



Preliminary Findings & Recommendations from the Community-Centered Health Homes Demonstration Project

Louisiana Public Health Institute

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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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Executive Summary

The healthcare system is in the midst of significant transformation, moving towards value-based care that improves health outcomes efficiently, rather than simply paying for volume of services delivered. Amidst this transformation, there is an increasing appreciation of the impact that social, economic, and environmental factors have on health. Safety net providers like community health centers serve on the front line providing care to the most vulnerable in society. As such, community health centers are uniquely positioned to document and address the community factors that influence health. By leveraging this deep contextual understanding of health, healthcare organizations can take action with patients and community partners to address key upstream factors and improve health.

Realizing the proximity of community health centers to those most impacted by poor social and economic conditions, Prevention Institute (PI) developed the Community-Centered Health Home (CCHH) model, which describes how clinics might actively engage in creating safer, healthier, and more equitable communities through inquiry, analysis and action. In recent years, LPHI has worked in collaboration with PI and five community health centers along the Gulf Coast to operationalize the CCHH model and promote community prevention. The participating clinics in New Orleans, Louisiana (2), Biloxi, Mississippi (1), Mobile, Alabama (1), and Pensacola, Florida (1) have developed and implemented initiatives addressing food insecurity, built and physical environment, youth engagement, cultural competency, and gender-concurrent identity documentation.

To support the participating demonstration sites, LPHI served as the central office to administer the project, co-developed a training curriculum with PI, delivered technical assistance modules, and provided tailored coaching and support through a team of project officers. Lessons learned from the implementation of the Demonstration Project, include:

- Health centers are quick to develop actionable projects; however, the initial focus of their efforts addressed clinical quality improvement opportunities and direct services. To go upstream, it is important to develop a specific aim statement that addresses community prevention.
- Health center culture and practice changes take time to absorb new concepts and it takes supportive coaching to help health centers apply these concepts to clinic and community realities, develop and hone applied skills, and institutionalize new practices.
- The inquiry and analysis processes were hindered by electronic health record issues and limited staff experience working with data and translating data into insights about community prevention trends or opportunities.
- All demonstration sites have built new partnerships or strengthened existing authentic community partnerships. Where the LPHI team recognizes room for improvement is in assuring that action is something that is truly co-created equally with partners and represents community-driven prevention priorities.
- All demonstration sites have struggled to rethink their roles as healthcare service providers and view it more broadly as partners and advocates for community prevention.

An integral part of supporting clinics has involved regular and intensive coaching around moving beyond their clinical conception of a community issue and an associated clinical or direct service solution.

LPHI is eager to continue working with PI and additional partners that are committed to supporting healthcare organizations and their partners to move upstream and positively impact their communities. Based on our experience with the Demonstration Project, LPHI has identified five recommendations to further advance testing, integration, and enhancements to the CCHH model and related initiatives.

Recommendation 1: Promote additional demonstration projects to better understand the diverse possibilities of operationalizing the model.

Recommendation 2: Intentionally integrate detailed training modules into a standard CCHH training curriculum designed to meet the needs of healthcare organizations.

Recommendation 3: Develop a strategy to build and coordinate evidence of the impact on population health at the organization and community levels.

Recommendation 4: Clarify the relationship and mutually reinforcing aspects of CCHH with other aspects of health system reform and transformation.

Recommendation 5: Align CCHH with other major health improvement initiatives.

To activate these recommendations, LPHI proposes continuous learning among early designers and implementers of CCHH. Coordination at the health center, community, regional, and national levels would be helpful to promote and direct implementation efforts, monitor and evaluate progress and impact, compile and disseminate promising and innovative practices, and support harmonization and alignment of healthcare-driven community prevention initiatives across the nation. The LPHI team, with over two years of in-depth, on-the-ground experience in helping clinics to operationalize CCHH, is poised to play a contributing role in administering future demonstrations, learning collaboratives, and efforts that promote the uptake of the model in healthcare organizations nationwide, and to support continued refinement of the model in order to move from theory to practice.

Introduction

As the healthcare system shifts from paying for volume to paying for value, there is increasing interest to address the multiple, complex determinants that influence health. Growing evidence demonstrates that social factors are major influencers of health outcomes and that healthcare services alone are necessary but not sufficient to sustain a healthy population. Researchers estimate that social, economic, and environmental circumstances account for the majority of health outcomes.^I

With stronger incentives and innovation around addressing patients' social needs alongside medical needs, more providers and payers are deploying successful approaches to transform care delivery. There has been significant progress in demonstrating how the healthcare system can better meet individuals' health and social needs. Leading healthcare providers have built robust systems to systematically screen for and address patient social needs, often through connections to local services, at the individual level.^{II, III, IV} Community health worker interventions have been shown to improve health outcomes and reduce healthcare expenditures among certain patient populations.^V Still, most existing initiatives remain targeted at individual patients with less focus on the need to improve community circumstances related to the upstream social, economic, and environmental factors that influence health. The healthcare system has a critical leadership role to play in the effort to move upstream and improve community environments. To create sustainable improvements in population health and to attain health equity, it will be vital for healthcare leaders (executives, clinicians, allied health professionals) to draw connections from the patterns of health experienced by individuals in order to support community and population-wide health improvement initiatives.

The Community-Centered Health Home (CCHH) model, developed by the Prevention Institute (PI), provides a conceptual framework for community health centers to actively engage in creating safer, healthier, and more equitable communities. Inspired by PI's 2011 report introducing the concept of CCHH,^{VI} the Louisiana Public Health



Map of community health centers participating in the Primary Care Capacity Project

Institute (LPHI) integrated a pilot of the model as a special project under the broader Gulf Region Health Outreach Program's (GRHOP) Primary Care Capacity Project (PCCP).^{*} 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. As the program administrator

^{*} The Gulf Region Health Outreach Program (GRHOP) is a series of integrated, five-year projects designed to strengthen healthcare 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.

for PCCP, LPHI provides funding, technical assistance, and direct practice coaching to participating community health centers related to patient-centered medical home recognition, optimization of health information technology, clinic workflow, population health management, and analytics.

In close collaboration with PI, the team leveraged PI's vision for the model and LPHI's deep relationships and vast experience with clinic transformation to develop a framework for a two-year demonstration project. The main goal of the CCHH Demonstration Project was to enhance the capacity of participating community health centers to become active participants in improving upstream determinants of health in their communities. At a higher level, the program was intended to generate valuable insights about how CCHH can be operationalized in practice and what it takes to support community health centers in this ambitious transformation.



Source: Adapted from Prevention Institute

After nearly two years of supporting community health centers to operationalize the CCHH model, LPHI has developed unique expertise regarding the implementation of the CCHH model. We are eager to share our experiences and learnings, collaborate with others who are exploring and investing in CCHH, and contribute our expertise in grant administration and healthcare-facing technical assistance to current and future CCHH efforts. The purpose of this document is to:

- Describe the demonstration project and the advancements LPHI has achieved with community health centers implementing the CCHH model;
- Outline early findings and recommendations from the experience; and
- Present opportunities and proposed next steps to continue the advancement of CCHH concepts, program initiatives, and outcomes of interest.

CCHH Demonstration Project: Administration Highlights

Selection of Grantees

To initiate the Demonstration Project, LPHI designed a robust request for proposals (RFP), establishing detailed proposal scoring criteria. The team engaged PI as well as several GRHOP partners from across the four states to participate in a collaborative selection review process. Of the 20 community health centers eligible to apply, nine submitted proposals.

The first important lesson from the Demonstration Project came during the review of submitted proposals. All applicants expressed enthusiasm to participate and presented thoughtful ideas on how they could address the social, economic, and environmental needs of their communities. The methods they proposed to use, however, landed in the realm of clinical quality improvement and focused on direct service to a specific set of patients. We learned that in addition to orienting clinics to the CCHH model and concepts, substantial guidance would be needed to help them view their communities through a CCHH lens and identify opportunities to actively engage in community prevention, which PI has identified as the key distinguishing feature of a CCHH. With that realization, LPHI set ahead to identify the most promising clinics and work with them to better incorporate the model into their goals and vision.

LPHI granted awards to the most promising applicants in each state, contingent upon a satisfactory revision of their proposal with support from LPHI's team. The resulting assembly of grantees included a total of five community health centers spanning all four PCCP states. Each awardee received \$280,000 in total grant funds with \$20,000 each dedicated to a specific "action" project to be implemented in close collaboration with partners. Most health centers have allocated the majority of funds to support staff salary, primarily for full-time CCHH Managers as well as data analysts and leadership. Other top spending categories include materials for community meetings or events, staff travel, staff training, and incentives for participation by community members and partners. Efforts pursued by clinics participating in the Demonstration Project span a diverse range of topics and partners. The table below provides an overview of the health center awardees, their top areas of focus, and the types of community partners involved.

<i>Location</i>	<i>Health Center</i>	<i>Community Prevention Focus</i>	<i>Community Partners</i>
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

Program Administration and Technical Assistance

As the central program office for the Demonstration Project, LPHI handled all aspects of program administration and financial management, including granting of program funds, establishing and reviewing financial and programmatic reporting documentation, and monitoring the status of health centers' efforts via detailed work plans. Each clinic was assigned a project officer at LPHI who served as the primary point of contact and provided consistent, tailored support through regular check-in calls (every 2-4 weeks) and occasional site visits (approximately 3 per clinic).

In addition to the project officer support, LPHI offered personalized technical assistance and group-based opportunities for collaborative learning and peer exchange. 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.
- **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.

“Not only did we identify areas for improvement, we built on our strengths.”

– Chenita LeBlanc, CCHH Manager, Daughters of Charity

Preliminary Findings and Recommendations

The Demonstration Project has provided unique insights into the challenges and opportunities of operationalizing the CCHH model in a community health center setting. The LPHI team is eager to share these learnings with other CCHH innovators, implementers, and funders in order to complement existing efforts and inform future programming. All participating demonstration sites have made significant progress along the path to becoming a CCHH. Still, they require additional time and effort to fully transform in complete fidelity with the model. Through close interactions with the sites over the course of the Demonstration Project, LPHI has identified important takeaways regarding the implementation of the three CCHH functional elements – inquiry, analysis, and action – as well as several key organizational factors involved in building CCHH capacities. While the official program evaluation is pending, preliminary findings are summarized here.

Inquiry

The demonstration sites used a variety of approaches and methods to collect data and gather general information to support their inquiry work. While all health centers have electronic health records (EHRs) through which they collect clinical data, EHRs were not the only tool for new data collection. Surveys and other assessment tools were also used to gather data. In addition, several sites dedicated some of their inquiry efforts to gathering qualitative data through focus groups or community meetings. Sites that engaged community members or partners in this way found that it was an effective way to better understand the community’s perspectives and priorities and to

“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

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.

While all sites performed the basic components of inquiry, LPHI observed several challenges throughout the course of the Demonstration Project. Early on, several sites struggled to develop clear and measurable objectives related to their CCHH focus areas. As a result, it was difficult to identify relevant and meaningful data variables, either clinical or community-focused, that

could be used to inform community prevention efforts and monitor progress over time. Another trend was that EHR issues or barriers led several sites to use surveys as their primary source for data collection and documentation, making it harder to integrate new data collection processes into existing workflows. Overall, most CCHH teams progressed slowly in their inquiry work, likely due in part to a lack of previous experience working with data or accessing secondary data sources (e.g. County Health Rankings).

Based on these observations, LPHI has identified a few steps that health centers could take to improve the inquiry practice. First, health centers should ensure that CCHH Managers, or any staff person responsible for



Nick Payne, Reginald Vicks, and Josh Fegley of CrescentCare

leading day-to-day CCHH efforts, have basic data collection experience and skills. Second, health centers and their partners should use logic models, driver diagrams or other program planning tools to develop their goals, objectives, and measures of success early on. Lastly, LPHI believes there is room to expand the technical assistance offered to health centers to provide more structured support and in-depth content related to data collection, analysis, and translation of data-oriented messages for community audiences.

HIGHLIGHT: CrescentCare

CrescentCare has a long history of being a leading provider of HIV and LGBT 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 explore and implement to better capture, analyze, address the 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

Participating health centers analyze their data in a several ways. Those that use EHRs for data collection are able to aggregate and report on new data elements with traditional clinical data at the patient-level. Those that use other data sources have developed their own processes for reporting. CCHH teams – sometimes with support and input from clinicians, community partners, and LPHI staff – review, discuss, and strategize around the data.

Demonstration sites have faced several common challenges implementing analysis. In general, many community health centers struggle to generate clinical reports that accurately reflect their patient population due to inconsistent methods of capturing the data (e.g. one provider uses free text to document information while another uses a discrete field or template). Demonstration sites with EHR-related issues faced barriers to querying and analyzing data, which is important to note as this is a key aspect of the model. On the other hand, sites that turned to surveys and assessments for data collection were less likely to aggregate newly collected data with clinical data, which limited opportunities for meaningful data analysis. In order to realize the full vision of CCHH, most health centers will have intensive work to perform around optimizing their health information technology (HIT) systems and the workflows associated with entry of selected data elements, particularly if it is a new data

“We are taking clinical information, taking it to the community, and they are leading the change.”

– Chenita LeBlanc, CCHH Manager, Daughters of Charity

element that has not been collected in the past. This insight is also highly relevant to the inquiry component of the model.

Furthermore, CCHH teams had trouble interpreting and drawing meaningful conclusions from analysis outputs. Some teams did not have the skills needed to target meaningful data for analysis or to translate data into insights about community prevention trends or opportunities. Collaboration with internal quality improvement staff and dedicated time from data analysts were helpful when it came to executing analyses, but a community prevention mindset is needed to interpret and make decisions based on the data.



Chenita LeBlanc of DCSNO with partners

Based on these observations, LPHI recommends having an extremely robust curriculum focused on the use of HIT as well as other broader methods of data analysis to support health centers attempting to implement the CCHH model. Specifically, beyond what LPHI has provided in the Demonstration Project, the team would like to develop additional educational content to further assist healthcare organizations in conceptualizing and integrating a wider range of data sources (e.g. aggregate clinical and social variables, combine individual-level and population-level data, etc.) and apply analytic strategies using existing resources (e.g. disease registries, population-specific EHR templates, etc.).

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

Authentic partnership development has been the keystone of the demonstration sites’ efforts to put CCHH into action. All sites have 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 have hosted and facilitated community educational and training events, designed and established new health and wellness programming targeted at the community's priority areas, mobilized patients and residents to create advisory and leadership groups, and advocated for local infrastructure investments. Demonstration sites have found many creative and exciting ways to engage with partners on community prevention activities.

The majority of demonstration sites have appeared to be most comfortable working in the action space as opposed to inquiry and analysis, as suggested by the disproportionately large amount of time, effort, and financial resources dedicated to this side of their work. Where the LPHI team recognizes room for improvement is in assuring that action is something that is truly co-created equally with partners and represents collaborative community-driven prevention priorities. An integral part of supporting clinics in action involved regular and intensive coaching related to instituting mechanisms for listening to community framing of issues and priorities instead of imposing clinically-focused ideas about health improvement. The LPHI technical assistance team exerted a lot of time and energy around helping clinics to move beyond their clinical conception of a community issue and an associated clinical or direct service solution. For example, if a health center expressed interest in addressing high rates of diabetes by linking patients to cooking and exercise classes offered by a community partner, the LPHI team encouraged them toward collaborating with partners to understand the environmental and social factors contributing to

“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,
Family Health

HIGHLIGHT: Mobile County Health Department/Family Health

The Mobile County Health Department (MCHD) and its affiliated health center, Family Health, have banded together with cross sector partners to tackle high rates of teen pregnancy in the Dauphin Island Parkway area. 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.

diabetes and identifying upstream solutions, such as consistent access to healthy food or safe space to exercise. All demonstration sites, even those with the strongest community



MCHD and Family Health staff

partnerships, have found it challenging to rethink their roles as healthcare service providers and view it more broadly as partners and advocates for community prevention.

LPHI recommends that healthcare organizations interested in pursuing CCHH become well versed in the concepts of the Collective Impact Model.^{vii} Ideally, all key stakeholders in the community should come together to co-create a set of priorities and action plans to guide health improvement investments and activities in the community. A collective approach, especially during the CCHH planning phase, can encourage co-creation of solutions, ensure roles and responsibilities are established clearly and up front, and maintain regular strategic input from community partners.

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. With its primary, long-term partner BreakOUT!, CrescentCare developed a comprehensive guide for transgender-inclusive supports related to social determinants of health such as housing and violence.

One of the key needs identified through the collaboration was for legal assistance to support legal name changes for transgender individuals. A lack of identity 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. Beyond the guide and the name change fund, CrescentCare is active in advocating with partners for policy change to fight the criminalization of LGBT youth and creating a more supportive, equitable environment for the transgender community.

Building Capacity for Organizational Transformation

Involved Senior Leadership: The level and type of leadership involvement varied across the demonstration sites, making it difficult to draw general conclusions about their experiences. However, it is clear that the journey to becoming a CCHH requires organizational change as well. Active support from some level of leadership is necessary to pave the way for organizational transformation. 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 operations and culture. They have the authority to influence organizational strategies, which can be powerful tools for structural and cultural change.

"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

HIGHLIGHT: Escambia Community Clinics, Inc.

When 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.”



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

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. LPHI recommends that those interested in promoting CCHH utilize the rich evidence based

material available from the field of change management and transformation, such as John Kotter’s *Leading Change*, *Switch* by Dan and Chip Heath, and Jim Collins’ *Good to Great*.

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, Cheyneitha Fountain, and Tameka Coby of CFHC

Integrated CCHH Manager: As with other practice transformation initiatives, CCHH must become part of a health center’s cultural identity. It cannot be a side project focused on only tactical milestones that remains isolated from everyday operations. At the demonstration sites the CCHH Managers are responsible for putting CCHH goals and objectives into action and therefore

play an important role in ensuring that CCHH efforts align with and are integrated into health center operations. LPHI required that demonstration sites identify one full-time staff person to assume the CCHH Manager role. At several sites, the CCHH Managers wear more than one hat and have roles related to PCMH and other components of clinical operations. Close proximity to the health center's day-to-day operations can boost the CCHH Manager's level of effectiveness. First, it enables the CCHH Manager to better understand the more traditional aspects of the site's operations, which is important when considering opportunities for improvement through a CCHH lens. Second, it positions Managers in other aspects of work, making it both strategically and logistically easier to spread CCHH concepts and efforts into other lines of health center operations.

Modest Financial Investment: Health centers can make significant progress toward becoming a CCHH with a modest amount of money. Some direct funding may help ensure that demonstration sites identify and dedicate the time and effort of a staff person with the needed skills and capacity to move the day-to-day work forward. The value of this kind of work seemed to resonate especially well with some of the demonstration sites. Several sites quickly began to view active community involvement as a prime opportunity for a health center to strengthen its reputation within the community. Attracting new patients and increasing volume are powerful incentives for health centers and, although not tied to value, they are a helpful motivator of community health centers that still operate in a largely fee-for-service environment. Beyond a modest award for demonstration sites, investing in technical assistance and dedicated coaches is critical to the success of a demonstration project. LPHI has exerted significant effort designing, developing, and delivering technical assistance and the Demonstration Project has affirmed that intensive and tailored coaching is necessary to support the CCHH transformation.

Advancing CCHH

Corresponding to the preliminary findings, LPHI has identified opportunities to advance CCHH implementation in the community health center setting and further explore innovative applications of CCHH concepts in other healthcare and community settings.

Recommendation 1: Promote additional demonstration projects to better understand the diverse possibilities of operationalizing CCHH.

Action 1.1: Promote implementation in diverse community settings (e.g. urban, rural, and tribal settings) and across geographic regions throughout the United States.

Action 1.2: Explore the model as a means of collaborating with and addressing the needs of special and/or vulnerable populations (e.g. LGBTQ and other communities that are not just place-based).

Action 1.3: Explore implementation in other healthcare delivery settings (e.g. hospitals and health systems, Accountable Care Organizations, clinically integrated networks, post-acute care settings, etc.).

Action 1.4: Continue to refine the CCHH model based on findings from unique pilots and demonstration projects.

Recommendation 2: Intentionally integrate detailed training modules into a standard CCHH training curriculum designed to meet the needs of healthcare organizations.

Action 2.1: Define and develop needed training modules focused on enhancing capacity to collect and analyze data and to translate data into meaningful information. LPHI suggestions include the following topics:

- Overview of data for program planning and program monitoring
- Collecting new and innovative patient data using the PRAPARE Tool^{VIII}
- Using patient data to assess population health and identify trends
 - Population health data and measurement
 - Data aggregation, analysis, and reporting
- Integrating data collection and analysis into clinical workflow
- Accessing and leveraging community data sources
- Linking clinical and community data for a sharper picture
 - Aligning individual-level and population-level data
- Qualitative data collection and analysis
- Community collaboration around data
 - Translating and communicating data to the public
 - Community data sharing strategies (e.g. health information exchanges, community health databases)

Action 2.2: Develop and integrate needed training content into new or existing modules focused on concepts and tools that support organizational transformation. LPHI suggestions include the following topics:

- Change management theory and practice

- Using logic models for program design and planning
- Using the Collective Impact Model to create community change

Recommendation 3: Develop a strategy to build and coordinate evidence of the impact on population health at the organization and community levels.

Action 3.1: Establish a standard program evaluation framework, including a basic list of core process and outcome measures.

Action 3.2: Develop a research agenda to explore questions related to effective implementation and impact.

Recommendation 4: Clarify the relationship and mutually reinforcing aspects of CCHH with other aspects of health system reform and transformation.

Action 4.1: Explore opportunities to leverage community benefit requirements for non-profit hospitals and health systems.

Action 4.2: Pursue opportunities to simultaneously leverage and reinforce health systems progress made by nascent Accountable Communities for Health or the Center for Medicare and Medicaid Services' model, Accountable Health Communities.

Action 4.3: Explore opportunities to leverage alternative payment models and value-based payment approaches.

Recommendation 5: Align CCHH with other major health improvement initiatives (e.g. Data Across Sectors for Health, BUILD Health Challenge, 100 Million Healthier Lives, Culture of Health, etc.)

Action 5.1: Map initiatives and outline synergies with CCHH.

Action 5.2: Perform targeted outreach to leadership of selected initiatives.

Action 5.3: Collaborate on alignment strategies.

Moving Forward

To activate these recommendations, LPHI recommends continuous learning among early designers and implementers of CCHH. Coordination at the clinic, community, regional and national levels would be helpful to promote and direct implementation efforts, monitor and evaluate progress and impact, compile and disseminate promising and innovative practices, and serve as a coordination hub for collaboration and advocacy for health-related community prevention programming across the nation. The LPHI team, with over two years of in-depth, on-the-ground experience helping clinics operationalize CCHH, is poised to play a contributing role in administering future demonstrations, learning collaboratives, and efforts that promote the uptake of the model in healthcare organizations nationwide, and to support continued refinement of the model in order to move from theory to practice.

In addition to specialized CCHH expertise, LPHI brings over a decade of experience designing and administering major investments in community health center capacity building. After Hurricane Katrina, LPHI managed the \$100 million Primary Care Access and Stabilization Grant, which earned recognition from the National Committee for Quality Assurance and established the foundation for numerous community health centers in the New Orleans region to achieve PCMH status. Additionally, LPHI administered the \$13.5 million Crescent City Beacon Community program, which was one of several communities funded by the Office of the National Coordinator for Health Information Technology to build and strengthen local HIT infrastructure and test innovative approaches to improving quality of care and population health outcomes. Also, as the administrator of the New Orleans Charitable Health Fund, LPHI has worked extensively with healthcare providers in the greater New Orleans area to implement integrated models of primary and behavioral healthcare and social services, and to build and lead a regional learning collaborative for local providers that continues to operate today.

For each of these initiatives, LPHI drew on its extensive national network of industry leaders and experts to assure excellence of program design and to provide a unique breadth and depth of technical assistance support. The LPHI team itself has a suite of offerings that can support future CCHH initiatives from concept development to program evaluation. Below is an outline of services that could support a national effort to promote and drive the adoption of CCHH.

Grant Administration and Management

- RFP development and coordination of proposal review and selection
- Contract negotiation and management
- Project management and implementation oversight
- Re-granting and finance administration

Technical Assistance Services

- Contribute to design of a standard training curriculum for healthcare-facing technical assistance
- Develop needed training modules to support tactical implementation and institutionalization of CCHH
- Facilitate and delivery technical assistance trainings and learning events, including peer-to-peer sharing opportunities
- Provide intensive, personalized coaching
- Develop healthcare-facing CCHH resource guides and toolkits

Program Evaluation

- Contribute to design of a standard program evaluation framework
- Develop and conduct program evaluations
 - Apply both quantitative and qualitative methods
 - Design and conduct CCHH assessments and integrated community assessments
 - Develop written evaluation reports

CCHH Coordination and Collaboration

- Continuously gather, compile, and disseminate CCHH concepts, learnings, success stories, and new opportunities within the CCHH community of interest
- Monitor, document, interpret, and report on the growing evidence base and progress of CCHH concepts
- Facilitate networking, peer-to-peer sharing, and mentorship across communities
- Identify, plan, and convene needed collaborative sessions between CCHH innovators and relevant experts to discuss, strategize, and coordinate around critical topics or questions to help advance CCHH concepts

End Notes

ⁱ http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_123.pdf

ⁱⁱ <http://www.iorahealth.com/model/>

ⁱⁱⁱ <https://healthleadsusa.org/what-we-do/our-model/>

^{iv} <http://www.healthbegins.org/>

^v <http://jamanetwork.com/journals/jamainternalmedicine/fullarticle/1828743>

^{vi} https://www.preventioninstitute.org/sites/default/files/publications/HE_Cmty-centered%20health%20homes_032311.pdf

^{vii} https://ssir.org/articles/entry/collective_impact

^{viii} <http://nachc.org/research-and-data/prapare/>



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