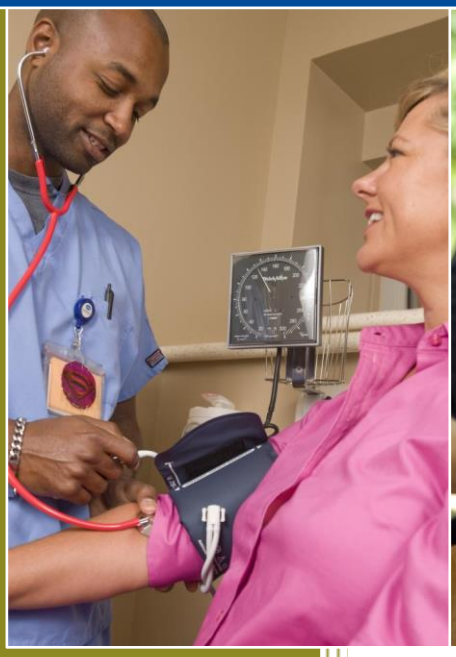
The Community-Centered Health Homes Model: Updates & Learnings



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"The Community-Centered Health Homes model has spurred a phenomenal transformation in our community and our clinic. CCHH is a way to make the connection to what we're doing in the community to the services & treatment that we provide in the exam room."

- Chandra Smiley, CEO, Escambia Community Clinics, Inc.
CCHH Demonstration Project Grantee

INTRODUCTION

Five years ago, Prevention Institute (PI) released its Community-Centered Health Homes (CCHH) report[1] at an event with then-Assistant Secretary of Health Howard Koh in PI's Oakland, California office. The response to the report since then has been both humbling and invigorating, as has the reaction to PI's work to advance the CCHH model as a critical strategy for ensuring that community prevention—the strategies to address the underlying community determinants of equity, safety, and health—is an integral component of health system transformation efforts. The model has catalyzed Community-Centered Health Homes projects in the Gulf Coast Region, North Carolina, and Texas, as well as inspiring action in other places around the country.

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We are seeing a rapid transformation in healthcare delivery and there is tremendous pressure to provide high quality care while reducing costs and improving the health of individuals and communities. Momentum is building for healthcare organizations to contribute to advancing population health – the health of every resident in the geographic areas where they operate. The Community-Centered Health Homes model provides a concrete framework for institutionalizing practices to achieve this. The Affordable Care Act has provided an enhanced focus on population health and new opportunities to bridge healthcare and community. This includes support for testing and spreading new care delivery and payment models that move us toward rewarding heath and quality care, and away from seeing as many patients as possible. Additionally, there is a growing recognition among healthcare providers and institutions that their patients will only be as healthy as the community in which they reside. People with Type II diabetes can't follow their clinician's advice to 'eat healthier' if they don't have access to fresh fruits and vegetables. They can't get out and walk more if they live or work in unsafe neighborhoods. More and more health systems acknowledge that a broad range of community factors outside of the exam room influence health—what's commonly known as the social determinants of health—and many have programs that link patients to basic needs such as housing, transportation, and healthy food. Some have dedicated staff or volunteers that monitor social service programs and actively refer their patients to community agencies. The next step, however, is increased attention and recognition that healthcare systems can also play a role in changing community conditions—for all patients *and* for the entire community. Improving these conditions (for example, supporting safe housing, affordable

[1] Cantor J, Cohen L, Mikkelsen L, Pañares R. Community Centered Health Homes: Bridging the gap between health services and community prevention. Oakland, CA: Prevention Institute. 2011. http://www.preventioninstitute.org/component/jlibrary/article/id-298/127.html. Accessed December 14, 2015.

transportation, and livable wages) helps not only individual patients, but has the potential to change the patterns of illness and injury across a community. It complements efforts to link patients to social services by helping to reduce the demand for those services *in the first place*. Healthier communities also means fewer people getting sick, reduced demand for healthcare services, and reduced unnecessary costs to the healthcare system.

Healthcare systems can play a role in changing community conditions—for all patients and for the entire community. Improving community conditions helps not only individual patients, but has the potential to change the patterns of illness and injury across a community. It complements efforts to link patients to social services by helping to reduce the demand for those services in the first place.

The CCHH model provides a concrete framework for healthcare organizations to systematically address the community conditions that impact their patients. It combines years of prevention experience about how to keep people from getting sick or injured, with insight gained from interviewing healthcare organizations around the country who were inspired to improve their patients' health and the health of the communities around them. By distilling promising practices from healthcare and the public health prevention field, the CCHH model presents activities for improving community conditions that healthcare can implement internally and in partnership. For some, it has reaffirmed existing work to improve community conditions while treating patients. For others, it has sparked ideas about how to more systematically address community conditions. For many, CCHH has resonated tremendously and moved beyond a 'model' to become a metaphor for the type of healthcare system to strive for: one that prioritizes prevention, health, and well-being alongside quality treatment, so that communities and people have the opportunity to be healthy *in the first place*.

What is a Community-Centered Health Home?

A CCHH is a healthcare organization that is actively involved in advocating for community and policy changes that will improve health and well-being. A CCHH not only *acknowledges* that factors outside the healthcare system affect patient health outcomes, it *actively participates* in improving them. The vision of a CCHH is not an entirely new idea. It is inspired by the pioneering work of physician Dr. Jack Geiger and social worker/community organizer Dr. John Hatch, who established the Delta Health Center in Mt. Bayou, Mississippi in 1965 on the principles of Community Oriented Primary Care practice; and builds on the Patient-Centered Medical Home model that seeks to better coordinate and deliver comprehensive services. CCHHs go a step further by encouraging healthcare institutions to take an active role in *strengthening their surrounding community*, in addition to improving the health of individual patients—and to institutionalize this community involvement.

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What We've Learned

This brief reviews and analyzes what we've heard from clinics actively involved in community change – particularly clinics doing early testing of the CCHH model – and summarizes what we've learned since first conceptualizing the model in 2011. Through talking with healthcare providers, presenting the CCHH model to various audiences, analyzing how some healthcare providers are engaging in various elements, and synthesizing learnings from demonstration projects currently underway, we identify lessons learned and common themes that have emerged for healthcare organizations that want to implement the CCHH model.

What has resonated for many is the need for a framework to conceptualize, plan, and implement strategies that address community conditions. In our original report on CCHHs, this framework was presented as the process of **Inquiry**, **Analysis**, and **Action**. It is important to note that the CCHH model is not linear, and depends on the starting place of the organization. More importantly, the CCHH model represents a set of core practices that are meant to serve as a menu for healthcare organizations interested in embarking on CCHH activities. These are presented below, along with sample activities.

Core Practices	Sample Activities
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	Convene regular discussions with staff and providers to identify potential community conditions influencing health outcomes (e.g. as part of regular clinical quality improvement meetings) Run reports of community-level health and safety trends (e.g. geomapping of where patients live and surrounding communities) or use external community data sources, like local public health data
Collect and analyze data on social, economic, and community conditions	Include questions on patient intake form, in provider-patient interviews, or focus/health education groups
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	Convene or participate in meetings with community coalitions focusing on housing Make data available to community partners (e.g. through data aggregation and analysis reports or data sharing agreements)
Identify strategies with community partners and coordinate action	Develop a strategic community action plan with diverse community leaders (residents, community organizations, businesses, local government, etc.)
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.)	Provide testimony (clinic staff or physicians) at city council hearing, and share findings with community residents Participate in educational visits to local elected officials
Mobilize patient populations to improve community conditions	Inform patients about opportunities to participate in policy advocacy campaigns and encourage patients to participate in community meetings Conduct voter education and registration drives
Build and strengthen authentic community partnerships	Host community meetings with residents and community organizations to discuss key health concerns and/or hear from community residents Establish formal structures for collaboration with community partners to leverage assets and identify opportunities for joint action
Establish model organizational practices	Have a healthy and local food procurement policy Offer a wellness benefit to employees

COMMUNITY-CENTERED HEALTH HOMES INITIATIVES UNDERWAY

Early application of the CCHH model and its concepts are underway in the Gulf Region, North Carolina, and Texas.

In the Gulf Region, Prevention Institute is partnering with the Louisiana Public Health Institute (LPHI) on the first-ever CCHH Demonstration Project. Funding is provided by the Gulf Region Health Outreach Program—Primary Care Capacity Project, administered by LPHI. The two-year demonstration's stated aim 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 medical home model and serve as trusted, effective partners in community prevention." Five clinics (two in Louisiana and one each in Florida, Alabama, and Mississippi) are testing strategic implementation of the CCHH model. At the start of the demonstration, the clinics participated in a six-month intensive technical assistance period to cement their understanding of community prevention, authentic community partnerships, and organizational change. According to Eric Baumgartner, Senior Community Health Strategist at LPHI, "The CCHH demonstrations have provided resources, guidance, and encouragement to clinics to go beyond just another quality improvement project to realize more of what they earnestly see as within their mission, to develop a sense of shared culture and reciprocal accountability among leadership and staff to work more effectively outside of their four walls. They are able to discover for themselves and demonstrate to community their ability to translate their opportunity as embedded caregivers into community benefit by evolving their core operations, data systems, and partnerships to realize their potential as supporters of community change that creates the circumstances for health equity."

> *The CCHH demonstrations have provided resources, guidance, and encouragement to clinics to go beyond just another quality improvement project.*
>
> *–Eric Baumgartner, LPHI*

The Blue Cross and Blue Shield of North Carolina (BCBSNC) Foundation has developed a strategic priority to increase the capacity of safety net health care organizations and communities so they can implement practices associated with the CCHH model. This effort began with Prevention Institute conducting a landscape analysis to determine North Carolina's assets and opportunities for CCHH implementation and adoption. PI interviewed a diverse mix of healthcare, public health, and community leaders in the state. The BCBSNC Foundation then hosted information sessions across the state to introduce the concept of CCHHs, followed by a limited, invitation-based hands-on, intensive workshop to develop a common understanding of community-based prevention, build a greater understanding of the CCHH model and related practices, and provide initial technical support. The Foundation offered small dollar, short-term "Action Learning" grants to all partnerships attending the workshop to begin field testing the CCHH model in their own communities. After this learning phase, the Foundation funded three communities for an 18-month planning process and continues to support other communities through technical assistance and continuous learning. "What we have found to date is that there is a clear understanding from both the clinical and community

perspectives that upstream preventive health efforts, done in partnership across sectors, are critical for the future of healthcare and for the health of our state. The investment we are making is in the technical assistance and organizational culture shifts that are required to take this from concept to concrete. It is not an easy lift, but we are excited for the interest and enthusiasm from our North Carolina communities leading the way on these changes," says Danielle Breslin Vice President at BCBSNC Foundation.

And in Texas, the Episcopal Health Foundation (EHF) has commissioned Prevention Institute to help strategically envision and develop a Community-Centered Health Homes initiative for their service area. The Foundation adopted a strategic plan in September 2014 that lays out its vision and strategy for "transformation to healthy communities." According to the Foundation, "We exist not alone but in community, and the health of our communities determines and is determined by the health of each individual member. We aim to transform the people, institutions, and places in our region to create healthy communities." The CCHH model embodies this vision and EHF expects that a dedicated initiative will complement its current grantmaking to clinics for basic operating support to include funding for implementation of the CCHH model. This includes grants for testing the model, as well as community and congregational engagement; convenings to support collaborative action; communications; and research, learning, and evaluation to strengthen the evidence base and further inform the initiative. Primary care clinics have an important contribution to make in this era of health system transformation—as witnesses to community conditions faced by patients, as health experts asked for advice on how to improve population health, and as (relatively) stable institutions in low-income and vulnerable communities. According to Lexi Nolen, Vice President for Impact at EHF, "The Foundation will increasingly shift its work from filling gaps in the social safety net to addressing systemic problems that cause and perpetuate gaps. This means moving from shorter- to longer-term investments, moving from downstream to upstream interventions, and supporting initiatives leading to self-organized, sustainable communities with strong and inclusive participation processes and structures. The CCHH model provides such an opportunity to address the causes of poor health by reimagining the role of community based health clinics in serving their patients."

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>
> *–Lexi Nolen, EHF*

Currently, community clinics are largely focused on delivering medical services, but more often than not, the medical problem for which the patient seeks care is rooted in the social or built environment. These systems are often viewed as external to and therefore beyond the traditional scope of influence of community clinics. If there were a broader view of the role of community clinics in promoting community health and well-being—beyond attending to specific medical issues—they would be better able to support the improvement of their patients' health. By supporting and working with clinics that want to embrace the CCHH model, EHF will enable clinics to be more effective in supporting prevention and health and well-being, beyond the delivery of medical services. The Foundation expects that supporting this transformational work will have a greater impact on community health than traditional health center funding strategies that only focus on "more." A strategy will be to advance the spread and scale of the CCHH model as an effective method for improving community health by catalyzing the development of a cohort of clinics and partners with the interest in and capacity to adopt the CCHH model.

REFLECTIONS FROM THE FIELD

In addition to learning alongside those putting the model into practice, PI has also learned from healthcare organizations around the country that are engaged in some of the CCHH core practices. Following are the lessons, themes, and essential capacities for CCHH implementation that have emerged:

Adaptive Model & Approach

CCHH is as much a metaphor as it is a model. As a metaphor, CCHH represents the transformation of the healthcare system from "a sick care system" whose only purpose is to treat injury and illness, to a system that improves community conditions. It is a paradigm shift that focuses on aligning healthcare delivery practices with values and actions that preserve and improve community health.

The CCHH model's central focus is on health*care* organizations. We've been asked where the CCHH model resides. Is it the clinic? Can it be a hospital? What about community coalitions? A CCHH is adopted by any entity providing clinical and healthcare services. While partnerships— and respect for community partners and coalitions— is part of the overall strategy and approach, the CCHH model is a set of institutional practices that *a healthcare* institution adopts. The proposed core practices are designed for any healthcare organization committed to improving its surrounding community conditions.

The model has several starting points, and is more flexible and fluid than a traditional "model." While we've found it helpful to refer to CCHH as a model to provide structure, it is actually more fluid than a typical model and depends on the starting point of a healthcare organization, including its efforts already underway. Through our discussions with clinical practitioners and leaders, we have seen several starting points for institutions committed to the CCHH approach. Some may start by re-examining their patient intake form when faced with a prevalent health condition; others may provide comments at a city council hearing when approached by a local coalition.

Transformation does not happen all at once. Even for those organizations deeply interested in implementing a CCHH model, it may take several interactions and touchpoints to understand exactly what a CCHH is and what it is designed to do—i.e., going beyond clinical quality improvement, service integration, or a comprehensive referral network, and also focusing on changing community conditions.

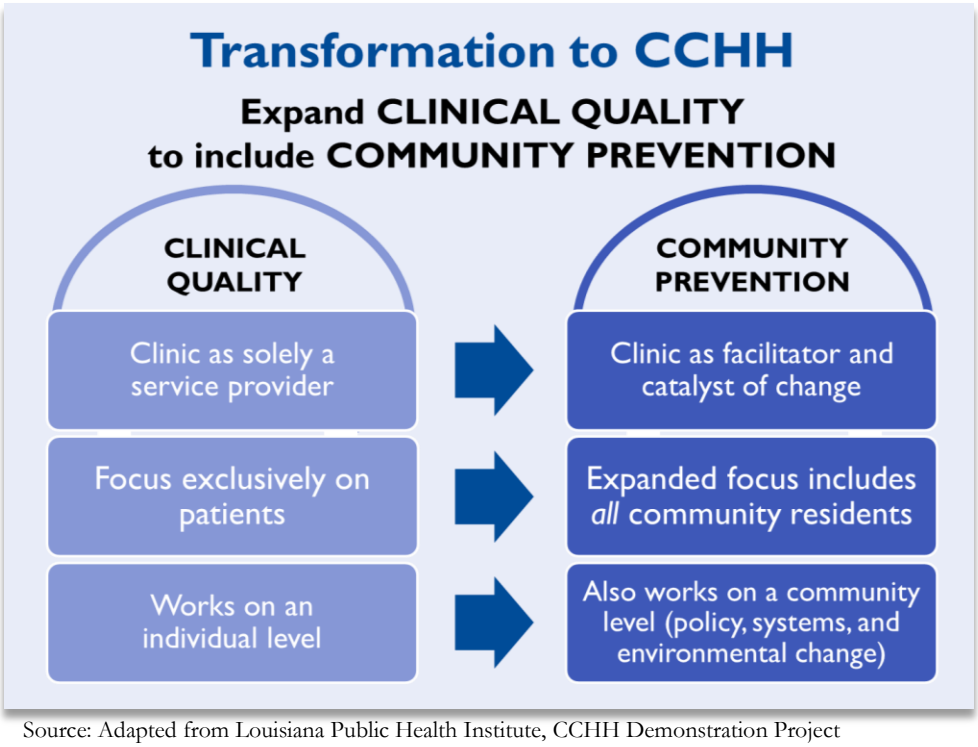
Expanding from Clinical to Community

A common starting point is to focus on one or two key medical concerns. A helpful first step is to select a common medical condition and trace the pathway back to health behaviors and exposures that are making people sick or injured. The next step is to determine what shapes those behaviors and exposures. For example, if Type II diabetes is the leading cause of patient visits, a common intervention might be to educate patients on healthy behaviors, like reducing sugar intake and incorporating physical activity into one's weekly routine. The next step would be to ensure the patients have access to affordable, healthy food options and safe places to exercise by collaborating with community partners.

It's critical to find a systematic way of analyzing clinical data, data on community determinants, and to link the two. Healthcare providers often sit on a wealth of real-time data collected for different purposes and funders, or to fulfill regulatory requirements. In some communities, these data are unavailable to local government or community coalitions, despite the fact that they may be invaluable for community change efforts. For example, knowing whether patients who frequent the ER due to

complications from asthma live in certain housing developments is useful for both individual patient care and for improving housing across a community. Sharing and analyzing this kind of data with community partners and residents (while protecting patient privacy) is critical for enacting broad-based change.

Individual healthcare providers have a desire and vested interest in changing community conditions. Increasingly, clinicians are frustrated by the limitations of a short office visit and patient care that happens in a vacuum, without consideration of community environments. There is an interest and desire to change this and the CCHH model continues to generate significant interest and positive response from the field. This interest is rooted in a desire for a structured strategy and approach, from a clinical perspective, toward addressing factors outside institutional walls.



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

Fostering Partnerships & Community Engagement

Healthcare institutions are credible partners whose assets are valuable for advancing community change. In almost every community, the healthcare institution is a well-regarded entity whose voice can be critical for changing local policy or community conditions. Having healthcare as an authentic partner can bolster the efforts of community groups, local public health entities, and others.

Partnerships and collaboration extend the reach of the healthcare provider. In the move towards value-based care, providers who see patients who are sicker or have multiple social needs (e.g. housing, food insecurity, etc.) may be held accountable for health factors that are not under their control. They may, for example, be penalized for high readmission rates. CCHHs can help providers advocate for changing the community factors that negatively impact their patients' health. To accomplish this, it is critical to form partnerships with external organizations and entities; healthcare organizations do not, and should not, have to enact change alone. The range and depth of partnerships needed, as well as the level of formality of the partnership, depends largely upon the priorities and capacity of the surrounding community. Collaboration with local partners and multi-sector stakeholders—such as community-based

organizations, businesses, local government, and schools—presents opportunities for leveraging assets and shared resources as well as mutually fulfilling work and engagement in CCHH activities.

Engaging patients and community residents is key. It is important that healthcare providers have strong, two-way relationships with patients and the community residents they serve. This includes being open and respectful of community input, providing opportunities and venues for authentic community engagement, and encouraging feedback on decision making around community health strategies.

Building Organizational Capacity

Dedicated CCHH staffing is needed for sustained coordination and implementation. Ideally, there would be at least one dedicated full-time employee at a healthcare institution who is responsible for coordinating and carrying out CCHH activities, has the ear of leadership, and regularly interacts with community partners and coalitions. This person (ideally, working with other champions) would also have the responsibility of educating, engaging, and mobilizing the entire staff in support of CCHH. Beyond the minimum of one dedicated staff person, individuals from various departments should carry out some aspect of CCHH activities as part of their job descriptions.

It is essential to have a leader who prioritizes CCHH principles as part of the organizations' mission, vision, and operations. Leaders of a healthcare organization set the tone and direction for implementing the CCHH model. Those who regularly draw upon the values of health for all people and a more upstream view of health are likely to work on addressing community determinants, even in the absence of dedicated resources.

It is essential that staff know and understand the role of environments and community conditions in health outcomes. The entire staff of a healthcare institution should have a firm understanding of how factors outside of the clinical setting shape health, as well as an understanding of their individual role in addressing those factors. Embedding this community knowledge and lens into daily operations, clinical quality efforts, and continuous learning and development supports systematic action and culture of working beyond their four walls to transform health in the communities they serve.

Strengthening the Field

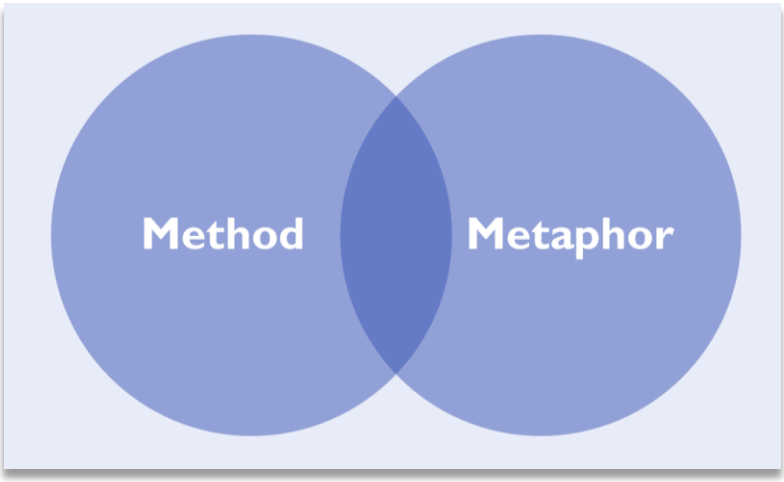
Lessons learned from effective community prevention practice need to be more broadly shared. The practice of community prevention has come far in recent decades and there is an established research base demonstrating its impact. These successes come from initiatives focused on tobacco control, traffic safety, and preventing violence, to name a few. Just like tested and measureable clinical quality initiatives, effective community prevention practice is a science. It's critical to ensure these learnings are translated for a healthcare audience.

Healthcare payment innovations are needed. Many providers and healthcare organizations cite the lack of reimbursement for CCHH-type activities as a barrier to adopting them. Yet many healthcare institution leaders have found ways to engage staff in community health, because of their organizational principles grounded in community change. Currently, these institutions rely on sources such as grant funding, community benefit dollars, or fundraisers to support their efforts. The national move toward pay-for-value, as well as accountability of healthcare for population health outcomes, is opening the door to more flexible financing, and provides an opportunity to promote healthcare engagement in community efforts as a way to meet these outcome goals. As this innovation proceeds, it's important for value-based payment systems to reflect that safety net providers treat patients with multiple health and social needs, often the sickest in a community.

What's encouraging is that in the time since PI's CCHH report was first released, momentum around new delivery and payment models has grown. In particular, the Accountable Community for Health (ACH) model has emerged as a promising vehicle toward reaching the full potential of improving population health at a regional level. An ACH advances previous efforts in community health by engaging healthcare as a central partner in community-wide health improvement. ACHs integrate medical care, mental and behavioral healthcare, and social service supports with efforts to improve the community conditions that shape health and wellbeing in a geographical area. At its core, an ACH is a structure for collaboration that represents a major change in direction in healthcare with tremendous opportunities and challenges.

ON THE HORIZON

Work and interest in healthcare–community integration to improve population health is growing exponentially, and will only intensify through increased health system transformation efforts. Focusing on community conditions has the potential to save lives, reduce illnesses and injuries, and facilitate healing. In many cases, this focus also saves resources for healthcare providers, payers, and patients.



Our Community-Centered Health Homes model will continue to provide a unique contribution to the discussion about health system transformation by highlighting the value of healthcare in partnering with its surrounding community. Importantly, the CCHH model serves as both a method and a metaphor for healthcare engagement in changing community conditions. As interest in the CCHH model continues to build, our work to advance the CCHH model will focus on testing and highlighting effective practices, facilitating shared learning, informing policies, and catalyzing healthcare to engage in community prevention strategies. Specifically, we'll continue to: deepen our on-the-ground knowledge of what it takes to implement the CCHH model by advancing and expanding pilots and synthesizing learnings; engage key government officials and thought leaders in the health field to deepen their understanding of CCHH learnings and challenges in the context of health system transformation; convene participants engaged in CCHH initiatives to learn from one another's challenges and successes, and inform the national conversation on health system transformation; and disseminate the CCHH model to diverse and influential audiences to build momentum for expanding the notion of population health beyond a clinical model.

About Prevention Institute

Prevention Institute (PI) is a national nonprofit dedicated to improving community health and equity through effective primary prevention: taking action to build resilience and to prevent problems before they occur. Our work is characterized by a strong commitment to community participation and promotion of equitable health outcomes. To help shape emerging approaches, policies, and practices, PI provides training and tools to communities, policymakers, academics, funders, and coalitions focused on health system transformation, improving healthy eating and activity environments, preventing violence, reducing injury and promoting traffic safety, and supporting mental health.