

Assessing & Promoting Adoption of the Community-Centered Health Home Model



FINDINGS FROM CALIFORNIA

THIS DOCUMENT WAS PREPARED
BY PREVENTION INSTITUTE

PRINCIPAL AUTHORS:

Rea Pañares

Dalila Butler

Leslie Mikkelsen

TABLE OF CONTENTS

Executive Summary	1
Introduction	5
Background & Purpose	7
Methodology	8
Findings	9
Overarching Findings	9
Key Learnings About Elements of the Community-Centered Health Home Model	11
<i>The Inquiry Phase</i>	11
<i>The Analysis Phase</i>	14
<i>The Action Phase</i>	16
Core Capacities for Implementing the Community-Centered Health Home Model	19
<i>Fostering Committed Leadership and Organizational Capacity</i>	19
<i>Building Partnerships to Advance Community-Centered Health Homes</i>	20
<i>Generating the Resources to Spark Innovation and Build Sustainability</i>	21
Recommendations	22
Conclusion	25
Appendix I: List of Participants in Site Visits and Phone Interviews	26
Appendix II: Interview Protocol for Site Visits	28

This work was made possible with funding from Blue Shield of California Foundation. We'd also like to thank the clinic staff that set aside their valuable time to host Prevention Institute staff during our on-site visits, as well as the numerous individuals that spoke with us via telephone. They are listed in Appendix I.

Introduction

Passage of the Affordable Care Act (ACA) has created a historic opportunity to move the nation's health care system from a "sick care system" to one that prioritizes health and well-being. Health care institutions are increasingly looking for ways to improve efficiency, reduce the severity of illness and improve population health, and save valuable time and resources. Community prevention—action to address the socio-cultural, economic, or physical factors in a community through changes in policy, systems, or the environment—is crucial for preventing illness and managing health conditions. An effective health care system will help foster community conditions that support health and safety as a complement to providing quality, coordinated clinical services. Engaging in community prevention not only offers opportunities for improving population health, but also can benefit individual patients by addressing community conditions that affect their ability to follow treatment recommendations (such as eating healthily or increasing physical activity). Community health centers have traditionally played a role in improving community environments, and since their founding, have implemented programs and strategies that address the cultural, social, and economic needs of their patients. Their efforts should be highlighted as other health care institutions begin to identify ways to improve population health and increase prevention activities.

Background and Purpose

With funding from the Blue Shield of California Foundation, Prevention Institute (PI) set out to understand how California community health centers engage in community prevention and how closely

these efforts follow PI's Community-Centered Health Home¹ (CCHH) model. Inspired by the principles behind community-oriented primary care and building upon existing models, such as the medical home and patient-centered medical home, a Community-Centered Health Home takes these models a transformative step further. The defining attribute of the CCHH model is active involvement in community advocacy and systems change. A Community-Centered Health Home not only acknowledges that factors outside the health care system affect patient health outcomes, but also actively participates in improving them. Using the CCHH model as a framework, we identified activities and practices that reflect elements of the model; looked at opportunities and challenges for stronger engagement in upstream prevention work; and provided recommendations that would facilitate wider adoption of the CCHH model in California.

This report builds upon conversations with community health centers and delves deeper into the CCHH model's three components: inquiry, analysis, and action. Our goal was to understand *how* health centers were engaging in the CCHH model to support improvements in community environments.

Findings

Through this work, we learned a great deal about community health centers' understanding of, engagement in, and readiness for community prevention. Below we highlight some of our key learnings about the Community-Centered Health Home Model and the core capacities necessary for health centers to engage in community change.

¹Prevention Institute, Community-Centered Health Homes: Bridging the gap between health services and community prevention (Oakland, CA: 2011). Available online at: www.preventioninstitute.org/component/jlibrary/article/id-298/127.htm

Key Learnings

The CCHH model consists of three phases: inquiry, analysis, action. We explored how health centers engage in each of these elements. Our findings are presented below.

In the **Inquiry** phase of the model, data are collected on individuals and the environment to identify community conditions that influence patients' health. We set out to understand what type of information health centers are collecting, and how. We found the following:

- Clinicians agreed that information on community conditions could be helpful, and that there are multiple opportunities at the clinic to gather this type of information outside of the clinical encounter. Information about patients' home and community environments could be collected at patient intake, during educational and group activities, during on-site enrollment in public programs or social service referrals, or via community health workers.
- The need for building systems for data collection varies depending upon the setting and size of the health center. Clinics with a smaller or more defined patient population (in terms of population, geography, or size) were often more connected to their patients, their needs, and the broader community. For clinics that spanned a greater geographic area or had a larger staff, there was a need for more deliberate data collection efforts, perhaps in partnership with the local public health department or community groups.
- The increasing use of electronic health records at clinics presents a continuing opportunity to gather information on community conditions and should be explored further.

In the **Analysis** phase of the model, clinic staff examine data collected by the clinic as well as from external sources to assess trends in the patient population and in the broader community. This phase is ideally conducted alongside community partners.

When asked how information was analyzed and shared, we heard the following:

- Conducting analysis alongside community partners benefits both the clinic and its partners. Data and information from the clinic can be used to bolster advocacy efforts, while partners may be able to provide context for understanding health issues faced by patients. Regular communication, which leads to trust, is key to establishing such relationships with community partners.
- Having a dedicated staff person would help facilitate consistent and proactive analysis, both for internal data as well as data collected by external sources, such as the local public health department or community partners.
- Collected and analyzed data does not always need to be quantitative. Qualitative stories about community conditions can help convey needs to the broader community, policy makers, and other local health care providers.

In the **Action** phase of the model, clinics engage in activities to change environments in their surrounding communities as well as in advocacy to bring about broader policy, systems, and environmental change efforts. Reflections from our interviews are provided below:

- There is enormous opportunity for clinics to expand their advocacy platforms to include changing community conditions. Most are already engaged in advocacy on issues that directly affect the clinic's core operations, and this foundation is key to expanding advocacy efforts to include broader systems change.
- Decisions about which issues to engage in are often made in response to specific community concerns. Ideas for programs are likely to come from patients and their families.
- Staffing and the capacity for engaging in policy advocacy work vary, depending upon the size and scope of the clinic.
- Clinic leaders struggle with balancing the allocation of resources between advocacy work and direct services.

Core Capacities

Committed Leadership and Organizational Capacity

Clinic leadership, specifically the CEO, sets the tone and direction for whether or not a clinic has the organizational capacity to implement the Community-Centered Health Home model. Leaders that regularly draw upon the clinic's founding values and roots in social justice are more likely to champion community prevention, even in the absence of dedicated resources. In planning for the next generation of clinic leadership, there is an opportunity to take that founding spirit of retiring leaders and cultivate it in new leaders, who may come from more traditional health care administration or management backgrounds.

A dedicated and diverse team, composed of individuals directed to carry out CCHH-like activities, is key to implementing the Community-Centered Health Home model. While a clinic's capacity to expand the staff focused on CCHH activities depends upon its size, most clinic leadership expressed a desire to have dedicated staff responsible for those activities.

Partnerships In the Community

Partnerships with external organizations or agencies are key to a clinic's ability to fully engage in community prevention and advance the CCHH model. The range and depth of partnerships needed, as well as the level of formality, depends largely upon the clinic's surrounding community. Collaboration with local partners and diverse stakeholders presents opportunities for mutually fulfilling work and engagement in CCHH activities.

Resources to Spark Innovation and Build Sustainability

Perhaps the most challenging aspect for clinics in moving toward a CCHH model is the absence of dedicated funding streams for community prevention. Clinic staff highlighted the complex balancing act of addressing the immediate needs of patients while advancing broader systems change. But there is an

exciting amount of innovation and transformation taking place, which has laid an important foundation for engaging in community prevention. Such innovation and transformation is funded largely by philanthropy. Clinic staff and leadership highlighted the importance of having funding to not only develop and implement innovative programs, but also to build infrastructures for sustainability.

Recommendations

We found that clinics have a strong desire to work further upstream by addressing community conditions. But even for clinics committed and dedicated to community-level change, it is difficult to *systematically* engage in this approach. Developing incentives and processes that would move institutions beyond singular efforts is necessary to support systematic practices for engaging in community change. Our interview findings highlight several opportunities to build toward this and provide the following recommendations for clinics and their supporters.

Practices for Community Health Centers

Clinics are engaging in elements of the CCHH model, and these activities can be built upon and institutionalized. We identified the following initial steps for doing so:

- Create dedicated time and space for clinic staff to discuss population health and deepen understanding of community prevention practices.
- Institute a formal process for regularly sharing information and ideas with community partners.
- Start with the most prevalent medical conditions and take a systematic approach to identifying community determinants and broader strategies.
- Designate staff whose role is to advance community prevention and CCHH practices within the clinic.

Trainings and Tools

While clinics' interest in engaging in CCHH activities is high, they need support to build capacity for doing this work. Government agencies, philanthropy, clinic associations, and others interested in supporting clinics

and strengthening health care's role in improving community conditions should consider the following:

- Increase training on community prevention for health center leadership, staff, and other interested partners. Training could also prepare clinical staff to be spokespeople or advocates for community prevention.
- Create templates or tools (to be used in multiple settings) that ask questions about a specific condition or disease in a more comprehensive and systematic way to identify underlying community conditions.
- Develop a menu of strategies for analysis and action, including information about how clinics have worked alongside partners to advance community change.

Policy Opportunities

With increasing emphasis on reforming the delivery system and finding efficiencies to reduce costs in health care, community prevention should be viewed as a strategy for accomplishing these goals. The Community-Centered Health Home model provides a systematic approach for identifying strategies that link health care and community prevention. Advocates, policymakers, and others should explore existing and emerging policy vehicles for advancing CCHH activities, such as:

- 1115 Waiver Process: States have the ability to test or pilot demonstration projects promoting the objectives of the Medicaid and Children's Health Insurance Program (CHIP) programs, if approved by the federal government. Most states, including California, used the waiver process to expand health

insurance coverage. Because the ACA expands coverage, states may use this as a vehicle to develop innovative service delivery systems or provide services not typically covered by Medicaid. This is a prime opportunity to test payment mechanisms for community prevention or CCHH activities in the Medicaid program.

- Change in Federal Reimbursement Policy: A recent federal rule change allows state Medicaid agencies to reimburse for preventive services provided by professionals that may fall outside a state's clinical licensure system, as long as the services have been recommended by a physician or other licensed practitioner. The new rule offers state Medicaid agencies the option to reimburse for more community-based preventive services, particularly those provided by community health workers or similar practitioners, potentially allowing community health workers to play a key role in implementing Community Centered Health Homes.

Conclusion

This work is meant to identify which elements of the Community-Centered Health Home model (inquiry, analysis, and action) are most utilized, and provide evidence for building upon and enhancing those elements within the clinic setting. This work reaffirmed that community health centers are best positioned among health care institutions to share strategies for engaging in community prevention. With increased dialogue on the importance of integrating primary care and population health, health centers should be looked to as examples of effective action, and their activities should be supported and expanded.

INTRODUCTION

Passage of the Affordable Care Act (ACA) has created a historic opportunity to move the nation's health care system from a "sick care system" to one that prioritizes health and wellbeing. The legislation also has reinvigorated a national dialogue about the best way to accomplish this goal.

The Triple Aim is an approach for optimizing the performance of health systems, which has informed the way both public and private health systems are

like chronic disease management (earlier screening, health education, targeted case management, and service referrals) are helping patients manage their conditions and prevent illnesses from progressing. In addition, community-level prevention efforts are crucial to preventing illness and injury across an entire community. A core component of prevention efforts is to improve the community environment. For example, patients with diabetes or heart disease will be more likely to comply with recommendations to eat

"FOOD INSECURITY IS A MAJOR HEALTH ISSUE FOR THE REGION WE SERVE. IN SOME OF OUR MEMBER CLINICS, WE'VE HAD DOCTORS IN THEIR OWN PRIVATE OFFICES STORING CANS OF FOOD AND DOING THEIR OWN FOOD PANTRIES. THEY SAW THAT THEIR PATIENTS—PARTICULARLY YOUNG MOMS—WERE MAKING DECISIONS ABOUT BUYING FOOD FOR THEIR FAMILIES OR PAYING THE RENT, ELECTRICITY, OR OTHER BILLS. THE DOCTORS WERE SAYING, 'THERE'S NO WAY I'M GOING TO BE ABLE TO TREAT THESE MEDICAL ISSUES IF WE CAN'T GET THESE FOOD SECURITY ISSUES UNDER CONTROL.'"

—TIM RINE, CEO OF NORTH COAST CLINICS NETWORK

organized and financed. The Centers for Medicare & Medicaid Services (CMS) turned to the Triple Aim when developing the framework for its Center for Medicare & Medicaid Innovation, which supports the development and testing of innovative models for health care payment and service delivery. The Triple Aim has three critical objectives:

- Improving the health of populations;
- Improving the patient experience of care (including quality and satisfaction); and
- Reducing the per capita cost of health care.

It is encouraging that one of the objectives is "improving the health of populations," and that health care institutions are increasingly turning to prevention as a strategy for accomplishing this. Tools

healthily and be active if their environment reinforces these behaviors. This is particularly critical for patients with lower incomes who live in communities with a history of systematic underinvestment. Strategies such as increasing access to fresh, healthy foods, creating walking trails to promote exercise, and ensuring neighborhood safety will improve patient and community health status.

The shorthand term for such community-level actions is **community prevention**—taking action to address the socio-cultural, economic, or physical factors in a community through changes in policy, systems, or the environment. Environments have a direct impact on health—exposing community members to toxins, infectious agents, and stress—and

they have a powerful impact on shaping behaviors that contribute to underlying medical conditions.¹ By some estimates, the combination of behavioral, social, and environmental factors accounts for as much as 60 percent of premature deaths.² An effective health system will foster community conditions that support health and safety, as well as provide quality coordinated clinical services.

Successful prevention strategies benefit patients and communities, *and* save health systems valuable time and resources. By the time some patients enter the health care system, their conditions require expensive, multi-faceted care. Efforts to improve community-level health determinants can benefit these patients in two ways: by reducing the severity of their illnesses, and by supporting treatment plans that require behavioral changes. An emphasis on community prevention not only strengthens the goal of improving the health of populations, but also potentially addresses the two remaining elements of the Triple Aim: improving patient experience of care and reducing health care costs. Moreover, health care institutions play a valuable role in supporting

community prevention efforts because of their recognized voice and leadership.

As health care organizations become more involved in population health efforts, they can learn valuable lessons from community health centers. These institutions have long been at the forefront of efforts to improve community environments. Most health centers were formed by local leaders who were deeply engaged in their communities and saw the need for accessible, high-quality health care. Many started small, with volunteer staff, eventually standardizing operations and building to Federally Qualified Health Center (FQHC) status. Today's clinics, through decades of experience in their communities, have developed programs and strategies that address the cultural, social, and economic needs of their patients. These centers are natural allies and leaders in illuminating strategies to advance the Triple Aim's population health objective. Their efforts should be highlighted as other health care institutions begin to structure population health and prevention activities.

¹ Cohen, L. Chávez, V., and Chechimi, S. Chapter 1: Beyond Brochures. In: Cohen, L. Chávez, V., Chechimi, S. *Prevention is Primary: Strategies for Community Well-Being*. 1st ed. San Francisco, CA: Jossey-Bass; 2007: 3-24.

² McGinnis, M.J., Williams-Russo, and Knickman, J.R., The Case for More Policy Attention to Health Promotion, *Health Affairs*, 2002, Vol. 21, No. 2, 78-93

BACKGROUND & PURPOSE

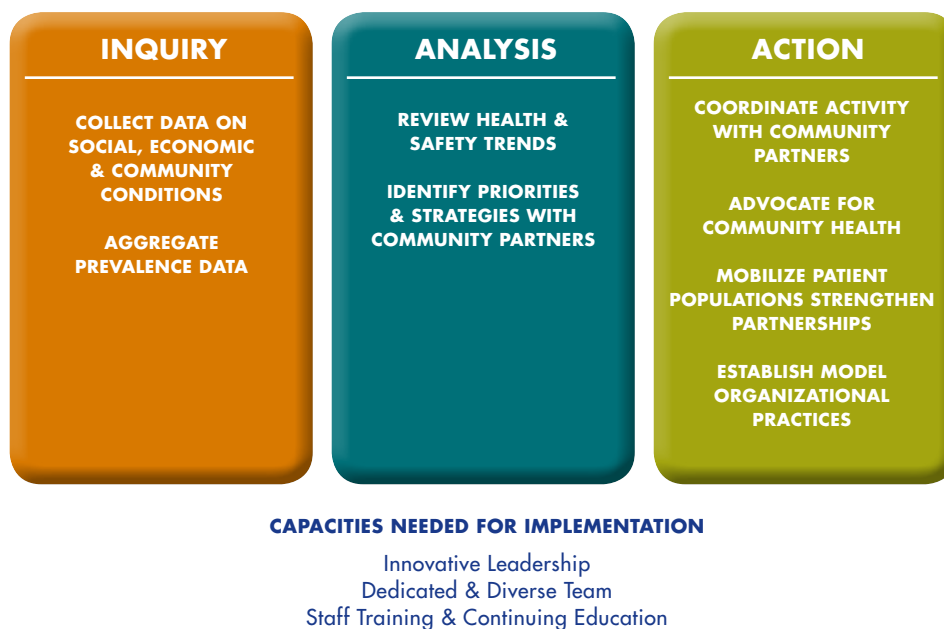
With funding from the Blue Shield of California Foundation, Prevention Institute (PI) set out to understand how California community health centers engage in community prevention. In particular, PI focused on how health centers address prevention through improving community conditions that have a strong impact on health outcomes.

A useful part of the background for this work is an earlier PI report from March 2011, *Community-Centered Health Homes: Bridging the gap between health services and community prevention*.³ It highlights how community health centers address factors in their patients' communities that shape health, even as they continue to deliver high-quality clinical services. The report lays out a three-part framework, including actions and activities for health care institutions to engage in to advance community prevention (see Figure 1 below). It is inspired by the principles behind community-oriented primary care, and builds

upon existing models, such as the medical home and patient-centered medical home. *Community-Centered Health Homes* (CCHH) takes these models a transformative step further by providing a framework for health care institutions to actively engage in strengthening their surrounding communities. The defining attribute of the Community-Centered Health Home is active involvement in community advocacy and systems change. A Community-Centered Health Home not only acknowledges that factors outside the health care system affect patient health outcomes, but actively participates in improving them.

Using the Community-Centered Health Home model as a framework, we identified activities and practices that reflect the model (or pieces of it); looked at opportunities and underlying challenges for stronger engagement in upstream prevention work; and provided recommendations that would facilitate

Figure 1. Community-Centered Health Home Model



³ Prevention Institute, *Community-Centered Health Homes: Bridging the gap between health services and community prevention* (Oakland, CA: 2011). Available online at: www.preventioninstitute.org/component/jlibrary/article/id-298/127.htm

METHODOLOGY

Prevention Institute staff conducted one-day site visits with five community health centers in California, selected in consultation with Blue Shield of California Foundation. The sites represent the state's geographic and cultural diversity, and PI had an existing relationship with most of them.

They included: St. John's Well Child & Family Center (Los Angeles), LifeLong Medical Care (Berkeley), Clinic Ole Community Health (Napa), Hill Country Community Clinic (Round Mountain), and San Ysidro Health Center (San Diego/Mexico Border). Prior to the on-site interviews, PI staff conducted an initial phone conversation with health center leadership to describe the project, answer questions, and begin planning the full-day site visits. The day followed roughly the same format, which included:

- A meeting with leadership to discuss organizational capacity and leadership support for community prevention;
- A series of meetings with staff to learn more about the following:
 - Payment for primary prevention;
 - Data and analysis of community factors that impact health, including implementation of electronic health records;
 - Advocacy efforts; and,
 - Experience working with external partners.

Appendix II (pages 28-30) includes a sample of the interview tool we used. After compiling findings from site visits, we conducted eight additional telephone interviews with community health centers, clinic consortia, and one nonprofit health plan (see Appendix I, pages 26-27). Telephone interviewees were chosen not only to reflect the geographic diversity of the state, but also for their experience with or their participation in a health home innovation grant program. A shorter version of the interview tool was prepared for telephone interviews.

wider adoption of the CCHH model in California. We developed the Community-Centered Health Home model through a series of conversations with community health centers across the country, and it is informed by their work.

For this report, we built upon those conversations and delved deeper into the Community-Centered Health Home model's three parts. Our goal was to understand *how* community health centers were engaging in the steps of inquiry, analysis, and action to support improvements in community environments. Throughout this report, we refer to these steps, or

any combination thereof, as "CCHH activities." Specifically, we wanted to know:

- Where did CCHH activities originate? Was there a specific incident or impetus for starting these activities?
- Were there formal systems and practices in place that supported the Community-Centered Health Home model (or any one of its three elements)?
- How were CCHH activities funded?
- Which staff members were involved in carrying them out?

FINDINGS

Through this work, we learned a great deal about community health centers' understanding of, engagement in, and readiness for community prevention. At many of the community health centers, both leadership and staff were eager to speak with us. They acknowledged the value of an integrated approach and expressed interest in the Community-Centered Health Home model, particularly if they had seen presentations on the model by PI staff, participated in Webinars, or read the 2011 report. All were gracious with their time, especially at the five sites where we conducted daylong site visits, many of which included meetings with multiple staff from various departments. Most staff and leadership mentioned how the in-depth conversations with us were a welcome reprieve from day-to-day operations, and an opportunity to reflect on how their practices and operations aligned with their missions and values. Many staff reminded us of their roots in community-oriented primary care and their organization's founding by individuals dedicated to social justice.

We found that clinics are engaging in a range of activities that promote community health and reflect the Community-Centered Health Home model. At the same time, the health centers are under enormous pressure to provide high-quality medical care and comply with regulations, which can take precedence over advancing community-level initiatives. Emerging changes in health care delivery, fueled in large part by the ACA, present a unique opportunity to create the incentives and support needed for CCHH activities to become systematically incorporated into the standard operations of clinics.

Overarching Findings

Clinic leadership and staff have a strong desire to work further upstream and address community conditions that cause or contribute to many of the medical problems their patients face. Clinic



staff are implementing this work in different ways and engaging in some or most elements of the Community-Centered Health Home model. Their efforts would likely be more focused and strategic if there were monetary reimbursement or other incentives for community prevention activities built into the health care system.

Clinics are turning to prevention to address certain health conditions through health education, referrals for social services, or case management for chronic conditions. While this contributes to improved quality of care and better health outcomes, community prevention activities are less frequent. For health centers that want to engage in community change, a useful way to start is by focusing on a particular medical condition and tracking community conditions that might affect it. For example, treatment recommendations for a diabetic patient might be to modify the individual's behavior by eating fewer processed or high-sugar foods. However, in taking a step back, the community-level change may be improving access to fresh, whole foods for the entire community. When described and framed in this way during our interviews, the Community-Centered Health Home model became more tangible for clinics.

In addition to being a venue for accessing comprehensive health services, clinics are serving as a

hub for community building activities. Some clinics, for example, provide free Internet access for the entire community, lend books to patients, and offer healthy cooking classes. Clinics may sponsor programs that develop youth leadership skills and connect elderly residents to prevent social isolation. Some community health centers even sponsor community events, using their physical space to showcase local artists and connect community members to one another.

Most programs or activities related to CCHH were funded first by grants, and clinic leadership acknowledges that these initial investments allowed them to pursue projects they would not have otherwise gotten off the ground. Some clinics were able to maintain the activities and build the internal capacity needed to engage in community prevention. Philanthropy and other innovative funding sources play a critical role in seeding innovation, as well as in developing strategies for maintaining these efforts.

Leadership is key to establishing the organizational commitment to advancing a CCHH approach. Because most community clinics are rooted in the principles of social justice, leaders who were part of the initial founding of the clinics are more likely to champion community prevention, even in the absence of dedicated resources. Newer CEOs who were not part of the community health center movement, or who have come from traditional health care institutions, may be more focused on the bottom line and data-driven health outcomes. With many CEOs nearing retirement, there is a need to ensure that the founding spirit of community clinics is not lost.

Established relationships with community partners and an awareness of other community players are critical to advancing the Community-Centered Health Home model. Community partners can extend the health center's efforts so that it doesn't have to choose between spending resources on addressing upstream determinants or providing services. Strong partnerships enable a clinic to more readily identify an appropriate role for clinic staff in community change efforts, whether it is sharing data



to support local advocacy efforts, participating in local coalitions, or starting community gardens.

Elements of the Community-Centered Health Home model can be thought of as building blocks or a menu of options to integrate over time; a clinic need not implement all components at once. Some clinics are taking steps in that direction, and others are poised to move beyond piecemeal activities to systematically address community determinants.

Clinic staff and leadership are extremely interested in identifying innovative payment mechanisms that would allow them to systematically implement CCHH activities. Some of the clinics we spoke with are thinking about how to fund community prevention activities through ACA implementation. For example, some clinics are exploring ways to utilize outreach and education funding through Covered California to support outreach workers in assessing the social needs of the community. Clinics could then use that information to strengthen community change efforts.

Clinic staff appreciated the opportunity to step out of their typical role of providing services to think about community determinants and the role of primary prevention. The process of talking with us and going through the interview questions (see Appendix II, pages 28-30) helped them think about how to be more proactive in pursuing community prevention activities.

Learnings About the Community-Centered Health Home Model

INQUIRY THE INQUIRY PHASE

During the Inquiry phase of the model, information and data are collected, not just on individual patients, but also on the community environment that may contribute to the conditions bringing patients into the clinic. This phase includes aggregating data on patient conditions to paint a picture of population health trends or gathering information on conditions in the surrounding community that are known to contribute to illness and injury. The latter is especially useful when done in collaboration with outside partners that might already have the data, such as local public health departments, community groups, or others. Useful information and data include:

- Information from patients about their home, school, and work environments, to help inform medical diagnoses and create an appropriate treatment plan, as well as assess the overall community;
- Aggregated patient information on medical conditions (such as asthma prevalence) broken down by neighborhood, zip code, or other key demographics;
- Information from the health care team about common challenges patients experience and their impact on medical conditions, such as how food insecurity affects their ability to manage diabetes or cardiovascular disease; and
- Community resources that may promote health (parks, full-service grocery stores, etc.) and community disadvantages (such as exposure to diesel pollution, poor air quality, increased crime, etc.) particularly in a defined geographic area.

During the interviews, we set out to understand how health centers were collecting information and what type of information they were collecting. Are patients asked about community conditions? How is this information recorded and compiled?

Beyond clinicians, are there other staff members who gather information from patients? Is publicly available data, such as those from local public health departments, accessed by clinic staff to inform clinical decision-making or programs? Is there a time and place for health center staff to share impressions about community factors that might be contributing to illnesses and injuries they see? We found the following:

There are multiple opportunities at the clinic to gather information from patients about their home and community environments.

Many clinic staff members we spoke with recognized the importance of understanding the ways in which community conditions affect the health of their patients. They acknowledged that gathering information about these factors is the “right thing to do,” and ultimately, a more efficient way of diagnosing and treating patients. And because clinics, more than other health care institutions, offer services beyond the medical encounter (case management, nutritional counseling, or fitness classes, for instance), there are several opportunities to collect, and—ideally—aggregate this information.

In the interviews, we explored how to best collect this information and relay it back to clinicians to help inform their diagnosis and treatment plans, as well as how to convey it to other departments such as planning or fund development (for whom this information could be useful in developing and sustaining programs).

We asked about the feasibility of adding standard prompts or questions (based on common chronic conditions) to the patient visit with the clinician. While the clinicians and clinic administrators we spoke with acknowledged that this could be helpful in theory, many felt this level of information gathering would be challenging in practice. Conducting a comprehensive assessment that asks about a patient’s community and environment is difficult during the medical encounter, given the pressures to streamline an already limited patient visit, complex reimbursement mechanisms, and benchmarks for



the number of patients seen. Moreover, from some perspectives, if the goal is to understand the medical issue the patient is experiencing, engaging in detective work that identifies underlying issues contributing to the medical condition may take time away from diagnosis and treatment.

Encouragingly, clinic staff discussed a number of occasions in which more detailed patient information is already being collected. The data collection process could be expanded to include information on community conditions. Opportunities for collecting such information include:

- During patient intake, either through a self-administered form or with assistance;
- During case management services (which many clinics offered for patients with diabetes, heart disease, or other chronic conditions);
- During educational and group activities such as cooking or fitness classes;
- During on-site enrollment into public programs or social service referral encounters; and,
- Through community health workers or similar staff when providing education to patients and the larger community.

For example, in one clinic, St. John's Well Child & Family Center, staff chose to gather information by developing an intake questionnaire that included questions related to housing conditions in order to better understand the origins of the high prevalence

of rodent and insect bites, skin conditions, and lead poisoning they were seeing among their patients. Most clinics employ care coordinators, case managers, or community health workers whose primary role is to follow up with patients to help manage their conditions, and may also work to address underlying issues that contribute to their poor health. *Promotoras* or community health workers, in particular, have a strong link to the community and could potentially collect data to help the clinic identify patient needs as well as to help guide community efforts.

The need for building systems for data collection varies, depending upon the setting and size of the health center.

We interviewed both urban and rural clinics and found some important distinctions, particularly related to collecting data and sharing information. The clinics with a more defined patient population, either in terms of population, geography, or size, were often more connected to their patients, their needs, and the broader community. Because clinic staff regularly interact with one another, as well as with patients and others in the community, both professionally and personally, there did not seem to be much need for sophisticated feedback loops for sharing information.

For clinics that spanned a greater geographic area or had a larger staff, there was a need for more targeted data collection. Current efforts are primarily focused on collecting patient information to improve health outcomes through individualized case management, care coordination, or referral services. Some clinic staff, though, discussed using data to inform overall clinic operations. For example, information gleaned from community health workers is not only useful for clinicians to have as context for common health conditions, but also could be helpful for development staff to use when seeking or applying for funding to support CCHH-like activities within the clinic, or to engage in partnership opportunities. Data collection can be accomplished through having a dedicated time and place where health care team members come together to share reflections and information.

The increasing use of electronic health records at clinics presents a continuing opportunity to gather information on community conditions.

A common thread throughout conversations with clinic staff was the move toward Electronic Health Records (EHR) and how clinics were setting up systems, if not already in place. Systems varied, and there were differences in the clinics' flexibility to add certain fields in the records for collecting community information. While there was general agreement that including fields related to community conditions or social factors would be ideal, it was clear that this presented some challenges. Specifically:

- Clinics are focusing on regulations and their requirements, leaving little energy or time to expand beyond them.
- While a wealth of information and research exists in public health and in the social sector about potential questions and prompts, there is a lack of coordination and standardization among health care systems in using these resources.

- Some EHR systems are flexible enough to allow clinics to add new fields, but clinic leadership doesn't want to overburden staff, which would be responsible for collecting this information. Because staff typically receive training when new fields are added, making such changes would require additional time and resources. Moreover, adding prompts related to the community environment requires a general understanding of the impact of community conditions on health, an understanding that varies.
- There is a balance between standardizing the information collected and being too prescriptive about the clinical visit and what is discussed during it. Some EHR templates may lead clinicians through specific questions in a way that compromises clinician insight and expertise.

Regardless of these challenges, clinic leadership and staff generally agreed that it would be a missed opportunity if they do not figure out the best way to capture information on community conditions.

ANALYSIS

THE ANALYSIS PHASE

In this part of the Community-Centered Health Home model, clinic staff examine information and data—ideally with community partners—to assess trends in both the patient population and in the broader community. Once data on key health determinants and community conditions are collected during the **Inquiry** phase, an important consideration is how that information is shared with, translated for, and used by clinic staff who play a role in patient care and clinic operations. The **Analysis** phase is not only useful in improving population health, but can also facilitate the medical diagnosis and strengthen treatment recommendations. When asked how information was analyzed and shared, clinic leadership and staff shared the following:

Partnerships with organizations outside the clinic are mutually beneficial and strengthen analysis.

Conducting analysis alongside community partners benefits both the clinic and its partners. Data and information from the clinic can be used to bolster advocacy efforts. At the same time, partners may provide some context to help clinics better understand and address health issues faced by patients. Establishing relationships needed to have this trusting and regular communication is key. For example, San Ysidro Health Center (SYHC) has its own Health Promotion and Research Department, which conducts research and positions the health center to link with community partners and initiatives.

One such initiative is LiveWell San Diego, a ten-year, comprehensive strategy to improve the health and well-being of San Diego residents, launched through San Diego County's Health and Human Services Agency in 2010. LiveWell strengthens existing relationships and fosters new partnerships across a diverse range of stakeholders, including health care providers, faith-based groups, businesses, schools, county departments, and other local jurisdictions such as tribal governments and cities. Through work

on LiveWell strategies, the SYHC Health Promotion and Research Department is expanding the health center's partnerships and supporting advocacy efforts that promote healthy, safe, and thriving San Diego communities and foster active community empowerment and engagement.

The presence of a dedicated staff person would help facilitate consistent and proactive analysis.

A common need that emerged from the interviews was to have the appropriate internal staff to consistently analyze and disseminate data collected by the clinic. Another role for this internal staff person would be to examine the clinic's data in relation to data from external sources, such as local public health departments and community partners. In the absence of an immediate need or threat, clinics often find it difficult to decide what to do with clinic-collected data. Without a dedicated staff person in place, the analysis phase becomes a reaction to events.

Collected and analyzed data does not always need to be quantitative.

The Data Department at the Native American Health Center (NAHC) in Oakland, California, has six staff and a data manager, who have leveraged innovative ways to capture and share data highlighting their community's experience. NAHC's Digital Storytelling program uses digital stories as part of the healing process for patients, and to convey the experiences of Native American residents to the broader community, local policymakers, and other local health care providers. The stories have helped demonstrate the relationship between community conditions and health in the Native American community. NAHC staff has organized community events, such as panels and screenings, to showcase the stories, foster discussions and reflections around their themes, and serve as a catalyst for planning collective community action.

BUILDING A GARDEN—AND A COMMUNITY

OPEN DOOR COMMUNITY HEALTH CENTER-DEL NORTE (CRESCENT CITY, CA)

For more than twenty-three years, the Del Norte Community Health Center has served as an important hub to access critical health services for the Northern California community of Crescent City. But despite excellent care provided, clinic staff saw their patients facing persistent challenges to achieving optimal health. Through close connections with community residents and an understanding of the conditions outside the clinic, clinic staff identified food insecurity as a major barrier to good health.

In response to this challenge, local clinics started informal food pantries. But staff realized that a much larger solution was necessary to ensure residents had sustained access to fresh, healthy fruits and vegetables. With a grant from the Community Clinics Initiatives (CCI, now the Center for Care Innovations), the health center worked to develop a barren plot of land nearby. These efforts not only produced a community garden, but also built a safe place for residents and families to come together in the spirit of community building—and become active participants in the process.

Knowing that they couldn't do it alone, community health center staff looked to partners in the local community who were involved in community gardens. Outreach through flyers, newspaper ads, and word of mouth brought together representatives from local nonprofit

organizations and city agencies, as well as elementary school children, high school students, and parents. Over the course of six days, roughly fifty to a hundred residents of all ages participated in building the garden space—tilling the soil, building plant boxes, preparing more than eighty garden beds, and deciding which vegetables to plant. A playground, exercise stations, and three walking trails were also added.

Several factors helped facilitate this work. First, clinic staff has a keen, personal understanding of the community and its needs. Second, deep relationships between clinic staff and community members garnered action. For example, some nurses and other clinic staff members were married to farmers, who brought expertise and passion to the project.

Seed funding from CCI allowed for this type of innovation.

Building upon the momentum and initial successes of the Del Norte Community Garden, community gardens in three additional community health centers in Humboldt and Del Norte Counties are now in the works. Staying true to the spirit of this work, all are guided by the same community-driven process and participatory spirit that brought together the local Crescent City community to improve access to fresh, local, and healthy food.



Del Norte Community Health Center's Wellness Center and Garden

Image Source: <http://www.opendoorhealth.com/opendoor/del-norte-community-wellness-center-and-garden>

ACTION

THE ACTION PHASE

We found examples of community clinics engaging in activities that went beyond delivering clinical care, from providing health education on managing and preventing certain conditions to linking patients to services in the community. A number of clinics were also involved in efforts to improve their patients' home and community environments. Examples include creating walking trails on clinic grounds for patients and staff, planting community gardens, and setting up a clinic lending library with free Internet access. In the **Action** phase, clinics engage in both activities to change environments in their surrounding communities as well as in advocacy to bring about broader policy, systems, and environmental change efforts. Reflections and examples from our interviews are discussed below:

There is enormous opportunity for clinics to expand their advocacy platforms to include changing community conditions, if they are not already doing so.

Most clinics, sometimes in partnership with state and national organizations, are involved in advocacy on issues directly affecting the clinic's core operations. Health center leadership emphasized that their primary role as community health centers is to deliver high-quality health care services for low-income and uninsured residents. Given budget cuts and constant threats to public funding for the safety net, clinics have naturally needed to stay abreast of and remain active on these issues. For example, when adult dental care was threatened by funding cuts to the Medical program, clinic leaders protested those cuts and articulated the impact it would have on patient care and their bottom line. Similarly, during the health care reform debate, clinic leaders participated in various ways: displaying signs supporting reform, informing staff and patients of the need to lend their voices through petitions or volunteering for call-in days, and signing letters of support. This foundation in advocacy is critical to engaging in broader systems change. Because the skills, experience, and infrastructure

needed to engage in policy advocacy work are similar across issues, having these elements in place presents an opportunity for clinics not already working on changing community conditions to expand their advocacy platforms.

Clinics respond to community concerns.

We asked clinic leaders how they choose which issues to engage in. For the most part, decisions have been made in response to specific community concerns. Ideas for programs often come from patients and their families; for example, one clinic started a youth job training program in response to patient feedback. When discussing broader systems change efforts and advocacy to improve community conditions, one clinic emphasized the importance of "engaging in advocacy that affects the lives of real people and improves patients' lives." Similarly, another clinic described its goal as working closely with patients to ensure that changes the clinic supports or seeks are responsive to patients' needs.

Staffing and the capacity for engaging in policy advocacy work varies, depending upon the size and scope of the clinic.

Across the clinics we visited, staffing was structured in a variety of ways. In some clinics, policy and government affairs work is handled by only one person, who, especially in smaller clinics, may even be the CEO. In others, there is a dedicated position or a separate department that handles advocacy and

"WHEN YOU CONSIDER JACK GEIGER AND THE PRINCIPLE BEHIND COMMUNITY HEALTH CENTERS, YOU HAVE TO ASK THE QUESTION, 'HOW COULD IT POSSIBLY BE THAT A COMMUNITY HEALTH CENTER SIMPLY PROVIDES INDIVIDUAL MEDICAL CARE AND DOESN'T ENGAGE THE FUNDAMENTAL CAUSES OF DISEASE TO TRY AND PREVENT THOSE CAUSES?'"

—JIM MANGIA, CEO OF ST. JOHN'S WELL CHILD & FAMILY CENTER



public affairs initiatives, in addition to a community engagement and outreach department. The staffing structure and size dictate the extent to which clinics are able to engage in advocacy activities. However, because smaller and more rural clinics are often the major players (and sometimes a major employer) in a community, their close ties to the community can be as beneficial as a large staff is for carrying out advocacy work.

Clinic leaders talked about the balances and trade-offs in engaging in advocacy work.

One consideration is whether a clinic should build its internal capacity to do advocacy work, or act in partnership with other groups, such as local coalitions, statewide groups like the California Primary Care Association, or the National Association of Community Health Centers. Another issue is that the time and resources required to engage in advocacy activities should not take away from providing clinical services. For example, staff members from one clinic shared that, while they have done some policy advocacy work, it is difficult for them given their size and location. They need to balance between spending resources on longer-term change efforts versus direct services.

Through our interviews, we found several examples of clinics actively engaged in policy, systems, or environmental changes in their communities:

- Through a community health education program at La Clínica de la Raza called Project LIFT, youth

advocates and peer leaders helped to raise awareness and drive action around second-hand smoke exposure at public transit hubs. Their campaign became part of broader advocacy efforts that helped to push for a systems-wide policy change that now prohibits smoking at local bus stops and shelters.

- A few years ago, Hill Country Health and Wellness Center was faced with the possibility of a high-voltage power line running close to the clinic, and the clinic's new LEED-certified facility being in the shadow of a planned 200-foot transmission tower. In response, the clinic provided support to a local organizing effort opposing the project and housed information and an educational display in the clinic lobby.
- St. John's Well Child and Family Center organizes the Right to Health Committee, a patient-led community project with the mission to fix the broken health care system in South Los Angeles by ensuring health care is affordable, accessible, of high quality, and provided by people with quality jobs. The Right to Health Committee's collaborative includes the health center and several local partners: Service Employees International Union–United Healthcare Workers West, Strategic Actions for a Just Economy, Esperanza Community Housing Corporation, and Service Employees International Union Local 721. Together, this collaborative develops goals, policy targets, and activities based on community assessments, patient input, and member discussions. The committee meets monthly.
- Planned Parenthood of the Pacific Southwest, Coachella Clinic, expanded its adult promotoras program to include a youth program. Clinic staff acknowledged the importance of making advocacy efforts accessible to the young people in their community to empower them and build leadership. In addition to conducting outreach to peers, youth promotoras have had the opportunity to visit Sacramento and Washington, D.C., advocating for changes to address important health issues in their communities.
- Clinic staff at the Native American Health Center (NAHC) are intimately aware of the importance

YOUTH LEADERS MAKING A CHANGE TO PROTECT BUS RIDERS FROM SECOND HAND SMOKE

LA CLÍNICA DE LA RAZA (OAKLAND, CALIFORNIA)

It was clear to the group of youth leaders involved with Project LIFT (Leaders in the Fight against Tobacco) that smoking at public transit stops was not good for the health of their community—and they wanted to do something about it. A community health education program with La Clínica de la Raza, Project LIFT provided a safe space and guidance for these young peer educators to channel their motivation and passion for prevention work toward community action and policy change.

With the support and guidance of La Clínica staff, youth leaders designed stickers and posters they could place at public bus stops to raise awareness of the impact of secondhand smoke. They developed a community survey assessing the prevalence of smoking at local bus stops. They met with officials from the city of Oakland as well as from AC Transit (the local bus system in Alameda County) to



propose putting these materials at all bus shelters. Project LIFT members then played an active role in implementing the plan and getting the creative “No Smoking” stickers at all local bus shelters.

These youth-led advocacy and outreach efforts helped to raise awareness and drive action around the issue of smoking and secondhand smoke exposure at public transit hubs. The campaign became part of broader advocacy efforts for a systems-wide policy change that now prohibits smoking at local bus stops and shelters.

The success of this campaign was shared not only by youth leaders and peer educators involved with Project LIFT, but also by the entire community of residents and bus riders who can now breathe easier on their way to work or school.

Example of a youth-designed poster placed at AC Transit bus shelters

of taking care of the whole person. In addition to addressing health and behavioral needs, they recognize that poverty is one of the major issues their patients face and it greatly impacts their health. NAHC is working to not only expand its care coordination and housing subsidy programs, but also to secure funds to develop an innovative microfinance program for patients that would support local economic development. Working with the nonprofit organization Kiva, the proposed program would provide small loans to patients with community entrepreneurship projects. For example,

“FOR A LOT OF THE PEOPLE WHO COME THROUGH [THE CLINIC], THE BEST THING THAT WILL HELP LIFT THEM OUT OF THE DIFFICULT SITUATIONS THEY ARE IN IS THE ABILITY TO BRING IN MONEY AND TAKE CARE OF THEMSELVES AND BE ECONOMICALLY SELF-SUFFICIENT.”

—SERENA WRIGHT, DIRECTOR OF COMMUNITY ENGAGEMENT,
NATIVE AMERICAN HEALTH CENTER

members of a local beading circle have wanted to sell handmade native products they produced, which were recently featured at a local Oakland public library. NAHC would like to take these efforts to the next level by providing seed money.

Core Capacities for Engaging In Community Change

Fostering Committed Leadership and Organizational Capacity

For each of the on-site interviews and many of the telephone interviews, we spoke with the clinic's CEO. Some interviews included a significant amount of time with the CEO and other senior staff or executive leadership. One on-site interview included a few board members as well. It is clear that leadership, specifically the CEO, sets the tone and direction for whether or not a clinic has the organizational capacity to engage in a Community-Centered Health Home approach. Many CEOs we spoke with saw the connection to community as integral and necessary to patient care. Clinic size also dictated the level of organizational capacity needed to engage in CCHH-like activities, and the extent to which the clinic worked beyond its walls to improve the health of its patients. We found the following:

There appears to be a distinction between founding (or near-founding) CEOs and newer leaders that should be explored further.

Clinic leaders who were present during—and in some cases actively involved in—the clinic's founding were more likely to discuss social justice values and describe community prevention as “the right thing to do,” whether or not there are dedicated resources for it. These leaders typically worked in and around the clinic before it gained FQHC status, with its accompanying requirements to comply with federal guidance. Newer CEOs who were not directly connected to the community health center movement, or who may have previously worked for traditional health care institutions, tended to be more focused on data-driven results, outcomes, and the bottom line. As we heard from one CEO,



understandably, their primary responsibility is to make sure bills are paid, equipment is functional, and patients are receiving high quality health care services.

In planning for the next generation of clinic leadership, there is an opportunity to take that founding spirit of retiring leaders and cultivate it in new leaders from medical or operational backgrounds. The time is right to return to these origins as experts work to redefine what health care *should* look like in the era of health reform and beyond. This could be accomplished through a learning collaborative among retiring and new leaders. The goal would be to provide a space for founding or longstanding leaders to share their perspectives on and experience in the community health center movement with the new generation of leaders.

Direction from the CEO is critical to determining whether or not the health center has the capacity and drive to implement all or part of the Community-Centered Health Home model.

Such direction includes setting organizational structure and staffing in advocacy or government affairs, development, and other key areas; opportunities for clinician training and education about community prevention; staff meeting discussion topics; staff participation in external coalitions; and other activities.

As with any organization, the size of the clinic often determined whether or not it had the staffing diversity to carry out the Community-Centered Health Home model.

A dedicated and diverse team, comprised of individuals tasked with carrying out CCHH-like activities, is key. While some clinics had individual positions dedicated to diverse roles involving government affairs, local coalition building, case management, development, and other key areas, other clinics had one person playing a combination of those roles. Regardless of their setup, most clinic leadership expressed a desire to have staff responsible for carrying out various pieces of the Community-Centered Health Home model. In our interviews, we identified several key (and, for the most part, unique) positions within clinics that are integral in advancing Community-Centered Health Homes, including Community Liaison Manager, Promotora Program Lead, and Director of Social Medicine and Health Equity.

An organizational culture that fosters collaboration among departments can bolster and support community prevention efforts.

In addition to having staff dedicated to community prevention, clinic leadership expressed the desire to have structures in place that encourage diverse departments to share information, data and reflections, and to support each other's work. One clinic we interviewed, for example, did not originally have a formal system for communicating information that would help facilitate the Community-Centered Health Home model. They decided to create a new position to better coordinate public affairs and community health education departments. The promotoras gather information and stories from the community about health needs, but only occasionally work with public affairs staff, such as when accompanying them to legislative visits. Clinic leadership realized that the rich community information gathered from promotoras was not being regularly shared with public affairs staff to help them develop advocacy strategies for engaging with legislators, the public, and key stakeholders. This new position aims to better integrate information, communication, and efforts across both fronts.

Community health centers that regularly draw upon founding values and roots in social justice are more likely to incorporate elements of the Community-Centered Health Home model.

Clinics have traditionally been mission-driven, values-based organizations. For example, staff at one community clinic (Hill Country Community Clinic) described the clinic's values as not just about providing quality health care, but more about healing. Leadership wanted to make an inviting space that felt like a "healing place" when people walked in. At that same clinic, the founding CEO revisits clinic values and mission to set the tone in monthly staff meetings. This process involves recognizing that the clinic and its assets "belong to the community," and that their organization is not only values-driven, but also "place-based," and must be responsive to its community.

"WE HAVE A COMMITMENT TO ADDRESSING THE PROBLEM WHETHER IT MAKES US RICH OR NOT. IT HAS TO BE MISSION-DRIVEN. YOU NEED TO HAVE FAITH AND BE WILLING TO TAKE RISKS, EVEN IF THE OUTCOMES OR REWARDS ARE NOT READILY APPARENT."

—JIM MANGIA, CEO OF ST. JOHN'S WELL CHILD & FAMILY CENTER

Building Partnerships to Advance Community-Centered Health Homes

In addition to the need for strong leadership, another dominant theme that emerged was the importance of partnerships in order to fully engage in community prevention and advance the Community-Centered Health Home model. As previously discussed, the range and depth of partnerships needed, as well as the level of formality, depends largely upon the clinic's surrounding community. In rural areas or those with a defined patient population, connections and potential partnerships are more frequent and informal because most people know each other. Other reflections from the interviews:

Partnering with diverse stakeholders presents opportunities for mutually fulfilling work and engagement.

Clinics can engage in outreach and build relationships that develop creative solutions and meet multiple partners' needs. For example, a clinic may want to build a garden to help feed patients, or it can partner with schools or local colleges that may be looking for opportunities for youth engagement. Other potential partners that clinics identified include the local school system, hospitals, transportation agencies, food banks, farmer's markets, and community coalitions organized around a specific cause or geographic area.

While the range of potential partners varies by community, some common partners emerged.

For example, several clinics were in deep collaboration with local public health departments. While many of these efforts started with a specific program, the relationships that were built helped foster partnerships in other areas. For example, the Heart 2 Heart program is a collaboration among LifeLong Medical Care, the City of Berkeley's Public Health Division, and a broad-based community coalition. Building on the partners' aligned missions, Heart 2 Heart is a place-based approach to promoting health in a Berkeley, California neighborhood with high rates of cardiovascular disease. The program integrates medical care provided by the clinic with the work of the public health department and community partners—engaging residents, building capacity, and transforming the community. Their goal is to continue working with residents to create a neighborhood environment more conducive to healthy choices, increasing tobacco-free living, active living and healthy eating, and improving the social and emotional well-being of residents.

A keen understanding of potential community partners outside the clinic helps clinics more fully engage in this work.

Knowing what is available in the surrounding community and the potential role the clinic plays in improving community environments is key to advancing Community-Centered Health Homes. In

some communities, this may involve providing data to a local coalition or preparing clinicians or executive leadership to testify at local city council meetings.

Generating the Resources to Spark Innovation and Build Sustainability

Perhaps the most challenging aspect for clinics in moving toward a Community-Centered Health Home model is the absence of dedicated funding streams for community prevention. Clinic staff highlighted the complex balancing act of addressing the immediate needs of patients while still advancing the larger vision of prevention embodied by the CCHH model. While clinic staff we spoke with agreed it made sense to engage in community prevention efforts, and that such efforts were a natural fit with their missions, implementation always came down to resources or lack thereof.

Despite the fact that many clinics spend the bulk of their limited time and resources on complying with regulations, there is an exciting amount of innovation and transformation taking place. This innovation, largely funded by philanthropy, has laid an important foundation for engaging in community prevention. In many cases the innovation changed the clinic staff's way of thinking about what's possible and the role the clinic plays in changing community environments. Most activities that were or are in place have been funded by grants for limited periods, so sustainability continues to be a challenge.

Clinic staff and leadership also discussed the need for funding, not only to develop and implement innovative programs, but also to build "infrastructures for sustainability": the critical tools needed to accurately measure and track the impact of seed funding and community prevention work. One clinic discussed the challenges of conveying the "hard and fast return" on a community garden, given that current reporting parameters focus on the number of completed CalFresh applications, rather than on patients' access to fresh food. For wide-scale change to take root, funding is needed to identify the process and mechanism for developing measures to capture the full value of community clinics' prevention efforts.

Through these interviews, we found that clinics have a strong desire to work further upstream by addressing community conditions. They recognize their patients' health is influenced by factors outside the medical system. This commitment is primarily reflected by clinic activities that link patients to supports and resources outside the clinic, such as walking clubs and housing or employment resources. Some clinics, through dedicated and innovative leadership, engage in community change efforts aimed at improving health across the whole population.

But we found that even for clinics committed and dedicated to community-level change, it was difficult to *systematically* engage in this approach. What's needed is the development of incentives and processes that would move institutions beyond singular efforts and instead support systematic practices for engaging in community change. Based on the interview findings, we see several opportunities to build toward this and provide the following recommendations for clinics, as well as for those that support clinics, such as government agencies, foundations, clinic associations, and others. Lastly, we present policy opportunities that would help facilitate systematic adoption of the Community-Centered Health Home model.

Practices for Community Health Centers

Clinics are engaging in elements of the Community-Centered Health Home model and these activities can be both institutionalized and built upon. Based on our interviews, we identified the following initial steps for doing so:

Create dedicated time and space with clinic staff to discuss population health and deepen understanding of community prevention practices.

Clinic staff and leadership expressed a genuine appreciation for having time to discuss community

prevention in-depth through this project. Clinics can establish regular meetings for staff to share their reflections on how community conditions are influencing their patients' health and brainstorm new ideas. All staff members—from frontline staff to clinicians to community health workers—may have observations to share about existing resources in the community and barriers their patients face following medical advice. For example, these discussions can highlight where there is free physical activity programming, or where there is a schoolyard that could potentially be opened for out-of-school recreation. This knowledge forms the building blocks for developing partnerships to take community action, strengthen community assets, and improve conditions that are fostering illness and injury.

Have a formal process in place to regularly share information and ideas with community partners.

For some clinics in rural areas or with more defined patient populations, relationships with outside partners were strong and did not necessarily need a formal mechanism for information sharing. Larger clinics, however—particularly those with established relationships with local community coalitions or local public health departments—benefitted from these partnerships. While it is possible for community health centers to collect data and observe trends within the patient population (*Inquiry*), community partners like health care coalitions or public health departments may be better suited to analyze that data and share it for community action planning (*Analysis*). Moreover, community organizations and government agencies should contribute their knowledge to delineate multi-faceted solutions (e.g., related to transportation, parks and open space, safety, food access) that address the conditions patients face.

Start with the most prevalent medical conditions to identify strategies that address community determinants.

Most clinics could identify one or a few medical conditions that have a big impact on their patients' health, ranging from diabetes to heart disease to asthma. Focusing on one of these conditions provides a realistic starting point for implementing CCHH practices and taking a systematic approach to identifying community determinants and broader strategies. For example, clinics concerned about Type 2 diabetes may recommend healthy diets and regular physical activity for controlling blood glucose. By working with community partners engaged in improving access to healthy food and safe places to be active, the clinic can both help address barriers making it difficult for patients to follow healthy behaviors and improve healthy behaviors throughout the entire community.

Designate staff whose role is to advance community prevention and Community-Centered Health Home practices within the clinic.

Depending upon the size of the clinic, the right structure and number of full-time-equivalent employees will vary, but having someone dedicated to advancing this work is critical. This would include staff positions to serve as liaisons with community partners and coordinate community efforts, serving as a "prevention coordinator" or "integrator." Importantly, there will need to be mechanisms for ensuring these staff members have authority and can influence decision-making within the institution.

There is also the opportunity to examine current staff roles and identify opportunities for them to contribute to advancing CCHH activities. For example, community health workers already spend time on the ground talking to community residents and visiting different locations. They bring valuable information back to the clinic about community conditions.

Trainings and Tools to Advance Community-Centered Health Home Work At Community Health Centers

While clinics' interest in engaging CCHH activities was high, they need support in building their capacity to do this work. Government agencies, philanthropy, clinic associations, and others interested in supporting clinics and strengthening health care's role in improving community conditions should consider the following recommendations:

Increase trainings on community prevention for health center leadership and staff, including board members and other interested partners.

The practice of community prevention has come a long way over the past few years, and there is a growing research base demonstrating its importance. Health care practitioners may not be keeping abreast of these advances because their primary focus is clinical care or clinical prevention. We found clinic staff and leadership to be receptive to developing a shared working knowledge and understanding of how community determinants impact health. Trainings can be conducted for individual clinics, health center leadership, or clinic membership associations and similar organizations. These trainings could also help prepare clinicians or other staff within the clinic to be spokespeople or advocates for how community conditions affect patient health.

Create templates or tools (to be used in multiple settings) that ask questions about a specific condition or disease in a more comprehensive and systematic way.

In our interviews, we found that information on community conditions could be collected in multiple settings, from the clinical encounter to other services offered by most clinics. For example, some patients are referred to case workers, nutrition counseling, and/or cooking classes offered by the clinic to help them manage their chronic illnesses. In the context of providing education and teaching self-management,

valuable information can be collected from patients about their community environments. Questions about community determinants and environments could be targeted depending upon the health condition. This not only helps the clinic paint a picture of what's happening in the patient population, but could also help inform the clinic's work, strategies, and approach, especially if this information is relayed effectively to clinicians, administrators, and others.

Develop a menu of strategies for analysis and action, including information about how clinics have worked alongside partners to advance community change.

In our interviews, we found examples of clinics that have worked with community partners after identifying common medical conditions affecting their patient populations. Often, this includes forming partnerships with diverse stakeholders in a local community to address priority health conditions from the medical, public health, and environmental and community perspectives. Sharing and disseminating these experiences more broadly among clinics can spur ideas and action.

Policy Opportunities to Support Community-Centered Health Homes within ACA Implementation and Health Care Delivery Reform

With increasing emphasis on reforming the delivery system and finding efficiency in health care while reducing costs, community prevention should be looked to as a strategy for accomplishing these goals. The Community-Centered Health Home model provides a systematic approach for identifying strategies that link health care and community prevention. Advocates, policymakers, and others should explore existing and emerging policy vehicles for advancing CCHH activities. Two specific recommendations are discussed below:

Waivers

There are existing policy vehicles that provide states the flexibility to explore innovative solutions that would increase resources for community prevention

and public health, such as the state waiver process and new federal reimbursement regulations. Through Section 1115 of the Social Security Act, states have the ability to test or pilot demonstration projects promoting the objectives of the Medicaid and CHIP programs, if approved by the federal government. The purpose of these demonstrations, which give states additional flexibility to design and improve programs, is to demonstrate and evaluate policy approaches such as expanding eligibility to individuals who are not otherwise Medicaid or CHIP eligible; providing services not typically covered by Medicaid; and using innovative service delivery systems that improve care, increase efficiency, and reduce costs.

To date, states have mostly used the 1115 waiver process to expand eligibility for individuals who are not otherwise eligible for Medicaid or CHIP. Because the ACA has expanded coverage options, states may explore using the 1115 waiver process to develop strategies for promoting the other two policy approaches—designing innovative service delivery systems and providing services not typically covered by Medicaid. This is a prime opportunity to test payment mechanisms for community prevention or CCHH activities in the Medicaid program.

Federal Rule Change

CMS created a new rule, effective January 2014, which allows state Medicaid agencies to reimburse for preventive services provided by professionals that may fall outside of a state's clinical licensure system, as long as the services have been initially recommended by a physician or other licensed practitioner. The new rule for the first time offers state Medicaid agencies the option to reimburse for more community-based preventive services, particularly those provided by community health workers or similar practitioners. As described above, because there is the potential for community health workers to play a key role in implementing Community-Centered Health Homes (e.g., through collecting data on environmental conditions facing patients or patient organizing and advocacy), this avenue should be fully explored.

CONCLUSION

This work is meant to identify elements of the Community-Centered Health Home model (inquiry, analysis, and action) that are working, and provide evidence for the importance of building upon and enhancing those elements within the clinic setting. The CCHH model provides a systematic process for how health care institutions can prioritize community prevention activities, and lays out a strategic approach for doing so. While the need for and implementation of individual steps will vary from health center to health center, the model provides a guide of what's needed to advance this approach. Health care institutions are increasingly interested in improving population health, but the specific mechanisms for doing so, particularly when it comes to changing community environments,

have not been clearly identified. Using the CCHH model as a framework and systematically incorporating elements of the model can go a long way toward advancing these efforts.

This work reaffirmed that community health centers are the best-primed health care institutions to share strategies for engaging in community prevention. They have been doing this work as part of their missions and values, and recognize their role in the broader community. With the increased dialogue about the importance of integrating primary care and population health, health centers should be looked to as examples of effective action and their activities should be supported and expanded.

List of Participants in Site Visits and Phone Interviews

Site Visit Participants

Clinic Ole Community Health

Kathy DeMaggio, Director, Planning and Education
 Maria Stel, Grants Manager
 Ninad Athale, Family Physician, County Campus
 Priscila Gonzalez, Director of Clinical Operations
 Tanir Ami, CEO
 Tina Zoppel, Clinic Manager
From Napa County Public Health
 Connie Moreno Peraza, Director, Alcohol and Drug Services
 Jaye Vanderhurst, Director, Mental Health
 Jennifer Henn, Epidemiologist
 Jim Featherstone, Former Assistant Director, Health and Human Services

Hill Country Health and Wellness Center

Bridget Schafer, Chief Information Officer
 Ellen Sugg, Board Member
 Lynn Dorroh, CEO
 Lynn Erickson
 Pat Stewart, Health Information Services Director
 Richard Hardie, Chief Financial Officer
 Tammy Allan, Licensed Clinical Social Worker, Behavioral Health Director
 Terri Orwig, Licensed Vocational Nurse
 Tom Stockton, Board member
 Vicky Everett, Chief Operating Officer, Compliance & Quality Improvement

LifeLong Medical Care

Marty Lynch, CEO
 Nance Rosencranz, Director of Strategic Planning and Business Development

San Ysidro Health Center

Ana Melgoza, Director of Government Relations and Public Affairs
 Caryn Sumek, Health Promotion and Research Manager
 Ed Martinez, CEO and President
 Elizabeth Bustos, Director of Strategic Operations
 Elizabeth Ramos, Clinic Director
 Greg Talavera, Director of Clinical Affairs
 Kevin Mattson, Senior Vice President
 Maria Carriedo, Chief Medical Officer
 Rosana Scolari, Director of Operations
 Terry Whitaker, Vice President of Operations

St. John's Well Child & Family Center

Farid Hassanpour, Chief Medical Officer
 Gary Zimble, Chief Information Officer
 Jim Mangia, CEO
 Laurie Dressler, Health IT Analyst; Clinical Informaticist
 Lisa Hubbard, Strategic Initiatives/Public Affairs
 Liz Meisler, Chief Financial Officer
 Sonia Perez, Billing Director

Phone Interview Participants

La Clínica de la Raza

Viola Lujan, Director of Business and Community Relations

Native American Health Center

Serena Wright, Director of Community Wellness Department
 Esther Lucero, Director of Policy and Programming
 Charlene Harrison, Site Director

North Coast Clinics Network

Tim Rine, CEO

Trisha Cooke, Project Director

Morgan Gard, Project Coordinator

Open Door Community Health Centers

Breanne Sorrells, Enrollment Coordinator

Alissa Pattison, Community Garden Coordinator,
Willow Creek Health Center

Teri Humphrey, Willow Creek Health Center

Partnership Health Plan

Sonja Bjork, Director of Policy and Program
Development

Dr. Robert Moore, Chief Medical Officer

Planned Parenthood of the Pacific Southwest, Coachella Clinic

Olga Montes, Associate Manager Community
Engagement, Eastern Riverside County

Jacqueline Vargas, Promotoras Program
Coordinator

Redwoods Rural Health Center

Tina Tvedt, Executive Director

The Coalition of Orange County Community Health Centers

Isabel Becerra, CEO

Rocio Magdaleno, Director of Member Services

Sample Interview Questions for Site Visits

I. Leadership Support and Organizational Capacity

1. When you hear the term community prevention, what does it mean to you?
2. How, from your perspective, does your health center address community prevention?
3. How is community prevention institutionalized within the clinic? Can you describe any systems, programs, and/or personnel in place that work directly with community prevention efforts?
4. How do you assign roles or provide sufficient staff to support your community prevention work? How are staff trained and supported to engage in community change efforts?
5. How does your mission, along with other internal policies and practices, align with your commitment to community prevention?
6. How would a change in leadership influence the clinic's commitment to community prevention as a priority?
7. How do you set your organizational direction?
8. Is there time and space for community conditions discussions at staff meetings?
9. How are community prevention related programs developed?
10. How do you define health equity? How is health equity embedded in the clinic's internal practices and mission? How does health equity relate to the clinic's programs and community prevention activities?

II. Data & Analysis

1. How do you monitor the health of your patient population? How do you recognize and understand emerging health trends among your patients?
2. Do you use any additional data sources beyond clinic data to enhance the understanding of the health status of the population your clinic serves?
3. What are the implications of health information technology implementation on your clinic's operations? Are you utilizing health information technology to collect information that focuses on the social determinants of health or asks about community conditions? If so, how?
4. How does information get recorded, compiled, and analyzed?
5. How is data used to make decisions about new initiatives, programs, or practice changes to improve population health?

III. Advocacy Efforts and Partnerships

1. What do you see as your clinic's role in advocacy and policy change? And how do you staff that role?
2. How do you decide which coalitions you are involved with?
3. Are you involved with or connected to any advocacy organizations? If so, which ones? (i.e., CPCA, NACHC, Health Access, housing coalition, food and farm coalition, etc.)?
4. Are you also involved in efforts around policy change or changes to community environments? Are there policies (local, state, federal) that the clinic has helped champion or changes to specific community conditions that support health?
5. How do you pay for staff time to do advocacy work?
6. What partners do you work with outside the health care sector? How do these partnerships inform your work?
7. What is the nature of your partnerships with surrounding or local health care organizations?

IV. Payment and Funding for Primary Prevention

1. What are your major sources of funding, in general? How do the funds break down?
2. How are efforts that focus on changing community conditions currently funded? If you have found any limitations that exist with current funding streams, how do you work through/around those limitations?
3. What are you able to accomplish with current funding streams (Medicaid, Medicare, etc.)?
4. Do you see opportunities within the ACA for paying for community prevention? Do you see any opportunity for intersection with the CDC's Community Transformation Grants (CTG) or other federal funds?
5. How are philanthropic (or other) dollars leveraged?

V. Clinician Perspective

1. What information are you collecting during the appointment? How are you recording your information?
2. How often are patients asked about other factors (housing, environment) that may contribute to their health conditions during the clinical encounter?

For the Medical Director...

3. How are you standardizing information that is collected by different clinicians? Is data on social, economic, and community conditions collected from individual patients on the patient intake form?

VI. Final Overarching Questions

1. Who are you connected to that would promote changes at the local, state, and federal level to support this work?
2. Who do you look to for leadership around issues related to population health or community prevention?
3. How can we be helpful to you?