The Community-Centered Health Homes Demonstration Project

2017 Report

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The Louisiana Public Health Institute (LPHI) is a 501c(3) nonprofit public health institute that translates evidence into strategy to optimize health ecosystems. Our work focuses on uncovering complementary connections across sectors to combine the social, economic, and human capital needed to align action for health. We champion health for people, within systems, and throughout communities because we envision a world where everyone has the opportunity to be healthy.

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We would like to thank everyone who has contributed to and supported this work. The Community-Centered Health Homes (CCHH) Demonstration Project is funded by the Deepwater Horizon Medical Benefits Class Action Settlement which was approved by the U.S. District Court in New Orleans on January 11, 2013. This project is a component of the Gulf Region Health Outreach Program (GRHOP), a series of integrated, five-year projects designed to strengthen health care in Gulf Coast communities. We are grateful to the members of the GRHOP Coordinating Committee for their continued guidance and support.

We would like to extend a special thank you to the five community health center sites of the CCHH Demonstration Project – Coastal Family Health Center, CrescentCare, Daughters of Charity Services of New Orleans, Escambia Community Clinics, Inc., and Mobile County Health Department/Family Health – for their participation and hard work. This would not be possible without their dedication and drive to serve their communities. We also thank the community partners who have engaged in and contributed to the CCHH initiatives.

We thank our former teammates who contributed to this work during their time at LPHI. Dr. Eric Baumgartner, MD, MPH, former Senior Strategist for Community Health, led LPHI's early GRHOP efforts and spearheaded the integration of CCHH into the program. Jaymee Desse, MS, and George Hobor, PhD, were instrumental during the project's development and kick off. Alexandra Priebe, PhD, served as the Senior Evaluation and Research Manager and contributed to the design and implementation of the program evaluation. Lastly, we are thankful to Prevention Institute for their development of the CCHH model and for serving as a valued partner and collaborator throughout this process.

Executive Summary

As the health care system shifts from paying for volume to paying for value, there is increasing interest in addressing the non-medical determinants that influence health. There is a growing body of research showing that social and environmental factors have a major influence on health outcomes, and that health care services alone are not sufficient to sustain healthy communities. The Community-Centered Health Home (CCHH) model, developed by Prevention Institute (PI), calls on health care organizations to actively contribute to improving the upstream factors that influence health, such as employment or housing. The model puts forward three functional elements – *inquiry*, *analysis*, and *action* – to guide health care organizations and their partners in the use of data to understand and prioritize community needs, and work together to create community change.

The Louisiana Public Health Institute (LPHI) designed and implemented the two-year CCHH Demonstration Project, the nation's first demonstration of the model. Five community health centers in the Gulf South participated in the two-year program. With support of funding and technical assistance, health centers and their community partners pursued a range of data collection, analysis, and community prevention activities. The primary objective of the CCHH Demonstration Project was to generate valuable insight about CCHH implementation in a clinic setting and what is needed to support community health centers in this work.

Location	Health Center	Community Prevention Focus	Community Partners
New Orleans, LA	Daughters of Charity	Access to Healthy Food, Built Environment	Food Bank, City Parks Department
	CrescentCare	Culturally Competent Transgender Environments, Medical-Legal Partnerships	LGBTQ Youth Advocacy Org.
Biloxi, MS	Coastal Family Health Center	Environmental Asthma Triggers	Community Collaborative, Local Schools
Mobile, AL	Mobile County Health Dept./ Family Health	Teen Pregnancy Prevention, Youth Engagement	Youth Advisory Council, Local Schools
Pensacola, FL	Escambia Community Clinics, Inc.	Community School Wellness Cottage, Food Insecurity	Community School, Public Housing Complex, Food Bank

Overall, CCHH model is a promising tool to help health care organizations begin to address the upstream factors that influence health. Based on this experience, several foundational components were identified as facilitators of success in CCHH implementation, including: 1) active engagement from executive leadership; 2) designated staff roles and responsibilities; 3) diverse community partnerships; and 4) extensive technical assistance, particularly when tailored to meet the unique needs of each health center.

Based on the two-year Demonstration Project, LPHI has identified several opportunities to further advance the CCHH model:

- ***Promote Additional Demonstration Efforts***: To supplement the findings from this Demonstration Project, additional demonstrations are needed to continue learning about and refining the CCHH model, how implementation can be successful in different practice settings, and how it can contribute to improvements in population health. Additionally, there is opportunity to build connections across project sites in order to systematically gather evidence on the impact of CCHH.

- ***Engage Health Systems and Other Anchor Institutions in CCHH:*** There is vast opportunity to engage anchor institutions, such as health systems, health plans, universities, and other large employers and organizations in CCHH. These institutions have specialized expertise, influential voices in their communities, and financial resources that can support CCHH efforts.

- ***Articulate How CCHH and Value-Based Care Can Be Mutually Supportive:*** Given the health care system's gradual transition from volume-driven to value-driven care, and the increasing focus on health care and public health integration, it is critical to clearly articulate how CCHH can be supportive of, as well as supported by, value-based care activities. As health plans and delivery systems are more incentivized to prevent adverse health events and improve health outcomes, their engagement and interest in improving community conditions and other upstream factors will continue to grow.

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Introduction

As the health care system shifts from paying for volume to paying for value, there is increasing interest in addressing the non-medical determinants that influence health.[1] There is a growing body of research showing that social and environmental factors have a major influence on health outcomes and that health care services alone are not sufficient to sustain healthy communities.[2] With greater incentives and best practices for the health care system to address patients' social needs alongside medical needs, more providers and payers are deploying successful approaches to transforming care delivery.[3] However, many existing approaches remain focused on targeting select segments of the population – particularly high-cost, high-need groups – and transforming the way care is delivered to individual patients.[4] There has been less focus on the need to improve community circumstances that influence health.

The Community-Centered Health Home (CCHH) model, developed by Prevention Institute (PI), provides a conceptual framework for health care organizations to actively engage in creating safer, healthier, and more equitable communities.[5] The model expands the traditional role of clinical service providers to also embrace the role of community partner and change advocate. Using the three functional elements outlined in Figure 1 – *inquiry, analysis, and action* – the model guides health care institutions, with a focus on community health centers, to 1) leverage their clinical data infrastructures to gather information about the community's clinical, social, and environmental conditions; 2) analyze and share health and community conditions data to contribute to community prioritization and strategic planning; and 3) coordinate with partners to put the community change agenda into action.

Figure 1: The Community-Centered Health Home Model

Source: Adapted from Prevention Institute

The model asserts that, in addition to providing quality care, health care organizations can address community environments in order to contribute to improvements in population health outcomes. To create sustainable improvements in population health and to attain health equity, it will be vital for

health care leaders to draw connections from the patterns of health experienced by patient populations in order to inform and optimize community-wide health improvement initiatives.

While PI designed CCHH as a tool for all health care organizations, the call to action has specifically targeted community health centers such as Federally Qualified Health Centers (FQHCs). Community health centers are located in some of the most disadvantaged areas and serve some of society's most vulnerable individuals. As neighborhood-based safety net providers, FQHCs are uniquely positioned to partner with their communities to champion prevention efforts and address the upstream determinants of health.

After over two years of supporting community health centers to operationalize the CCHH model, LPHI has gained unique insight into CCHH as a concept and a practice. The main objectives of this final report are to 1) describe the CCHH Demonstration Project and the progress achieved by participating health centers; 2) outline findings and lessons learned; and 3) present opportunities and proposed next steps to continue the advancement of CCHH concepts, programs, and outcomes of interest.

The Demonstration Project

The Louisiana Public Health Institute (LPHI) designed and implemented the nation's first demonstration of the CCHH model. The two-year pilot was part of the Primary Care Capacity Project (PCCP), which was funded by the Gulf Region Health Outreach Program (GRHOP).[i] PCCP focuses on building community health center capacity and increasing access to high-quality, sustainable, community-based primary care in the communities most affected by the Deepwater Horizon oil spill in Louisiana, Mississippi, Alabama, and the Florida panhandle. The primary objective of the CCHH Demonstration Project was to generate valuable insight about CCHH implementation in a clinic setting and what is needed to support community health centers in this work.

In collaboration with PI, LPHI designed a competitive Request for Proposals (RFP) process and invited submissions from twenty community health centers already engaged in the PCCP program administered by LPHI. The funding opportunity was intended to support five awards to at least one health center per state within the program's targeted geography. Nine health centers submitted applications. A review committee made up of staff from LPHI, PI, and other GRHOP partner organizations developed and used a scoring rubric to assess and score each proposal. Scoring criteria were focused on the applicant's readiness to implement CCHH and included consideration of leadership engagement, change management capacity, community relationships, prior experience performing CCHH-like functions, proposed CCHH initiatives, and proposed plans for sustainability. The final set of awardees included two health centers in New Orleans, Louisiana,

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

and one each in Biloxi, Mississippi; Mobile, Alabama; and Pensacola, Florida. Each health center received $280,000 in total grant funds with the majority of funding used to cover staff salary for full-time CCHH Managers designated to support the day-to-day CCHH work. Other top spending categories included materials for community meetings or events, staff travel, staff training, and a range of financial and other resources allocated to participating community partners and residents.

Participating health centers pursued a range of CCHH initiatives. The table below provides an overview of their areas of focus and the types of community partners involved.

Table 1: Overview of Participating Health Centers

Location	Health Center	Community Prevention Focus	Community Partners
New Orleans, LA	Daughters of Charity	Access to Healthy Food, Built Environment	Food Bank, City Parks Department
	CrescentCare	Culturally Competent Transgender Environments, Medical-Legal Partnerships	LGBTQ Youth Advocacy Org.
Biloxi, MS	Coastal Family Health Center	Environmental Asthma Triggers	Community Collaborative, Local Schools
Mobile, AL	Mobile County Health Dept./ Family Health	Teen Pregnancy Prevention, Youth Engagement	Youth Advisory Council, Local Schools
Pensacola, FL	Escambia Community Clinics, Inc.	Community School Wellness Cottage, Food Insecurity	Community School, Public Housing Complex, Food Bank

Each participating health center was assigned a project officer at LPHI who served as the primary point of contact and provided consistent, tailored support through regular phone calls (every two to four weeks) and periodic site visits (approximately three per health center). Phone calls and site visits were used to monitor health center progress and provide personalized technical assistance and guidance based on unique needs and interests.

In addition to personalized technical assistance, LPHI delivered a technical assistance curriculum to educate and train health centers on the foundational knowledge and skills that are central to the CCHH model. PI and LPHI collaborated to establish a rich curriculum of learning modules that were delivered in both web-based and in-person formats. The training curriculum included the following topics:

- ***Self-Assessment & Readiness Reflection:*** Introduction to the LPHI-developed clinic self-assessment tool; assess skills and capacity needed for clinical problem solving and community engagement; gauge understanding of CCHH concepts; and understand needs and challenges that should be addressed through technical assistance.

- ***CCHH & PCMH Connections:*** Overview of the CCHH and Patient-Centered Medical Home (PCMH) models; outline how the models are different; and explore opportunities to align efforts across the models.
- ***THRIVE & Two Steps to Prevention:*** Demonstrate tools to determine root causes of prevalent clinical issues; identify community factors that contribute to healthy populations outside of the clinical setting; and identify ways to work with non-traditional partners.

"Not only did we identify areas for improvement, we built on our strengths."
– Chenita LeBlanc, CCHH Manager, Daughters of Charity

- ***Turning Data into Insight:*** Identify sources of data; understand the purpose of data; and explore how to use data once collected, including using data to influence community work.
- ***Collaborative Leadership:*** Describe different types of leadership; encourage peer sharing and exercises around leadership challenges; demonstrate the core competencies of leaders; and describe how leaders can partner with communities to create change.
- ***Community Engagement & Patient Engagement:*** Develop a shared vocabulary regarding community engagement, community outreach, and patient engagement; and demonstrate tools to support community engagement.
- ***Change Management to Operationalize Work:*** Review change management concepts and skills; conduct exercise using RACI tool; and prime clinics to apply continuous improvement strategies to their work.
- ***Program Monitoring and Evaluation:*** Discuss the purpose of program monitoring and evaluation; demonstrate common activities used to perform monitoring and evaluation; and illustrate how monitoring and evaluation relate to the CCHH Demonstration Project as well as longer-term CCHH implementation efforts.

Assessment Approach

To evaluate the Demonstration Project, LPHI gathered and assessed program monitoring data and qualitative evaluation data. LPHI project officers took structured notes during site visits, phone calls, and other engagements with participating health centers and their partners. Health centers were required to document their planned and completed activities in a standardized work plan template to reflect their progress in implementing the *inquiry*, *analysis,* and *action* elements of the CCHH model. Work plans were submitted to LPHI project officers periodically throughout the program period.

LPHI's internal evaluation team conducted qualitative interviews with each health center in the second year of the program and facilitated two group roundtable discussions – one with CCHH managers and one with senior leadership – at the close of the program. The work plans, staff notes, and evaluation data were reviewed and key themes and patterns were extracted to inform the findings described in this report.

Findings

In general, participating health centers made significant progress along the path to becoming a CCHH, but all require additional time and effort to fully transform in complete fidelity with the model. Several important findings came out of the program evaluation and are discussed in detail below.

Inquiry

The CCHH model describes *inquiry* as the collection and aggregation of various types of data, including clinical data sources (e.g. asthma-related visits to a clinic) and social or community data sources (e.g. air quality or housing conditions). The ideal scenario outlined by PI is that these combined data will uncover patterns of health outcomes correlated to specific community conditions, thereby helping communities identify root causes of poor health and design target interventions to address them.

In the Demonstration Project, health centers were generally able to monitor health data through their electronic health records (EHRs) and occasionally through community-level data sources such as local health department data. However, methods for capturing social or community data varied widely. Three health centers leveraged their EHRs to begin collecting social data on their patients, although one health center limited data collection to a subgroup of pediatric patients with a specific chronic condition who were being targeted for an intervention. Data collected included questions on sexual orientation and gender identity, food security measures, and home and environmental hazard measures.

Although implementation of the data components of the CCHH model had a strong focus on EHR integration, several health centers found alternative data collection strategies useful. One team reported that a basic survey allowed them to bypass the lengthy internal processes of adding new fields in the EHR and the delays associated with pulling the data into reports. Another health center reported that a paper assessment tool was more appropriate for their initiative, which focused on teen pregnancy prevention, because it allowed patients to privately respond to the questions on a paper form rather than openly discuss them with the provider. Similarly, one health center was especially successful in surveying a large number of community residents in at local festival about how social and community conditions influence their health

> *"It will be nice to have more data to share as this will help others see where there are natural places for collaboration."*
>
> – Nick Payne, CCHH Manager, CrescentCare

behaviors. While these were effective means of collecting new data, this approach limited any exploration of correlations between social or community data and clinical data available in the EHR because of the additional time, sophistication, and skill required to aggregate and match the two data sources.

Additionally, several health centers dedicated some of their inquiry efforts to gathering qualitative data through focus groups, community meetings, and other non-clinical encounters and engagements. Health centers that engaged community residents or partners in this way found that it was an effective way to better understand the community's perspectives and priorities, and to articulate the focus of their work. Importantly, these community engagement activities were foundational to both the *inquiry* and *action* elements of the model because they fostered partnership development.

Nick Payne, Reginald Vicks, and Josh Fegley of CrescentCare.

HIGHLIGHT: CrescentCare

CrescentCare has a long history of being a leading provider of HIV and LGBTQ care. The organization continuously looks for opportunities to improve how they engage and serve patients throughout the clinical visit, particularly in response to New Orleans' growing transgender population. CrescentCare leaders decided to use CCHH as an opportunity to better capture, analyze, and address the specific needs of their transgender patient population. The team examined the patient registration form and explored opportunities to change how they gathered patient information. Upon review, the staff were surprised to learn that their current form had critical flaws that placed the staff and patients in uncomfortable positions when answering some of the questions. In response, the team set out to revise and supplement the form with more questions that were both respectful and effective for gathering important information. They incorporated structured questions about sexual orientation, gender identity, assigned sex at birth, and preferred name and pronoun. The new questions were piloted with patients and staff during a focus group session.

In addition to these targeted points of inquiry, CrescentCare also integrated questions related to education, employment, transportation, and housing. The reformatting of the registration form allows for an improved inquiry into the patient population served and their non-clinical needs, which have a direct impact on health outcomes.

Analysis

The *analysis* element of the CCHH model is intended to leverage data and insight from *inquiry* in order to inform community priorities, investments, and activities. This generally involves conducting analyses of both quantitative and qualitative data and, in collaboration with cross-sector community partners, interpreting the findings and using shared decision-making processes to determine next

steps. Both the technical and non-technical aspects of *analysis* presented challenges for participating health centers.

Designing and executing data analyses was a challenge for health centers as most involved staff were relatively inexperienced at working with data. EHR capabilities and technical staff capacity required for building customized data reports was a clear barrier to effective and efficient implementation of *analysis*. As one CCHH manager explained, “we only have two data specialists […] and a lot of their time is focused on mandated reporting for federal requirements and working towards PCMH.” Perhaps more importantly, health centers had trouble interpreting and drawing meaningful conclusions from data outputs. While staff with EHR and quality improvement expertise could enable some components of *analysis*, their knowledge and skillsets did not translate to the interpretation of social and community data in order to make inferences about upstream community factors impacting health. For example, one health center was relatively advanced in merging health data with social data. However, in their interpretation of various measures, they overlooked the fact that multiple indicators for employment issues (e.g. unemployment and poverty), when considered together, provided strong evidence for employment obstacles as the primary social determinant of health impacting their population of interest. Put differently, measures were examined individually rather than through a wider conceptual lens to see how measures intersect and compound. This trend across several health centers represents a critical challenge, not only because it raised concerns about objective analyses, but also because it complicated applications of findings. Measures guide decisions about interventions and selection of the wrong, or less meaningful, measures could lead to interventions that may be less likely to impact health. The most successful in conducting quantitative data analysis were health centers that leveraged external partnerships, such as local universities, with training or more experience with data related work.

“We are taking clinical information, taking it to the community, and they are leading the change.”
– Chenita LeBlanc, CCHH Manager, Daughters of Charity

Chenita LeBlanc of DCSNO, center, with residents at a farmer’s market.

Health center staff demonstrated impressive growth in the non-technical skills and functions that support *analysis*, such as drawing on available data and information to support decision-making and prioritization with community partners. One health center, for example, identified diabetes and related social factors as a potential area to focus its CCHH efforts based on the results of a clinical data analysis. When they engaged community residents to get their input on the area of focus, the community responded with a different but complementary suggestion. “We saw that there was high levels of Hemoglobin A1C in the community so we wanted to start with diabetes,” said the executive director, “but that did not match with the community priorities. They wanted to talk about food.” With food as the community-identified priority, the health center found a path forward to address a social

condition that can impact diabetes. By the end of the program, all health centers strengthened and applied their skills for assessing and interpreting qualitative data, particularly when related to community feedback and preferences, and incorporating it into decision-making and prioritization.

HIGHLIGHT: Daughters of Charity Services of New Orleans

When Daughters of Charity (DCSNO) began their CCHH work, they knew they wanted to focus on diabetes, which had been a major health concern in their community. Through CCHH, the team developed a more upstream mindset and began to think about the issue of diabetes differently. Their driving question morphed from "what we can do to get more patients educated about health?" to "what does the community need and want to do to create better health?" As a result of their CCHH efforts, the manner in which the health center engages the community has changed. To institutionalize this new focus on community engagement, DCSNO established an advisory council made up of patients and other community members that has advised the health center on media campaigns, educational materials, and partnerships with non-clinical support services.

"We saw that there was high levels of Hemoglobin A1C in the community so we wanted to start with diabetes," noted Stephanie Marshall, the executive director. "But that did not match with the community priorities. They wanted to talk about food." So food is one of the issues they focused on. DCSNO staff also located and reviewed several community data sources. Where there were gaps in local data, the team developed and administered survey tools to gather that information. Additional questions on food resources, physical activity, and safety were added to the patient registration and adult patient history forms. The health center is now engaged as a true partner to the community by addressing upstream factors related to safety, food deserts, health education, use of community space, and more.

Action

The *action* component of the CCHH model calls on organizations to work with community partners to develop and implement policy, systems, and environmental changes in the community to positively impact health. While health centers were enthusiastic about engaging in *action,* it took time for them to fully understand and internalize the distinction between population-level community prevention activities and the provision of individual-level services, which is traditionally a more familiar space for health and human service organizations. For example, one health center's proposed initiative targeted the health-related social needs of their diabetic patients by referring them to available cooking and exercise classes. This approach would not have impacted upstream factors in the community that influence healthy eating and physical activity. In response to this and several other proposals that illustrated deficiencies in understanding of the CCHH model, LPHI

instituted an intensive technical assistance period during the first six months of the program to help health centers refine their plans to more closely align with CCHH concepts.

"They approved for us to have a bus stop so that patients would not have to stand in the rain, but they did not approve the route to run right in front of the bus stop. So [the health officer] is actively working on trying to get the transit system to make the routes available in the areas where we have the most needs."

– Dr. Angelia Blackmon-Lewis, Director, Mobile County Health Department/ Family Health

With technical assistance from the LPHI team as well as insight and experience gained throughout the program, health centers thrived in *action*. Authentic partnership development was the supportive keystone of health centers' efforts to implement the *action* component of the model. All health centers built new or strengthened existing partnerships with a range of community organizations, including local government agencies, schools, social service providers, advocacy groups, business owners, and community coalitions. Together, they hosted and facilitated community events aimed at empowering residents, designed and established health and wellness programming targeted at community priority areas, mobilized patients and residents to create advisory and leadership groups, and advocated for local infrastructure investments. The majority of health centers appeared to be most comfortable when performing activities related to *action* as opposed to *inquiry* and *analysis*, as suggested by the disproportionate amount of time, effort, and financial resources dedicated to this side of their work, in addition to their passion for serving their communities.

Most health centers have already tapped into the strong partnerships with community organizations and residents that they developed during the Demonstration Project in order to

MCHD and Family Health staff at the Dauphin Island Parkway Health Center.

HIGHLIGHT: Mobile County Health Department/Family Health

The Mobile County Health Department (MCHD) and its affiliated health center, Family Health, joined together with cross sector partners to tackle high rates of teen pregnancy in the Dauphin Island Parkway area of coastal Alabama. The team has used the CCHH model as a frame to engage, empower, and mobilize youth in the community. With support from a diverse set of partners, they have established a youth leadership team, hosted and facilitated a wide range of community activities and educational events, and worked to make Family Health a more teen-friendly clinic. Through engagement with adolescents and families, they quickly pinpointed lack of transportation as a community barrier, not only to health care, but also other community resources and spaces. In response to this issue, the team arranged for school buses to transport students from local schools to the health center and its surrounding area, and they are advocating for a new public bus route into the area.

sustain and grow their initiatives. As one CCHH manager explained, “it’s important to identify those peer advocates – folks in the community that live and breathe in that community and say, ‘I own my community,’ – because we can be across town working on something else and they’re going to be the ones to advocate for the work that we did.”

HIGHLIGHT: CrescentCare

As part of its CCHH journey, CrescentCare strengthened relationships with community-based transgender organizations and identified collaborative strategies to reduce barriers to services and provide support to the local transgender community. CrescentCare is active in advocating with partners for policy change to fight discrimination of LGBTQ youth and to create a more supportive, equitable environment for the transgender community. One of the key needs identified in collaboration with CrescentCare’s partners, BreakOUT! and Louisiana Trans Advocates, was legal assistance to support legal name changes for transgender individuals. Lacking identification documents that affirm an individual’s gender identity can lead to discrimination, as well as deter people from seeking needed medical care or from applying for jobs, school, and public benefits. CrescentCare established a Name Change Assistance Fund and hosted workshops to support members of the transgender community in accessing financial and legal support to change their identity documentation.

CrescentCare also made numerous additions and modifications to its internal organizational policies to ensure a LGBTQ-inclusive clinic environment for all employees, patients, and visitors.

Discussion

The Demonstration Project indicates that CCHH is a promising tool for community health centers to begin to respond to the upstream factors impacting the health of the community. One of the most important learnings was the recognition that implementing the model is not a clear, linear process.[6] The model should be viewed as a fluid and flexible framework for engaging in community change rather than a strict path from *inquiry* to *analysis*. Health centers were most successful and productive when they began working where there was already momentum and traction. Health centers and their community partners benefit from the flexibility to find creative ways to implement the components of the model in accordance with their needs and at their own pace. This realization helped the LPHI team to begin to see the model as a set of practice guidelines and a compass for transformation rather than a rote set of requirements or deliverables to complete.

Through the program evaluation, several key themes and patterns emerged as potential facilitators of success, which are described below.

Involved Senior Leadership: As with other practice transformation initiatives, CCHH must become part of a health center's cultural identity. To facilitate this level of organizational transformation active support from some level of leadership is critical. Senior leaders, whether managers or executives, are important spokespersons of an organization's vision because they can open lines of communication with employees, the board of directors, and community leaders alike. Their involvement is needed to ensure that CCHH concepts and goals are not only understood throughout the organization, but also incorporated into organizational culture and operations. They have the authority to guide organizational strategies, which can be powerful tools for structural and cultural change. Additionally, focused leadership can help initiate and grow successful community partnerships. Leaders who actively engage in partnership development can signify to the partner organization and to the community as a whole that the partnership is a valued asset and a priority. By dedicating leadership time and attention to community partners, health centers can create more strategically aligned and effective partnerships, and help improve the community's perception of the health center as a trusted partner.

"I needed my chief and my top-level staff to understand that what we were doing was not just a flash in the pan… but that this was going to drive who we are moving forward."

– Chandra Smiley, CEO, ECC Community Clinics, Inc.

HIGHLIGHT: Escambia Community Clinics, Inc.

When long-time employee Chandra Smiley stepped into the position of CEO of Escambia Community Clinics, Inc. (ECC), the organization was just coming out of a financial crisis. Employee morale was low but there was a strong and continued connection to the clinic's mission and purpose. When ECC began engaging in the CCHH Demonstration Project, Smiley saw it as an opportunity to provide a vision and a frame for the organization's path forward. She developed a presentation to communicate her vision and "make the case" for CCHH and presented it to her senior staff, employees of all 12 clinic sites, and eventually the Board of Directors. Now CCHH is officially part of the organization's long-term strategic plan and something that all new staff learn about during the onboarding process because, as Smiley has said, "this is inherently who we are."

Designated Staff Role: Health centers were required to have a full-time staff person to lead the CCHH initiative and manage the day-to-day operations. CCHH Managers played a critical role throughout Demonstration Project as they were primarily responsible for putting health centers' and communities' CCHH visions and goals into action. The Demonstration made it clear that having a staff person at least partially dedicated to CCHH implementation is necessarily to ensure that the work moves forward. Health care organizations are constantly faced with many competing priorities. CCHH Managers reported that partner engagement and communication is time consuming

ECC staff at the Weis Community School Family Playground, which ECC helped to fund.

and laborious. By designating staff time to the Demonstration Project, health centers were able to create space for CCHH as an organizational priority. Additionally, at most health centers, the CCHH Managers had responsibilities outside of strictly CCHH-related work, such as PCMH accreditation activities and community outreach and marketing. The Demonstration revealed that when staff were integrated into other aspects of health center operations, it was both strategically and logistically easier for them to spread CCHH concepts and efforts into other lines of health center operations and staff, which helps facilitate organizational and cultural transformation. Health centers were also more likely to use internal funds to sustain CCHH Managers beyond the Demonstration Project when the staff had consistently contributed to work outside of CCHH. As of August 2017, all but one of the five health centers have sustained their CCHH Manager staff. These staff are poised to continue integrating CCHH into daily operations, especially where health center leadership has already formalized its commitment to CCHH through organizational strategies, policies, or projects.

HIGHLIGHT: Coastal Family Health Center

When Coastal Family Health Center (CFHC) noticed an increase in pediatric patients with asthma, Dr. Williams, a pediatrician at the clinic and a long-time champion for asthma patients, was eager to step up and address the problem. At the same time, families throughout East Biloxi were growing increasingly concerned about respiratory health issues due to poor air quality as a result of several long-term construction projects in the area. The combination of a strong physician advocate and a collective community interest led the health center to focus on pediatric asthma for their CCHH initiative.

Greg Wilson, Tameka Coby, and Cheyneitha Fountain of CFHC.

Diverse Community Partnerships: The Demonstration Project revealed that establishing partnerships with a range of local organizations helped advance CCHH efforts by providing access to a diverse set of skills and expertise. As previously mentioned, health centers that partnered with universities on components of *inquiry* and *analysis* tended to pursue more advanced approaches to implementation and encountered fewer obstacles along the way. Similarly, the two health centers that worked closely with local schools were able to access substantial information and intervention opportunities. For example, they established data sharing agreements to access school attendance data, provided health-related training and education to teachers and students, As a result, they were empowered to target upstream factors related to child health much more effectively. Overall, there is significant opportunity to strategically build partnerships to fill gaps in specialized knowledge and expertise, staff capacity, community influence and power, access to financing, and other assets that can help a CCHH initiative succeed.

Extensive and Personalized Technical Assistance: Technical assistance and coaching, particularly when tailored to the health center's needs, were foundational to the Demonstration Project. LPHI exerted significant time and effort developing and delivering technical assistance

CCHH health centers are presented with Certificates of Achievement at the Regional Care Collaborative forum in Pensacola, Florida in March 2017.

modules and providing personalized support to each health center. The program evaluation revealed that both executive leaders and CCHH Managers at most health centers viewed tailored coaching from LPHI project officers as the most helpful and valuable aspect of technical assistance provided throughout the Demonstration. At the group roundtable discussions that LPHI facilitated shortly before the close of the program, numerous comments were made about how the trainings and regular conversations with LPHI project officers helped health centers understand the model, the concepts, and the vision of CCHH. One CCHH manager explained, “when reading over the foundational documents […] I was like ‘yea, this sounds like a great idea,’ but the idea of being the point-person for making it actionable […], that seemed overwhelming and hard to know how to kick into drive.” Others echoed that experience of being “confused at the beginning” and struggling to “understand the concept.” However, most CCHH Managers also described that, with consistent guidance and support, they were able to draw on their own passion and excitement for this kind of work in order to learn about and adapt to the CCHH mindset.

Opportunities to Advance CCHH

Corresponding to the findings outlined in this report, LPHI has identified several opportunities to further test and advance CCHH concepts and practices.

Opportunity 1: Promote Additional Demonstration Efforts

To supplement the findings from this Demonstration Project, additional demonstrations are needed to continue learning about and refining the CCHH model, how implementation can occur in different settings, and how it can contribute to improvements in population health. To learn more about CCHH in practice, there is opportunity to explore implementation in diverse community settings (e.g. urban, rural, and tribal settings) and across geographic regions throughout the United States. Additionally, there is opportunity to assess how the CCHH model can be used to support community collaboration around addressing the community-level needs of special or vulnerable populations such as LGBTQ, disabled, and frail older adults. As more demonstrations take place, findings from

unique pilots and implementation efforts will continuously inform implementation of key components of the approach, such as the technical assistance curriculum and health center staff roles.

In coordination with promoting additional demonstration efforts, there is opportunity to build connections across projects in order to systematically gather evidence on the impact of CCHH. By aligning evaluation strategies and findings across multiple demonstration cohorts in diverse settings, programs could explore more advanced questions and analyses. Similarly, there is opportunity to develop a research agenda to investigate other questions of interest related to measuring the impact of CCHH implementation at the organizational and community levels.

Opportunity 2: Engage Health Systems and Other Anchor Institutions in CCHH

There is vast opportunity to engage anchor institutions, such as health systems, health plans, universities, and other large employers and organizations in CCHH. These institutions have specialized expertise in a number of fields and practices, which can support community partnerships, as demonstrated by the two health centers that partnered with universities throughout the CCHH Demonstration Project. Hospitals and health systems can also be major assets in CCHH efforts. Health system executives and physician leaders often have strong and influential voices in their communities and may be able to draw on their organization's resources. A prime example of this is leveraging community benefit dollars that non-profit hospitals are required to invest in their communities to support CCHH. Newer requirements set by the Affordable Care Act require hospitals to periodically conduct community health needs assessments and improvement plans, a process that would ideally align with a community-wide partnership structure, much like what is envisioned in the CCHH model.

Opportunity 3: Articulate How CCHH and Value-Based Care Can Be Mutually Supportive

Given the health care system's gradual transition from volume-driven to value-driven care, and the increasing focus on health care and public health integration, it is critical that we clearly articulate how CCHH can be simultaneously supportive of and supported by value-based care activities. As health plans and delivery systems are more incentivized to prevent adverse health events and improve population health outcomes, their engagement and interest in improving community conditions and other upstream factors will continue to grow. For example, hospitals working to reduce Medicare readmission rates could support safe and healthy aging in the community by developing a community-wide network with senior centers or assisted living facilities, supporting meals on wheels programs, and advocating for age-friendly enhancements to streets and sidewalks. Leaders and collaborators of CCHH efforts should continue to reinforce the increasing value that community prevention investments and activities can bring to engaged health care institutions and their broader communities.

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