that integrates quality health care services with strategies to support people in living healthier lives. The strategies delineated here are applicable not only to community clinics but to every medical care provider. Community clinics are one important place for leadership—building on their commitment to community, equity and advocacy.

CASE STUDY

Beaufort-Jasper-Hampton Comprehensive Health Services, Inc.

Beaufort-Jasper-Hampton Comprehensive Health Services (BJHCHS) provides comprehensive medical and dental services in Ridgeland, South Carolina. Beginning in the 1970s, the clinic noted at least five to seven pediatric cases of soil-transmitted helminthes (ascaris, hookworm, and whip worm) each week, and attributed this pattern to poor water sanitation in and around the children's homes. Clinic staff knew that the best way to treat and prevent helminthes, and other diseases caused by poor water sanitation, was to first improve home sanitation. So the clinic sought grants to install septic systems and, in partnership with local community organizations, led the installation of septic systems and portable bathrooms in people's homes. Physicians ordered wheelchair ramps for those patients that needed them, and the environmental team associated with the project built the ramps. At its peak, the program installed 100-200 septic systems each year. The clinic, which now partners with the United Way, currently constructs between 20-25 septic units each year. The clinic's role in the community has expanded beyond alleviating unsafe water conditions to include rodent and parasite reduction and addressing other environmental conditions. Today, the clinic does not see any cases of soil transmitted helminthes disease in its patients.



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