Community Health Centers Leveraging the Social Determinants of Health

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Contents

Abbreviations

ACA	Affordable Care Act
ACO	Accountable Care Organization
APHA	American Public Health Association
ASTHO	Association of State and Territorial Health Officials
BPHC	Bureau of Primary Health Care, HRSA, HHS
CCHH	Community-Centered Health Home
CCM	Chronic Care Model
CDC	Centers for Disease Control and Prevention, HHS
CDN	Clinical Directors Network
CHC	Community Health Center
CMMI	Center for Medicare and Medicaid Innovation, CMS
CMS	Centers for Medicare and Medicaid Services, HHS
COPC	Community-Oriented Primary Care
DOC	U.S. Department of Commerce
DOD	U.S. Department of Defense
DOJ	U.S. Department of Justice
DOL	U.S. Department of Labor
DOT	U.S. Department of Transportation
ED	U.S. Department of Education
EPA	U.S. Environmental Protection Agency
FQHC	Federally Qualified Health Center
HHS	U.S. Department of Health and Human Services
HRSA	Health Resources and Services Administration, HHS
HUD	U.S. Department of Housing and Urban Development
IAF	Institute for Alternative Futures
IHI	Institute for Healthcare Improvement
IOM	Institute of Medicine
NACCHO	National Association of County and City Health Officials
NACHC	National Association of Community Health Centers
PCAs	Primary Care Associations (state or regional associations of CHCs)
PCMH	Patient-Centered Medical Home
SDH	Social Determinants of Health
TFAH	Trust for America's Health
UDS	HRSA/BPHC Uniform Data System
USDA	U.S. Department of Agriculture
VA	U.S. Department of Veterans Affairs
WIC	Women, Infants, and Children (a federally-funded health and nutrition program)

Community Health Centers in IAF's Database

- Anderson Valley Health Center, Boonville, California
- Avenal Community Health Center, Avenal, California
- Baltimore Medical System, Baltimore, Maryland
- Beaufort-Jasper-Hampton Comprehensive Health Services, Ridgeland, South Carolina
- Centro Cultural Chicano, Minneapolis, Minnesota
- Centro de Salud Familiar La Fe, El Paso, Texas
- Chicago Family Health Center, Chicago, Illinois
- Clinicas de Salud del Pueblo, Brawley, California
- Codman Square Health Center, Boston, Massachusetts
- CommuniCare Health Centers, Davis, California
- Community Health and Social Services Center, Detroit, Michigan
- Community Health Center of Buffalo, Buffalo, New York
- Community Health Clinic Ole, Napa, California
- Community Health Partners, Livingston, Montana
- Crescent Community Health Center, Dubuque, Iowa
- Dorchester House Multi-Service Center, Dorchester, Massachusetts
- East Boston Neighborhood Health Center, Boston, Massachusetts
- El Rio Community Health Center, Tucson, Arizona
- Family Health Care Centers of Greater Los Angeles, Bell Gardens, California
- Friend Family Health Center, Chicago, Illinois
- Golden Valley Health Centers, Merced, California
- HealthFirst Family Care Center, Fall River, Massachusetts
- HealthPoint, Seattle, Washington
- Hill Country Health and Wellness Center, Round Mountain, California
- Hudson River HealthCare, Peekskill, New York
- Joseph P. Addabbo Family Health Center, New York, New York

- Kokua Kalihi Valley Comprehensive Family Services, Honolulu, Hawaii
- La Clínica de La Raza, Oakland, California
- La Maestra Community Health Centers, San Diego, California
- LifeLong Medical Care, Berkeley, California
- Lowell Community Health Center, Lowell, Massachusetts
- Mariposa Community Health Center, Nogales, Arizona
- Mary's Center for Maternal and Child Care, District of Columbia
- Mattapan Community Health Center, Mattapan, Massachusetts
- Mountain Health and Community Services, San Diego, California
- NorthPoint Health and Wellness Center, Minneapolis, Minnesota
- Open Door Community Health Centers, Arcata, California
- Primary Care Providers for a Healthy Feliciana, Clinton, Louisiana
- Primary Health Care, Des Moines, Iowa
- Project Vida Health Center, El Paso, Texas
- Ravenswood Family Health Center, East Palo Alto, California
- Santa Barbara Neighborhood Clinics, Santa Barbara, California
- Santa Rosa Community Health Centers, Santa Rosa, California
- Sea Mar Community Health Centers, Seattle, Washington
- Sixteenth Street Community Health Center, Milwaukee, Wisconsin
- Southwest Louisiana Center for Health Services, Lake Charles, Louisiana
- St. John's Well Child and Family Center, Los Angeles, California
- The Dimock Center, Boston, Massachusetts
- Thundermist Health Center, Woonsocket, Rhode Island
- Urban Health Plan, New York, New York
- Vista Community Clinic, Vista, California
- Winters Healthcare Foundation, Winters, California

Executive Summary

There are important opportunities for health care to increase its impact on health and wellbeing by leveraging the "social determinants of health" (SDH) – i.e., the social, economic, and physical conditions that underlie and shape health. The Institute for Alternative Futures' project on Community Health Centers Leveraging the Social Determinants of Health charts a path forward for the many health care providers who understand the importance of the SDH for their patients' health, but feel powerless to address their needs along non-medical dimensions. Based on a review of community health center (CHC) efforts in this domain, this report offers leaders in CHCs, public health, and policy an understanding of how health care providers can move beyond health care services alone to improve the health of the population.

Various researchers have shown that health care accounts for only 10-25 percent of the variance in health over time.[1] The rest is shaped by genetics (up to 30 percent), health behaviors (30-40 percent), social and economic factors (15-40 percent), and physical environmental factors (5-10 percent).[2]

This report introduces SDH efforts in the context of an increasing focus on the social determinants in federal health policy, academic research, and emerging care models. It then identifies trends and forces shaping health care and CHCs. The report presents the methods used to study the SDH efforts of CHCs and provides an overview of the patterns observed across the many programs. It concludes with recommendations developed at a national workshop of CHC leaders and other experts to expand and enhance these efforts.

CHCs engage in a wide range of efforts to address a variety of SDH needs. They tend to identify opportunities for this type of work from within the community, as both staff and Board members typically come from the populations CHCs serve. CHCs that launch SDH efforts have committed leadership who draw together local and national resources. Funding is often limited to a few years and some programs become sustainable either as non-profit "spin offs" from the CHCs or as enduring efforts funded by CHC budgets. Yet funding challenges do restrict many worthwhile SDH efforts and lead to shorter duration or narrower impacts for those efforts.

A focus on the SDH has a long history within the medical profession. Hippocrates in the 4th century BC, for example, recommended that physicians pay attention to the environmental, social, and behavioral context in which illness occurs. Similarly, early 20th century medical education reformer Abraham Flexner, who is considered "the father of the biomedical paradigm," exhorted physicians to consider conditions such as "a bad water supply, defective drainage, impure food, [and] unfavorable occupational surroundings" in their work. He went further by suggesting that doctors have the duty "to promote social conditions that conduce to physical wellbeing."[3]

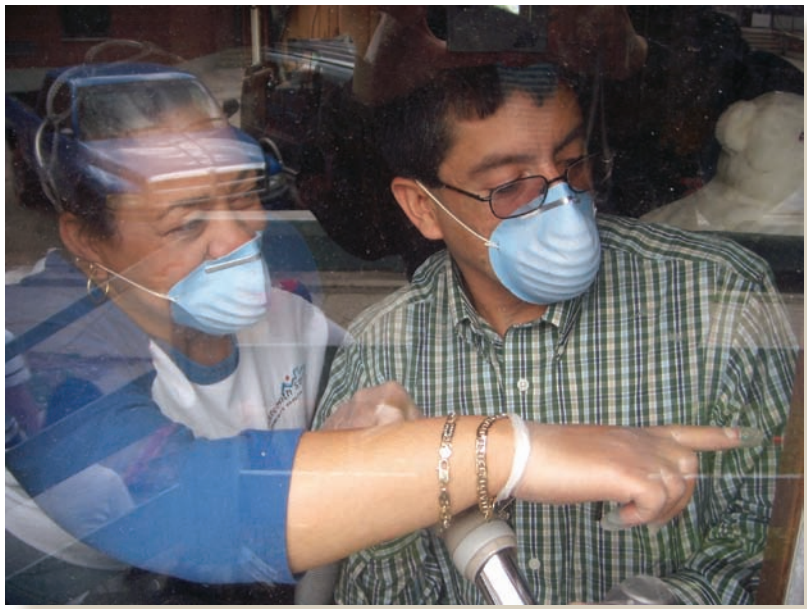
Although most physicians today recognize the importance of the patient's community and social conditions, many report that they are "not confident in their capacity to address their patients' social needs," and that they believe this impedes their ability to provide quality care.[4]

CHCs, however, can point the way forward for health care providers looking for ways to help care for the *whole* person and their community. For over 40 years, CHCs have been providing primary care to people from America's poorest communities. In 2010 alone, CHCs in the U.S. served nearly 19.5 million patients through over 8,100 locations. Furthermore, leveraging the SDH is "in the DNA" of CHCs. This type of health care organization evolved out of the community-oriented primary care (COPC) movement in which the responsibility

of primary care providers extended beyond the illness being treated to include the patient's family dynamics and whatever community factors might be affecting the patient's health. For example, the earliest CHC physicians wrote prescriptions for food when they observed malnutrition among their patients, encouraged families to grow vegetables, and even created a farm cooperative where locals could grow their own food to share.[5]

The problem is that little is known about the patterns of CHC efforts to leverage the SDH. There are a few nationwide programs linked to CHCs such as Reach Out and Read, National Center for Medical-Legal Partnership, and Health Leads. And there is some reporting by the Bureau of Primary Health Care's UDS monitoring system for CHCs. Beyond these it is difficult to know how many CHCs reach beyond clinical care and how they do this. To fill this knowledge gap, the Institute for Alternative Futures (IAF) and the National Association of Community Health Centers (NACHC), with the support of the Kresge Foundation, have conducted a year-long effort to identify, document, and learn from these efforts.

IAF has created a database of 176 activities, projects, programs, and interventions by 52 different CHCs as of printing date, as well as in-depth case studies of 10 CHCs. We interviewed experts, reviewed the literature, and held webinars and interactive sessions at NACHC and other meetings to gather information on CHC activities. The efforts identified through this process cover an impressive range of areas, such as youth development programs, family and social support, access to healthy foods, physical activity and exercise, community safety, and many more. (The database, this report, and other project materials are available at *http://www.altfutures.org/leveragingSDH*.) Our database and case studies, while not necessarily a representative sample, offer an unprecedented opportunity to review these efforts in a systematic manner. The recommendations developed at the national workshop, which are presented at the end of the report, point to important opportunities to support CHCs' efforts in this area.



A community health worker shows a pediatrician how heavily leaded paint turns to dust inside window casings in older homes. Photo credit: Sixteenth Street Community Health Center.

The key learnings that emerge from this review of efforts are that:

- Most SDH efforts originate as a response to an issue or problem that is brought to the attention of the clinic by the CHC board, leadership, staff, or patients. CHCs do conduct periodic community assessments to identify the needs of the community served, however most SDH efforts have been prompted by a variety of other means, most often through the open dialogue CHCs maintain with their own staff and leadership, their patients, community leaders, and partner organizations to identify opportunities to better serve their communities.
- CHCs will not and cannot go it alone. Since many SDH efforts require skill sets and resources beyond what CHCs have available in-house, partnerships are crucial to leveraging the SDH, and CHCs have become adept at seeking and maintaining them at the local, state, and federal levels. Even if CHC staff do possess the necessary skills, partnerships help to extend the reach of the effort and promote CHC efforts and services.

- CHC leadership and buy-in are essential to develop and sustain SDH efforts. In fact, CHC leaders are often a driving force behind their organization's consistent efforts, with some directly instigating new activities.
- Most SDH efforts are designed by CHCs themselves, but a number of existing programs are available for CHCs to adopt. CHCs can build upon existing programs such as the WE CAN! curriculum to improve nutrition and physical activity, or partner with non-profits (e.g., Reach Out and Read, Health Leads, National Center for Medical-Legal Partnership), or federal and state (e.g., WIC, charter schools) programs to leverage the SDH.
- Funding is a constant challenge. Few SDH efforts are self-sustaining. Most are launched and conducted with the support of time-limited, most often 1- to 3-year grants. Given the difficulties with obtaining and sustaining funding for SDH efforts, many CHCs conduct large annual fundraising events to help support their SDH efforts. If necessary, several CHCs recommend that outside funding should be provided for a minimum of three years in order to achieve and demonstrate impact.
- CHCs often rely on specialized staff, departments, or subsidiaries with dedicated staff to manage efforts in leveraging the SDH. Other efforts are seamlessly integrated with clinic operations, or operate as independent organizations or semi-independent coalitions.
- Although many SDH efforts show impressive results, most have not been formally evaluated.

To further enhance the ability of CHCs to leverage the SDH, participants at the national workshop proposed the following recommendations:

- Develop and implement a systematic process for identifying community strengths and needs, beyond clinical and basic demographic information, to identify and map the SDH.
- Create and promote the use of a standardized health risk assessment for each patient that goes beyond conventional physical or behavioral health conditions to include the SDH.
- Recognize leveraging the SDH as an important component of case management, and provide support accordingly.
- Enhance CHCs' position as role models of socially just workplaces and health-promoting organizations.
- Recognize and raise awareness that leveraging the SDH is integral to the work of CHCs and other health care providers.
- Pilot learning communities should test ideas and interventions for CHCs and other organizations engaged in leveraging the SDH.
- To create a national learning community, HRSA should include the leveraging of the SDH in *existing* national breakthrough collaboratives.
- HRSA, CMMI, and CDC should reward action steps towards addressing the SDH as part of relevant payments and non-economic recognition available to all CHCs.
- National organizations relevant to leveraging the SDH, including NACHC, the Prevention Institute, the Association of State and Territorial Health Officials (ASTHO), the National Association of County and City Health Officials (NACCHO), Trust for America's Health (TFAH), and the American Public Health Association (APHA), should work to create and shape research and a Request For Proposals for CMMI's Population Health Models Group, which includes representatives from other sectors (e.g., education, housing, agriculture).
- Driven by the HHS secretary, HRSA should lead a formal inter-agency group that systematically promotes, advances, and supports efforts addressing the SDH within communities.

- Cross-sectoral dialogues on leveraging the SDH in multiple settings should be organized to build partnerships between health and other sectors.
- Philanthropy should support building a bridge between the SDH and the clinical setting.
- Those promoting efforts to leverage the SDH should frame them in ways that are intuitively meaningful to multiple sectors, the general public, and the entire community.
- CHCs and other health providers should collaborate with community members to articulate a clear vision for the community's future, and align efforts to leverage the SDH with that vision.

Community Health Centers Leveraging the Social Determinants of Health grew out of IAF's commitment to identify the most promising advances for bringing health gains to the poor and underserved and to accelerate the development and deployment of these advances to reduce disparities. IAF has contributed to and facilitated many "applied futures" efforts focused on health equity as part of its Disparity Reducing Advanced (DRA) Project. The DRA Project recruited a variety of partners focused on health equity who contributed to IAF reports, workshops, and foresight briefings for national policy makers. To see how this report fits into the larger IAF effort, please visit *http://www.altfutures.org/draproject*. The DRA Project showed the importance of leveraging the SDH and inspired IAF to seek the support of the Kresge Foundation and partner with NACHC for this project focusing on community health centers. CHCs and other health care providers leveraging the SDH will make important contributions to health equity. This report identifies the patterns of activity, lessons from experience, and recommendations for moving forward for CHCs and other health care providers in leveraging the SDH.

Notes

[1] Franks P, Clancy C, Gold M. "Health Insurance and Mortality. Evidence from a National Cohort." *Journal of the American Medical Association*, 27(6):737-741. 1993; County Health Rankings. University of Wisconsin Population Health Institute. 2011. *http://www.countyhealthrankings.org/our-approach*; and McGinnis JM, Williams-Russo P, Knickman JR. "The Case for More Active Policy Attention to Health Promotion." *Health Affairs*. Vol. 21, No. 2. March/April 2002.

[2] County Health Rankings. University of Wisconsin Population Health Institute. 2011. *http://www.countyhealthrankings.org/our-approach*; and McGinnis JM, Williams-Russo P, Knickman JR. "The Case for More Active Policy Attention to Health Promotion." *Health Affairs*. Vol. 21, No. 2. March/April 2002.

[3] As cited in Roz D. Lasker and the Committee on Medicine and Public Health. "Medicine & Public Health: the power of collaboration." New York Academy of Medicine. 1997; pp. 23. *http://www.cacsh.org/pdf/MPH.pdf.*

[4] "Health Care's Blind Side: The Overlooked Connection between Social Needs and Good Health (executive summary)". Robert Wood Johnson Foundation. December 2011. Accessed December 8, 2011. *http://www.rwjf.org/files/research/RWJFPhysiciansSurveyExecutiveSummary.pdf*.

[5] "On Common Ground." Against the Odds: Making a Difference in Global Health, an exhibit developed by the U.S. National Library of Medicine. Accessed December 27, 2011. *http://apps.nlm.nih.gov/againsttheodds/exhibit/community_health/common_ground.cfm*.

Introduction

A growing number of institutions, policies, medical models, academic research, and health care providers are converging on the idea that there are important opportunities for health care to increase its impact on health and wellbeing by addressing behavioral, social, and environmental determinants of health. By strengthening the social environment in communities and by helping to address employment, education, safety, physical exercise, and nutrition, many community health centers (CHCs) are leading the effort to improve population health. These CHCs offer lessons in how health care providers can move beyond medical services alone to improve health.

A great deal of attention has already been focused on improving health care by addressing quality and costs. Since the 1970s, policy makers and employers have devised cost control tools trying to slow the growth of expenditures on health care. The government and private sector have also pursued quality improvement across a variety of settings.

However, little attention has been directed toward improving health by leveraging the social, economic, and physical conditions that underlie and shape health outcomes. This may have resulted in part from a healthcare system that reimburses medical and pharmaceutical treatments for acute and specialized care for the individual.

We need to pay more attention and develop the knowledge of how to address social, economic, and environmental factors that impact health, often on a population level, because research shows that health care itself plays a relatively small role in shaping the length and quality of life. Various researchers have shown that health care accounts for only 10-25 percent of the variance in health over time.[6] The rest is shaped by genetics (up to 30 percent), health behaviors (30-40 percent), social and economic factors (15-40 percent), and physical environmental factors (5-10 percent).[7] The latter two groupings fall under what may be referred to as the social determinants of health (SDH). (See definition in **Box 1**.)

Although the SDH have a long history within the medical profession and most in health care today understand that the SDH play an important role in shaping health over time, many feel that they lack the capacity, time, or staff support to address their patients' needs along these non-medical dimensions.[8]

CHCs, however, do reach beyond clinical care to shape their patients' health along these dimensions. This type of health care provider organization serves low-income communities that suffer from significant disparities in housing, education, employment, and other factors. Furthermore, CHCs evolved out of the community-oriented primary care (COPC) movement, in which the responsibility of primary care providers extended beyond the illness being treated to include the patient's family dynamics and whatever community factors might be affecting the patient's health. For example, the earliest CHC physicians wrote prescriptions for food when they observed malnutrition among their patients. In this sense, leveraging the SDH is "in the DNA" of CHCs. (See this project's definition of "community health centers leveraging the social determinants of health" in **Box 2**.)

The efforts of CHCs to leverage the SDH can offer lessons for the broader health care community as the nation seeks to improve health and wellbeing through a variety of initiatives, including the Institute for Healthcare Improvement's (IHI) "Triple Aim," the National Quality Strategy, Healthy People 2020, and the adoption of emerging models of primary care.

Unfortunately, very little is known about CHCs efforts to leverage the SDH. This project by the Institute for Alternative Futures (IAF), in partnership with David Stevens of the National Association of Community Health Centers (NACHC) and with support from the Kresge Foundation, aims to fill that knowledge gap. Over the course of a year, IAF commissioned a literature review from the Clinical Directors Network (CDN), solicited examples of SDH efforts from various networks, interviewed CHC leaders and other relevant experts, created a unique database of 176 examples from 52 CHCs, and developed more detailed case studies of 10 CHCs and their SDH efforts. The project was guided by an Advisory Committee, and culminated in a national workshop of more than 30 CHC leaders and relevant experts, who reviewed and enhanced IAF's findings and developed recommendations for how these CHC efforts could be expanded and improved. (Interviewees, Advisory Committee members, and workshop participants are listed in the Appendix.)

In this project, IAF's goal was to understand the scope of these efforts, as well as the patterns across them (e.g., issues targeted, funding, management, sustainability). Many of these efforts have identified their results, but few have been formally evaluated. However, as the first systematic review of CHCs' efforts to leverage the SDH, this report represents an important step toward learning how health care providers and others can leverage the SDH and improve population health. This learning can foster a culture of health that both celebrates local success and encourages many more efforts and partnerships to improve the total health and wellbeing of patients and communities.

Community Health Centers Leveraging the Social Determinants of Health grew out of IAF's commitment to identify the most promising advances for bringing health gains to the poor and underserved and to accelerate the development and deployment of these advances to reduce disparities. IAF has contributed to and facilitated many "applied futures" efforts focused on health equity as part of its Disparity Reducing Advanced (DRA) Project. The DRA Project recruited a variety of partners focused on health equity who contributed to IAF reports, workshops, and foresight briefings for national policy makers. To see how this report fits into the larger IAF effort, please visit *http://www.altfutures.org/draproject*. The DRA Project showed the importance of leveraging the SDH and inspired IAF to seek the support of the Kresge Foundation and partner with NACHC for this project focusing on community health centers. This report identifies the patterns of activity, lessons from experience, and recommendations for moving forward for CHCs and other health care providers in leveraging the SDH.

Box 1 — Defining the Social Determinants of Health

A number of definitions have been provided for the "social determinants of health" (SDH). For example:

- The World Health Organization (WHO) defines the SDH as **"**the conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels, which are themselves influenced by policy choices."[9] WHO adds that "[t]he social determinants of health are mostly responsible for health inequities – the unfair and avoidable differences in health status seen within and between countries."
- The Centers for Disease Control and Prevention (CDC) defines the SDH as "the complex, integrated and overlapping social structures and economic systems that are responsible for most health inequities. These social structures and economic systems include the social environment, physical environment, health services and structural and societal factors."[10]
- The Robert Wood Johnson Foundation (RWJF) has identified a simpler phrasing: "Health starts where we live, learn, work and play."[11]

Box 2 — Defining Community Health Centers Leveraging the Social Determinants of Health

For the purposes of this project:

- IAF considered the following types of health care providers as "community health centers" (CHCs): Federally Qualified Health Centers (FQHCs), FQHC Look-Alike Health Centers, free clinics, Indian Health Service clinics, and practices serving low-income and medically underserved populations.
- To be considered a "case" for this project, the effort (an activity, project, program, or intervention) must involve at least one of any of the clinic types listed above.
- A clinic is "leveraging the social determinants of health" when it moves beyond providing health care to changing the social and economic conditions that affect health and wellbeing.
- Efforts may focus on many factors, such as housing, built environment, air and water quality, training and education (including early intervention programs), K-12 educational outcomes, jobs, income, family strengthening, social exclusion (isolation, racism), harm reduction, community development, neighborhood safety, transportation, access to legal services, food quality, food availability, physical activity, and recreational opportunities.

Examples of a CHC leveraging the SDH include:

- Promoting the installation of septic tanks for the homes of its patients.
- Developing a charter school to expand employment in the community.
- Working with police to publicize when areas of the neighborhood are safe for walking, e.g. what segments of the boardwalk along the ocean will be patrolled and when.
- Using a community health worker to educate patients and to organize community action.

What is not included:

- Health care services, such as prevention, screening, and treatment.
- Accessibility services or medical outreach programs that simply increase access to health care, such as sending a mobile health care services van into the neighborhoods, or providing transportation to the clinic for medical visits.

Notes

[6] Franks P, Clancy C, Gold M. "Health Insurance and Mortality. Evidence from a National Cohort." *Journal of the American Medical Association*, 27(6):737-741. 1993; County Health Rankings. University of Wisconsin Population Health Institute. 2011. *http://www.countyhealthrankings.org/our-approach*; and McGinnis JM, Williams-Russo P, Knickman JR. "The Case for More Active Policy Attention to Health Promotion." *Health Affairs*. Vol. 21, No. 2. March/April 2002.

[7] County Health Rankings. University of Wisconsin Population Health Institute. 2011. *http://www.countyhealthrankings.org/our-approach*; and McGinnis JM, Williams-Russo P, Knickman JR. "The Case for More Active Policy Attention to Health Promotion." *Health Affairs*. Vol. 21, No. 2. March/April 2002.

[8] "Health Care's Blind Side: The Overlooked Connection between Social Needs and Good Health (executive summary)". Robert Wood Johnson Foundation. December 2011. Accessed December 8, 2011. *http://www.rwjf.org/files/research/RWJFPhysiciansSurveyExecutiveSummary.pdf*.

[9] "Social Determinants of Health." World Health Organization. Accessed December 27, 2011. *http://www.who.int/social_determinants/en*.

[10] "Social Determinants of Health." Centers for Disease Control and Prevention. Accessed December 27, 2011. *http://www.cdc.gov/socialdeterminants/Definitions.html.*

[11] "A New Way to Talk About the Social Determinants of Health: Health starts where we live, learn, work and play." Robert Wood Johnson Foundation. July 2010. Accessed December 27, 2011. *http://www.rwjf.org/vulnerablepopulations/product.jsp?id=66428.*

Low-income women participate in a CHC micro-credit program. Photo credit: La Maestra Community Health Centers.

An Increasing Focus on the SDH

The adoption of the "Triple Aim" as a national strategy to improve the quality of health care marks an important milestone for health policy in the United States: the shift from a focus on acute and specialized care for the individual to meeting the health needs of a population or "population health", including leveraging the SDH. Originally developed by IHI, the Triple Aim argues that health care organizations should pursue simultaneously the following goals:

(1) Excellent health care experience;

(2) Lower per capita costs (or at least slowing the rate of growth of health care costs); and

(3) Improved population health.[12]

These goals have been translated into National Aims as part of a unifying vision for the country, the National Strategy for Quality Improvement in Health Care released by the Federal Government in March 2011.[13] The National Aims of this National Quality Strategy are:

(1) To improve the health of the U.S. population by supporting proven interventions to address behavioral, social, and environmental determinants of health, in addition to delivering

(2) Higher-quality care and

(3) Affordable care.

Similarly, the Center for Medicare and Medicaid Innovation (CMMI) pursues its mission based on the Triple Aim,[14] and the military health services have adopted the "Quadruple Aim," which includes the components of the Triple Aim and adds the fourth component of readiness.[15]

The increasing focus on population health and the SDH can also be found in other areas, including other health policies of the Federal Government, academic research, and emerging care models. This section reviews these recent developments and explains why leveraging the SDH is "in the DNA" of CHCs.

Federal Health Policy

In recent years, health policies of the Federal Government have increasingly focused on the SDH. For example, every decade the U.S. Department of Health and Human Services (HHS) releases its Healthy People report to provide evidence-based, 10-year national objectives for improving the health of all Americans. The Healthy People 2010 report included "eliminating health disparities" as one of two overarching goals. The Healthy People 2020, released in December 2010, adds the achievement of health equity and a renewed and more explicit commitment to focusing on the SDH. For that purpose, Healthy People 2020 promotes Health Impact Assessments to identify, measure, and track the SDH.

Similarly, the 2010-2015 strategic plan of the Health Resources and Services Administration (HRSA) includes an emphasis on the SDH to improve health and wellbeing. The plan includes four core strategies to improve health:

(1) Improve access to quality health care and services;

(2) Strengthen the health workforce;

(3) Build healthy communities; and

(4) Improve health equity.[16]

Also included in the HRSA strategic plan are the following sub-goals, which are more explicitly focused on leveraging the SDH:

- Integrate primary care and public health.
- Lead and collaborate with others to help communities strengthen resources that improve health for the population.
- Link people to services and supports from other sectors that contribute to good health and wellbeing.
- Strengthen the focus on illness prevention and health promotion across populations and communities.
- Monitor, identify, and advance evidence-based and promising practices to achieve health equity.
- Leverage our programs and policies to further integrate services and address the social determinants of health.
- Partner with diverse communities to create, develop, and disseminate innovative community-based health equity solutions, with a particular focus on populations with the greatest health disparities.

Leveraging the SDH is also codified in the HRSA Health Center Program Expectations statement of August 17, 1998, which defines what federally funded health centers (including CHCs) are and what they are expected to do. (See **Box 3**.) This statement clearly authorizes the type of activities that we review in this report. Health centers meet these expectations in part through the enabling services system. Enabling services are "non-clinical services that support the delivery of basic health services and facilitate access to comprehensive patient care as well as social services."[17] Health center grantees are asked about some of these services as part of the annual Uniform Data System (UDS) reporting. Based on the 2007 UDS national summary report, health centers provided the following enabling services that fit this report's definition of leveraging the SDH: child care, eligibility assistance, environmental health risk reduction, health education, nursing home and assisted-living placement, parenting education, WIC services, Head Start services, food banks or delivered meals, and employment and educational counseling.[18]

In addition to providing medical care, HRSA expects CHCs to facilitate access to comprehensive health and social services. Photo by Chieko Horn, courtesy of Community Health Partners.

Box 3 — HRSA Health Center Program Expectations Related to Leveraging the SDH

"Improving health status among underserved populations is the ultimate goal of health center programs. Health centers must have a system of care that ensures access to primary and preventive services, and facilitates access to comprehensive health and social services. Services must be responsive to the needs and culture of the target community and/or populations.

[…]

B. 1. a. Required Services

Health centers must provide required health care services as described in statute and regulation. […] All health centers must also provide services which help ensure access to these basic health services as well as facilitate access to comprehensive health and social services.

Specifically, health centers must provide: case management services; services to assist the health center's patients gain financial support for health and social services; […]

b. Additional Services

Additional services may be critical to improve the health status of a specific community or population group. For example, health centers serving migratory and seasonal farmworkers should provide programs which reduce environmental and occupational risks for farm workers. Migrant health centers should be knowledgeable of the Environmental Protection Agency's Worker Protection Standard and other pesticide safety regulations. A program serving homeless people may decide that the provision of mental health services is critical to the effective provision of primary care. Services beyond the required health center services should be provided based on the needs and priorities of the community, the availability of other resources to meet those needs, and the resources of the health center."[19]

The Role of the SDH in Affecting Health Outcomes

Academic research has shown that the SDH play a larger role than health care in shaping life expectancy and health status over the life course. Among preventable deaths, McGinnis and colleagues estimate that only 10 to 15 percent could be avoided through better medical access to or quality of medical care.[20] Carolyn Clancy, Peter Franks, and Marthe Gold have argued that health care accounts for 25 percent of premature mortality.[21] The University of Wisconsin's County Health Rankings use a model that attributes 20 percent to clinical care, 30 percent to health behaviors, 10 percent to the physical environment, and 40 percent to social and economic factors.[22]

Thus, McGinnis and colleagues argue in a 2002 publication argue that health policy and funding must go beyond classic medical treatment.[23] They question the great amount of funding being provided for the health care sector rather than for population-wide opportunities to improve health, and note that 40 percent of deaths are caused by modifiable behavioral patterns that can be prevented by instituting prevention programs, adding that "[s]ocial circumstances and environmental exposure also contribute substantially to preventable illness."[24]

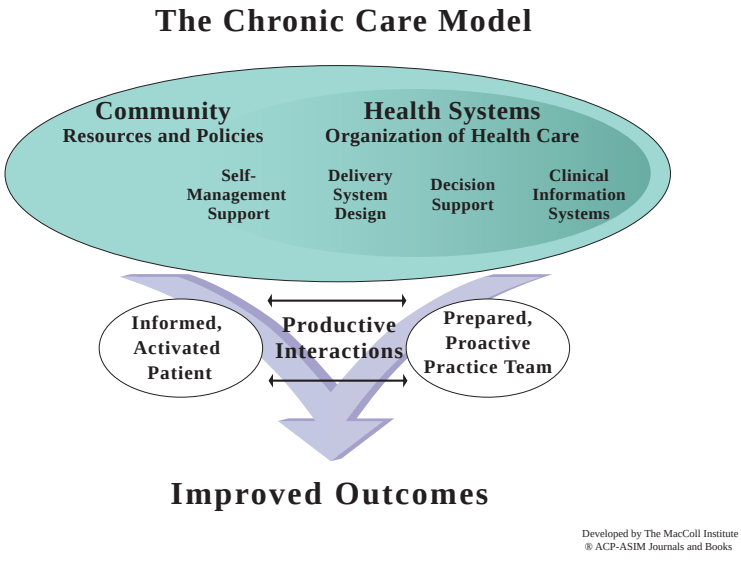
Many physicians recognize the importance of the SDH for their patients' health, even if they feel unable to address these factors. A recent national survey of primary care physicians and pediatricians revealed that 85 percent believe that their patients' social needs — e.g., access to nutritious food, reliable transportation, and adequate housing – are just as important as medical treatment for addressing their medical conditions. However, 80 percent of physicians surveyed are "not confident in their capacity to address their patients' social needs" and believe this impedes their ability to provide quality care.[25] In the same survey, 76 percent of respondents indicated that they wished the health care system would pay for the costs associated with connecting patients to services that address their social needs if a physician deems it important for their overall health.

Emerging Care Models

The evolution of care models has increasingly focused attention on the SDH. Examples of this can be found in the Chronic Care Model, the Patient-Centered Medical Home, and the Community-Centered Health Home.

The Chronic Care Model (CCM) represents a significant advance in health care delivery for patients with chronic disease. Developed by Ed Wagner and his colleagues at the MacColl Institute, the CCM identifies the essential elements of a system that encourages high-quality chronic disease care. (See **Figure 1**.) These elements include: the organization of the health system, including delivery system design, decision support, and clinical information systems; and community resources and policies, including self-management support. Evidence-based change concepts under each of these elements, in combination, foster productive interactions between informed patients who take an active part in their care and providers with resources and expertise. According to the CCM, health care providers should form partnerships with community organizations to support and develop interventions that fill gaps in needed services, and encourage patients to participate in relevant community programs. Over the last 15 years, CHCs have adopted the CCM through a series of Health Disparities Collaboratives organized by the HRSA Bureau of Primary Health Care (BPHC) and facilitated by IHI, and have used the model successfully to improve the quality of care and to reduce health disparities.[26]

Figure 1. The Chronic Care Model



The Canadian province of British Columbia has created an Expanded Chronic Care Model, or Expanded CCM. (See **Figure 2**.) Like the proposed "Comprehensive Health Home"[27] and "Community-Centered Health Home" (see below), this version of the CCM recognizes that health care providers must understand and leverage the SDH. The Expanded CCM clarifies the community components that health care providers should focus on more consciously: helping to build healthy public policy, creating supportive environments, and strengthening community action. It also adds the components of "Activated Community," "Prepared Proactive Community Partners," and "Population Health Outcomes."

Figure 2. The Expanded Chronic Care Model with an enhanced community focus

Created by Victoria Barr, Sylvia Robinson, Brenda Marin-Link, Lisa Underhill, Anita Dotts and Darlene Ravensdale (2002). Adapted from Glasgow,R., Orleans, C., Wagner, E., Curry, S., Solberg, L. (2001) "Does the Chronic Care Model also serve as a template for improving prevention?" *The Milbank Quarterly*, 79(4), and World Health Organization, Health and Welfare Canada and Canadian Public Health Association. (1986). Ottawa Charter of Health Promotion.

The Patient-Centered Medical Home (PCMH) also recognizes proactive management of the health of a population as a responsibility of health care providers. In primary care in the U.S., the PCMH has become a leading standard for enhanced primary care, and many health care provider organizations, including many CHCs, are becoming certified as PCMHs. Although the PCMH model does not focus directly on leveraging the SDH, this model includes better "population management" by having primary care providers proactively reach out to their patients to provide for all their health care needs or make appropriate arrangements, including the provision of preventive services. This is population management where the population targeted is limited to those who are patients of the health care provider.

The Prevention Institute has proposed further evolving the PCMH and the concept of the health home, as defined in the Affordable Care Act of 2010, into the Community-Centered Health Home (CCHH).[28] In the CCHH model, the population is defined not as the patients of the health care provider, but rather as the entire community. The CCHH, its proponents argue, provides high-quality health services while also applying diagnostic and critical thinking skills to the underlying factors that shape patterns of injury and illness in the community, i.e., the SDH. The CCHH builds on community-oriented primary care, which links clinical practice with community action, and adds the accumulated wisdom of prevention practice to create an approach that focuses efforts on policy and environmental change. Thus,

this model not only acknowledges the community factors that affect patient health outcomes, but also requires active participation in their improvement. Using a CCHH model, health care providers would perform the functions of a PCMH and go beyond to:

(1) **Conduct inquiries** – collect data on social, economic, and community conditions, and aggregated symptom and diagnosis prevalence data;

(2) **Conduct analysis** – systematically review health and safety trends, and identify priorities and strategies with community partners; and

(3) **Act** – coordinate activity with community partners, advocate for community health, mobilize patient populations, strengthen partnerships with local care organizations, and establish model organizational practices.

An Idea That Is Both Old and New

While leveraging the SDH is an emerging development in the fields discussed above, it is not a new idea. As early as the 4th century BC, Hippocrates urged physicians to consider the airs "peculiar to each particular region," the "properties of the waters," and "the mode of life of the inhabitants, whether they are heavy drinkers, taking lunch, and inactive, or athletic, industrious, eating much and drinking little."[29] In 1910, medical education reformer Abraham Flexner argued that physicians have a duty "to promote social conditions that conduce to physical wellbeing."[30] By actively leveraging the SDH as a central focus of their activities, CHCs reflect a long-standing recognition that health is not simply an outcome of what a health care provider does within the walls of the clinic, but rather that patients' social, economic, and environmental conditions are fundamental to their health and wellbeing and thus warrant the attention of their health care providers. For those health care providers who have not given these conditions their due attention, or who feel they lack the confidence or competence to do so, the experience of CHCs in leveraging the SDH represents a vital resource that they can use to develop this capacity.

CHCs Leveraging the SDH

Leveraging the SDH has been central to the work of CHCs since the origins of the CHC movement. These origins can be traced back to internist and epidemiologist Jack Geiger. Based largely on his experience as a visiting medical student in South Africa in the 1950s, Dr. Geiger saw health and the human condition as inseparable. This inspired him to study the principles of community-oriented primary care (COPC) with Sidney and Emily Kark and their colleagues in rural Natal, South Africa.[31, 32, 33]

In the COPC model, the health care provider's responsibility extended to include all family dynamics or community factors that might be affecting the patient's health. The physician's role was to stimulate family and community interest in health, and to provide education regarding the need to improve health, prevent disease, and seek suitable care when ill. The physician was not expected to do this all on his or her own, but rather to work with other staff and with the residents. This approach was found to produce health outcomes equal to or better than those in settings where health care providers did not address these factors.[34]

In 1967, as part of an Office of Economic Opportunity grant, Dr. Geiger opened the country's first community health center, the Delta Health Center (DHC) in Mound Bayou, Mississippi, and applied the lessons he had learned in South Africa. Beyond simply providing medical care for the individual, the staff at DHC addressed the socioeconomic problems that plagued the region, such as hunger, poor sanitation, and unemployment. Employment in the area had been hit hard by the mechanization of cotton picking.

Dr. Geiger and his staff assessed community needs by holding a series of town meetings in homes, churches, and schools. In the clinic, the physicians were seeing malnutrition, stunted growth, and infections among infants and children, whom they treated using medical means. But they also wrote prescriptions for food for the malnourished and encouraged families to grow their own vegetables.[35] The staff worked with local residents to install water pumps and sanitation facilities to prevent diarrhea-related illnesses that were common in areas lacking access to clean water. The health center's board of directors was drawn from local residents in order to enable community participation in decisions about the area's health and future. Beginning with the DHC and several others using similar approaches, the network of community health centers has expanded to 1,124 non-profit entities with over 8,100 sites nationwide serving 19.5 million people as of 2010.[36]

CHCs are not alone is leveraging the SDH. In the U.S., the SDH often fall under the purview of multiple government agencies with responsibility for housing, environmental regulation, education, transportation, and public safety. However, it is public health departments that are most directly charged with addressing the health of entire communities rather than that of individuals.[37] How they meet their responsibilities, however, varies widely because of differences in their structure, governance, funding, authority, capacity, and scope of work. Thus, public health departments may directly provide a service, broker particular capacities, perform regulatory functions (e.g., food safety assurance), or otherwise ensure that the necessary work is being done. CHCs leveraging the SDH cannot replace effective public health agencies any more than they can replace effective agencies for housing, education, and transportation. However, CHCs play a critical role in shaping the SDH in their communities. This report identifies their ongoing activities in this realm and rests on the premise that health care providers have a responsibility to recognize and shape the social conditions that affect their patients.

Notes

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Trends and Forces Shaping Health Care and Community Health Centers

There are several trends and forces in the external environment and within the health care system itself that increase the importance of understanding the efforts of CHCs to leverage the SDH. These include:

- **CHC users in the U.S. are forecast to double** from 20 to 40 million users after health care access is increased by the provisions of the ACA. IAF's own research suggests a range of forecasts raising the number of CHC patients to as high as 50 million by 2025.[38]
- **Health care cost pressures will likely continue to escalate.** Medicaid reimbursement rates will be made equal to Medicare in all states for 2013 and 2014, but both will see cuts in the years ahead. This could be hastened by any one of a set of major events, which could include another recession, higher interest rates, and higher energy costs.
- **The ACA's provisions to expand Accountable Care Organizations (ACOs) will create a greater focus on population health.** Leveraging the SDH is an important tactic for increasing population health that will likely garner increased attention on the part of ACOs. The impact that ACOs will have is not yet clear, nor is their exact relationship to CHCs. CHCs are prohibited from being ACOs, but they may partner with ACOs. The growth of ACOs that take responsibility for improving population health will likely increase attention on the SDH.
- **As of September 27, 2011, more than $103 million in Community Transformation Grant funding had been awarded to 61 states and communities across the country to create cross-sectoral collaborations that address the SDH.** The grant program envisions a future where providers are networked with neighborhoods and share their data (with appropriate privacy and security protections) with public health officials, who coordinate activities to improve population health.
- **A growing number of communities have begun efforts to build community resilience** across a wide range of areas (e.g., food, economics, and energy) in the face of such challenges as rising energy costs, climate change, and economic crisis. These efforts, in partnership with local organizations, seek to mitigate these converging global crises by engaging their communities in homegrown, citizen-led education, action, and multi-stakeholder planning to increase local self-reliance and resilience. According to the non-profit organization Transition Network, there are over 110 official initiatives of this nature in the U.S., and there is growing interest in actively using the group's Transition Model in other U.S. communities.[39]
- **There is a growing public conversation about the need for fairness or equity in society,** and this conversation is likely to grow as the economy worsens, more jobs are lost, and unemployment persists. There is a parallel recognition that health equity needs to be addressed through health care reform. A recent poll suggests that citizens are paying attention to these disparities, with 78 percent of Americans believing that more action should be taken to ensure that health differences between groups because of factors such as education and income no longer exist.[40]
- **Medical education is incorporating a more direct focus on the SDH**. A 2012 report of the Association of American Medical Colleges (AAMC) stresses the role of the SDH in medical practice and recommends explicit tools

and strategies for educators to employ in undergraduate medical education programs and in practice settings.[41] In conjunction, the Medical College Admission Test (MCAT) will be revised in 2015 to include behavioral and social sciences.[42]

- **The need for community health advocacy is likely to grow.** Despite positive trends, during this time of the "Great Recession" and related reductions in government spending, public health departments may focus more on their essential regulatory or protective functions and less on their broader advocacy for healthy communities. For example, in a survey of more than 700 counties, 26 percent said they would decrease public health services and 23 percent said they would decrease health care programs to address funding shortfalls.[43]
- **The evolution of primary care will likely create greater opportunities to leverage the SDH.** Changes anticipated in a recent set of scenarios for primary care in the year 2025 include:

  – Enhanced use of high touch wireless and virtual communication, smart biomonitoring, and digital coaches driven by CHCs' clinical protocols.

  – An expanded role for community health workers or *promotores de salud*[44] working in CHCs as health coaches, and the greater anticipation of patient needs and sensitivity to their values, culture, language, and socioeconomic needs.

  – Community mapping tools that can identify community health conditions and health threats in order to target resources more effectively. Efforts such as the Community Commons initiative funded by the CDC, HHS, and the Convergence Partnership foundations (*http://www.communitycommons.org*) will be making free or low-cost mapping available to communities.

  – Significant cost pressures. There are many possibilities in the coming years for drastic and abrupt cutbacks in health care spending. One scenario includes 10 percent across-the-board cuts in Federal spending, with such cuts made twice between 2018 and 2023 – including cuts to CHCs.[45]

Thus, there are trends and forces shaping the environment in which CHCs operate that may present significant challenges as well as opportunities to support the movement toward more conscious and effective leveraging of the SDH to improve patient and community health.

Notes

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Methods for this Project

Database and Case Collection

To identify efforts by CHCs and enter them into our database we used several approaches:

- Developing a website (*http://www.altfutures.org/leveragingSDH*) where anyone could nominate an example and where CHCs could enter their examples directly or with assistance from IAF;
- Soliciting input from the project's Advisory Committee as well as from many of the experts we interviewed;
- Through NACHC, asking the directors of the state and regional associations of CHCs, usually called Primary Care Associations (PCAs), to identify examples from among their members;
- Conducting our own online searches, including CHC websites and newspaper articles, and placing announcements in IAF's newsletter and on IAF's website;
- Drawing from a review of the peer-reviewed literature regarding CHCs leveraging the SDH, which was conducted by CDN as part of the project;
- Reviewing key literature on CHCs and related fields, such as the work of Bonnie Lefkowitz and of Roz Lasker;
- Holding presentations at conferences and webinars where we solicited examples – e.g., the March 2011 NACHC Policy & Issues conference, the August 2011 NACHC Community Health Institute Conference, an August 2011 CDN webinar, the November 2010 Clinicians for Social Justice conference; and
- Sending a request for entries to members of the Midwest Clinicians' Network.

Through this process, IAF has developed a database of 176 examples or cases by 52 CHCs leveraging the SDH. While they are all simply referred to as "CHCs" in this report, the 52 clinics include 50 FQHCs, one FQHC Look-Alike Health Center, and one social service agency that provides some medical services.

Comprehensiveness and Sampling

The database of cases compiled for this project is unique in that no other such database exists and that it is large enough to reveal patterns across these activities. However, the database is neither a comprehensive collection nor a statistically representative sample. We did not conduct a national survey and cases were entered based on active recruiting and voluntary agreement on the part of the CHCs concerned. The 176 efforts from 52 CHCs in the database represent an average of 3.4 efforts per CHC. It is likely that many, if not all, of the 52 CHCs have had other efforts that were not included due to any of a number of reasons, such as:

- Retirement or departure of key CHC personnel knowledgeable about past SDH efforts;
- Limited time of CHC personnel to enter additional efforts after some efforts had already been included in their description for our database;
- Focusing on efforts that had been more successful;
- Lack of documents describing past efforts, either in the CHC's archives or on the website; or
- The passage of time.

To improve our understanding and supplement our interpretations, IAF developed 10 in-depth case studies, discussed below, and queried the 2007 national summary report from the HRSA/BPHC Uniform Data System (UDS), also discussed below. This research and the feedback we received from the project's Advisory Committee and from participants in the National Workshop reinforce our sense of the relevance and appropriateness of the findings presented in this report. (IAF intends to keep the database open and to update the findings periodically.)

HRSA/BPHC Uniform Data System

Using the measures defined in the HRSA/BPHC Uniform Data System (UDS), health center program grantees report each year on their performance, including services they provide directly or through referrals to other organizations or providers. A number of these services are addressing SDH-related needs through, for example, parenting education, WIC services, and assistance in obtaining housing. Until 2007, information on such services and programs was collected annually and displayed in Table 2 of the UDS report. Since 2007, this data is no longer consistently reported, as CHCs submit this information only if changes occur to the scope of services they provide. Data from the 2007 UDS report on SDH efforts is presented in the "Patterns and Observations" section of this report. There are a few other Federal or nationwide programs that are linked to CHCs and whose activity can be counted in terms of CHCs or CHC sites. These include Reach Out and Read, the National Center for Medical-Legal Partnership, and Health Leads. Beyond information on these national programs, UDS reports, and the findings of IAF's project, it is difficult to know how many CHCs reach beyond clinical care in ways that meet this project's definition of leveraging the SDH.

CHCs offer a variety of educational programs for community members, including arts programs. Photo credit: La Maestra Community Health Centers.

Choice of Case Studies

This project developed 10 case studies of CHCs leveraging the SDH, taking the CHCs rather than their individual efforts as the unit of analysis. Doing so provided a more complete picture of the origin, administration, sustainability, and evaluation of the specific efforts. IAF chose CHCs as case studies based on the following criteria:

- Assure the selected center has several activities that conform to the definition of leveraging the SDH.
- Aim for variety in size, scope, and focus in terms of SDH efforts.
- Across the 10 cases, show variety in CHC size and geographic spread, including location, demographic, and urban/suburban/rural diversity.

- Select a set of cases that shows variety in how CHCs identify the need for SDH activities. For example, efforts may be prompted by prevalent medical conditions (e.g., an opportunity identified in-clinic); by systemic review using formal assessments, toolkits, and/or frameworks; or by identification of opportunities by patients, board members, volunteers, business or government partners; or by community events.
- Favor CHCs with programs that are well underway and that have at least some impact data.

Based on these criteria, IAF selected the following 10 CHCs as case studies:

- Beaufort-Jasper-Hampton Comprehensive Health Services in Ridgeland, South Carolina
- Centro de Salud Familiar La Fe in El Paso, Texas
- Community Health Partners in Livingston, Montana
- Hudson River HealthCare in Peekskill, New York
- Joseph P. Addabbo Family Health Center in New York, New York
- Kokua Kalihi Valley Comprehensive Family Services in Honolulu, Hawaii
- La Clínica de La Raza in Oakland, California
- La Maestra Community Health Centers in San Diego, California
- Sea Mar Community Health Centers in Seattle, Washington
- Sixteenth Street Community Health Center in Milwaukee, Wisconsin

Overviews of each case study are provided following the appendix. Full-length case studies are available at *http://www.altfutures.org/leveragingSDH*.

Many CHCs offer job skills training, internships, and work opportunities to community members. Photo credit: La Maestra Community Health Centers.

Patterns and Observations

CHCs persist in their commitment to leveraging the SDH despite the pressures that come from competing priorities, such as implementing health information technology as they gear up for the provisions of health care reform. As noted above, there are several reasons why CHCs leverage the SDH:

- The SDH play a much larger role in our health than health care;
- Leveraging the SDH is in the DNA of CHCs;
- HRSA program expectations call for it;
- Local public health agencies may need assistance from CHCs with addressing the SDH; and
- Models of primary care and health quality increasingly require improved population health.

This section identifies key patterns and observations that emerge from our review of our database, case studies, interviews, and national workshop.

CHCs view the success and effectiveness of health care services provided as heavily dependent upon the patient's circumstances with respect to the SDH. It is obvious to many CHC leaders and staff that conventional medicine alone cannot address the health problems of the communities they serve. In many cases, this recognition is not theoretical – it springs from what providers see and treat in the clinic. For example, what good is it to treat children infected by parasitic worms only to watch those same children return to unsanitary living conditions? Accordingly, many CHC staff and leaders believe their clinical work must be augmented by efforts to address the SDH and that sustainable impact on health requires community-level interventions. Unlike physicians in general, who express a lack of confidence in their own capacity to address their patients' social needs,[46] many CHCs are building the confidence and experience that these other physicians lack.

CHCs are well-positioned to leverage the SDH and have a major impact on their communities. This is so for several reasons. First, CHCs know their communities well. They typically maintain a long-term presence in their communities, conduct periodic community needs assessments, and draw many of their staff and directors from the communities and populations served. HRSA mandates that CHCs be governed by a Board of Directors composed by a majority (51 percent or more) of active, registered clients of the health center – also referred to as "consumer-directed" boards – who are representative of the populations served by the center. Such staffing and boards ensure that the organization is community-based and responsive to the community's needs.[47] Second, since their inception in 1965, CHCs have been helping their neighborhoods grow by providing substantial direct and indirect economic impact on their communities. For example, the CHCs covered by this project's 10 case studies employed between 150 and 1,500 personnel each. Also, CHCs are routinely involved in multiple local partnerships and coalitions.

CHCs' belief in and commitment to addressing the SDH is often reflected in their mission statements. Seven of the 10 CHC case studies developed for this project use formal mission statements that go beyond the organizational goal of providing quality, affordable, accessible, comprehensive, and preventive health care. At a minimum, these statements acknowledge the need for human services or community health, and some go further to articulate a commitment to address the SDH, such as:

- La Clínica de La Raza in Oakland, CA: "Commitment to recognize the total health needs of our patient population by considering its psychological, social, economic, and physical needs."
- La Maestra Community Health Centers in San Diego, CA: "…to provide quality health care and education; to improve the overall wellbeing of the family…"
- Kokua Kalihi Valley Comprehensive Family Services in Honolulu, HI: "work toward healing, reconciliation and the alleviation of suffering in Kalihi Valley, by serving communities, families and individuals through strong relationships that honor culture and foster health and harmony."
- Sea Mar Community Health Centers in Seattle, WA: "Providing leadership and advocacy to empower our communities."

Target Populations and Health Conditions

Some SDH efforts are focused directly on community conditions; others provide direct benefits to individuals. Some do both, such as those that create safer and more useable playgrounds and thus change the environment with a specific focus on youth. Unless it has been designed to target a particular set of community members, SDH efforts typically seek to benefit and directly involve working-age adults. Programs in our database that target a particular population or age group, however, most often focus on youth. The following numbers provide a picture of the target population of these efforts. Of the 176 efforts in the IAF database:

- 50 or more specifically focus on youth
- 15 or more focus particularly on women
- 15 or more explicitly focus on people from a particular race or ethnicity (most frequently those of Latino origin)
- 11 or more specifically focus on children ages 0-6
- 11 or more focus on parents
- 7 or more focus on seniors
- 6 or more efforts focus on survivors of family violence
- 4 or more efforts focus on farmworker families
- 4 or more efforts focus on men

Many CHCs provide new books for children to take home and encourage parents to read aloud to their children. Photo by Chieko Horn, courtesy of Community Health Partners.

Clinical issues that often inspire SDH efforts include frequent observations of conditions such as obesity, diabetes, hypertension, cardiovascular disease, and asthma. Other less frequent conditions that have been targeted by SDH efforts include soil-transmitted parasitic worms, mercury content in local fish, and Type II diabetes among young children. SDH efforts may also be designed to address behavioral or psychiatric problems among community members, such

as depression among socially isolated seniors. In such cases, CHCs may respond by improving access to behavioral health services and providing additional resources such as mentoring opportunities, youth development activities, job training, and assistance with finding jobs and opportunities for seniors to socialize with each other and build relationships with teens and youth.

Range of Social Determinants Addressed

CHC efforts to leverage the SDH address a wide range of activities. The list below illustrates the scope of the 176 efforts in the IAF database. These efforts are grouped under broader categories, in no particular order. (Some activities appear in more than one category.)

Education

- Promoting early childhood development and school readiness, including:
  - Offering childcare or preschool programs, including Head Start services
  - Providing new books to take home after pediatric check-ups and encouraging parents to read aloud to their children
- Providing youth development programs, including:
  - Establishing and operating charter schools
  - Offering after-school and summer programming for youth and families such as:
    - Mentoring and youth leadership opportunities
    - Nutrition and physical exercise activities
    - Life skills training and other efforts to encourage alternatives to violence and substance abuse
  - Supporting a music teacher for local elementary schools
  - Addressing truancy, encouraging youth to stay in school, and awarding financial assistance to pursue higher education
- Supporting the integration of access to the outdoors into classroom lessons
- Establishing and/or operating community resource centers to offer an array of services and activities
- Offering parenting classes, training, and advice to teens and adults
- Providing health education, including nutrition and healthy cooking workshops, and assistance in creating asthma-friendly indoor environments
- Offering adult education to help working-age community members:
  - Improve in English, reading, math, financial literacy, and computer skills
  - Prepare for GEDs, U.S. Citizenship tests, and post-secondary education
  - Access art programs such as photography, video production, poetry and creative writing, and drama classes, as well as to college-level courses for CHC staff and community members
- Developing, proposing, and/or conducting policy analysis, education, and leadership training related to educational and other social policies

Job Skills, Employment, and Workforce Development

- Assisting with job search and placement
- Training and hiring adults (e.g., as interpreters, community health workers, administrative staff)
- Providing income-generating skills training and college-level courses for career advancement
- Offering micro-enterprise assistance and lessons in financial literacy and business development
- Providing job skills training, including computer skills and personal development counseling
- Offering internships, paid or volunteer youth work opportunities, and leadership opportunities

Healthy Eating and Diet

- Providing nutrition education to youth and adults, including healthy cooking workshops and demonstrations, and recipe modifications
- Increasing access to healthy foods, including:
  - Creating community gardens or green houses, and providing gardening education and training
  - Organizing urban farm stands, or farmers' markets and providing equipment or various forms of vouchers to assist purchases by recipients of supplemental food assistance
  - Impacting the food selection in local grocery stores or meal options at restaurants and local schools
  - Providing healthy foods and/or meals through other means, such as WIC services, Community Supported Agriculture Farm Share programs, food banks, and meal programs

Physical Activity and Exercise

- Providing exercise equipment, including bicycles
- Improving trails and paths for walking and biking
- Providing or promoting opportunities for physical activity such as exercise classes, walking clubs, children's play areas, and gardening

CHCs often promote active living and weight management by offering or promoting regular exercise classes, including walking clubs. Photo credit: Sixteenth Street Community Health Center.

Social Conditions

- Promoting community safety, wellbeing, and involvement, including:
  - Organizing opportunities for youth, adults, and seniors to volunteer in their community
  - Conducting youth-led community assessments and action plans
  - Offering programs and activities to celebrate cultural diversity and promote cultural enrichment, understanding, sensitivity, and inclusion among youth and adults

  - Providing nurturing and safe environments and after-school programs for youth in order to promote personal development, healthy living, and alternatives to crime, violence, and substance abuse
  - Working with the local police department to reduce violence in the community and assisting former inmates with re-entering society
  - Promoting family involvement in local schools and the community
  - Promoting civic engagement and providing nonpartisan voter registration forms to all eligible patients
  - Providing educational and social activities specifically for seniors
- Promoting family and social support and emotional wellbeing, including:
  - Providing parenting education and domestic violence prevention, support, and education programs
  - Assessing and improving coordination of existing community resources and services provided by agencies
  - Encouraging intergenerational mentoring among children, youth, and seniors
  - Offering social and educational programs specifically for seniors to promote social inclusion and active living
  - Providing support groups for lifestyle changes such as walking and weight loss
  - Bringing together older and younger men to learn from each other and talk about life experiences and the importance of family
  - Helping youth and adults improve their coping skills and mental adaptation to handle stressors in their personal lives
  - Training youth as peer leaders to promote creative expression and healthy coping strategies
  - Providing services and transitional housing for men and women returning from jail or prison
  - Working to increase the awareness and understanding of domestic violence in the community, and helping community health educators create and distribute DVDs and CDs of personal stories for advocacy and education

Economic Development

- Enabling community members to start their own enterprises by supporting them with training on income-generating activities, financial literacy, business development and micro-enterprise
- Providing access to loans
- Developing land, infrastructure, and transportation to attract businesses and create jobs
- Building housing
- Providing farmers, community gardeners, and others with an opportunity to sell their wares and excess produce

Housing, Built Environment, and Recreational Spaces

- Ensuring healthy, safe, and affordable housing, including:
  - Establishing housing (including transitional, shelter, assisted-living, farmworker, and low-income housing)
  - Addressing concrete housing issues (including repairs, infrastructure, cleanliness, toxicity, safety, electricity, and bathrooms)
  - Working to centralize and integrate the strategic collection of health and housing data across project partners, and channeling data into a community organizing campaign to criminalize large-scale slumlords

  - Providing or referring patients to organizations that provide tenant services (including mediation, rent assistance, and security deposits)
  - Providing septic tank systems, wells, water systems, and fire protection
  - Organizing housing fairs, workshops, and assistance for first-time home buyers
  - Educating school staff, children, teachers, principals, and parents concerning an asthma-friendly environment
  - Inspiring a coalition made up of local social service agencies, businesses, and community members working on solutions to homelessness
- Creating recreational spaces and improving air and water quality in the community, including:
  - Working with local government to improve existing walking paths, and designing walking maps to designate paths with defined distance that are safe and well-lit
  - Promoting zoning, land use, and resource use that support the community's health needs
  - Developing parks and planting trees or engaging in reforestation
  - Helping community members track local sources of pollution, mobilizing community solutions, and securing action on the environmental risks that compromise air and water quality and the health and wellbeing of communities
  - Supporting community members in creating maps and digital stories to advocate for equity in access to healthy eating and active living opportunities
  - Designing a water policy initiative for improving water quality and the protection of major fresh water sources
  - Advocating for the successful passage of an amendment to a city charter to make the city bicycle- and pedestrian-friendly
  - Lobbying the county bus system in collaboration with community members to increase mobility

Policy, Advocacy, and Activism

- Providing instrumental support in creating a local foundation or planning and coordination of a group to advocate for and address the social determinants of health affecting the community
- Integrating legal assistance into the medical setting to help eliminate barriers to health care, family stability, education, and housing, including assistance with housing applications and wrongful evictions, issues of employment discrimination, and access to public benefits, child care, and child support
- Promoting civic involvement and advocacy for system changes in health, educational, and social policies
- Teaching community members the philosophy of community action, an understanding of group dynamics, and the skills necessary for leadership

Disaster and Emergency Preparedness

- Leading the way following disasters in the collection and distribution of food, clothes, household items, personal items, transportation, and many other essentials; also, replacing roofs and electrical wiring, and repairing damaged trailers
- Creating and implementing disaster preparedness plans for residents and farmworkers
- Organizing a group of emergency preparedness professionals and others to teach community members about emergency preparedness

Frequency of Social Determinants of Health Initiatives by Topic

What HRSA/BPHC Can Tell Us

The following observations come from an analysis of 2007 UDS data.[48] Of the 1,067 grantees reporting:

98.7 percent provided or made referrals for health education, i.e., personal assistance provided to promote knowledge regarding health and healthy behaviors, including knowledge concerning sexually transmitted diseases, family planning, prevention of fetal alcohol syndrome, smoking cessation, reduction in misuse of alcohol and drugs, improvement in physical fitness, control of stress, nutrition, and other topics. Included are services provided to the patient's family and/or friends by non-licensed mental health staff which may include psychosocial, caregiver support, bereavement counseling, drop-in counseling, and other support group activities.

98.3 percent provided or made referrals for eligibility assistance, i.e., assistance in securing access to available health, social service, pharmacy, and other assistance programs, including Medicaid, WIC, Supplemental Security Income, food stamps, state Temporary Assistance for Needy Families programs, and related assistance programs.

94.8 percent provided or made referrals for WIC services, which are nutrition and health counseling services provided through the Special Supplemental Food Program for Women, Infants, and Children.

It is in the DNA of CHCs to address the total health and wellbeing of the community. Photo credit: Sixteenth Street Community Health Center.

92.4 percent provided or made referrals for individual or group parenting education sessions.

91.1 percent provided or made referrals for assistance in locating and obtaining nursing home and assisted-living placements.

90.1 percent provided or made referrals for food banks or delivered meals (but not finances to purchase food or meals).

90.1 percent provided or made referrals for assistance in locating and obtaining suitable shelter, either temporary or permanent. This may also include assistance with locating costs, moving costs, and/or rent subsidies.

89.7 percent provided or made referrals for Head Start services, i.e., comprehensive developmental services for low-income preschool children less than 5 years of age.

89.0 percent provided or made referrals for employment and educational counseling services to assist an individual in defining career, employment, and educational interests, and in identifying employment opportunities and/or education options.

82.9 percent provided or made referrals for environmental health risk reduction programs by detecting and/or addressing unhealthy living conditions associated with water supplies, sewage treatment, solid waste disposal, rodent and parasitic infestation, field sanitation, housing, lead paint, pesticide management, and other environmental factors related to health.

68.1 percent provided or made referrals for child care during a patient's visit to the center.

In other words, in 2007 the majority of community health centers (68 to 99 percent) deemed it necessary to leverage the SDH either directly or by referral in order to meet their responsibilities and to promote health.

What IAF's Database and the CDN Literature Review Reveal

Below we identify the most frequent types of activities (occurring in 17 or more efforts) in our database. Some of these efforts fall into more than one category, e.g., community gardening programs are counted under the healthy food and physical activity categories.

Most Frequent Activities	Out of 176 efforts	Out of 52 CHCs
Youth development programs	28%	50%
Family and social support	25%	31%
Access to healthy foods	23%	60%
Job skills, employment, and workforce development	22%	40%
Health education	21%	50%
Physical activity and exercise	19%	48%
Community safety, wellbeing, and involvement	19%	44%
Nutrition education	16%	44%
Healthy, safe, and affordable housing	16%	33%
Recreational spaces and improved air and water quality in the community	11%	25%
Adult education	10%	21%

In comparison, the 15 reports and four websites that met CDN's inclusion criteria for the literature review focus on (from most to least frequent and including overlaps):[49]

- Obesity prevention (8);
- Addressing barriers to physical activity (5);
- Asthma prevention (4, representing 3 projects);
- Addressing childhood lead poisoning (3, representing 2 projects);

- Teen sexuality/parenting (2);
- Environmental degradation in general (1);
- Domestic violence (1);
- Educational disadvantage (1);
- Fall injury prevention (1); and
- Cultural dislocation (1).

An example of an overlap is a 2009 publication by Hamamoto, Derauf, and Yoshimura, which discusses two efforts: the development of an unused state park including archeological restoration and other culture-based activities (addressing cultural dislocation), and the establishment of a bicycle repair and recycling program (access to physical activity).

Identifying Opportunities for SDH Efforts

CHCs take care to maintain an open dialogue with everyone ranging from their own staff and leadership, to patients, community leaders, and partner organizations, and draw upon that dialogue and a variety of other means to identify opportunities to better serve their communities. Accordingly, CHCs often cite community support and enthusiasm as major factors in the development, design, and sustainability of an effort.

Based on IAF's database and case studies, CHCs most often identified opportunities to leverage the SDH through anecdotal observations or suggestions from CHC personnel and executive leadership, such as a social worker noting that seniors living in a public housing project were looking for opportunities to socialize and venture out; a community health worker making home visits and identifying home and neighborhood safety needs; clinical staff noting that parents were visibly uncomfortable when asked to read to their children; and charter schools that at two CHCs grew out of the vision and direction of the respective CHC's CEO.

SDH efforts have also been prompted by:

Suggestions from community members and members of the CHC's Board of Directors, e.g.:

- A client with a background in education and IT proposing a program to recycle and rebuild old, unused computers that could then be sold for a low fee to families and individuals in the community
- A patient suggesting that a CHC take the lead in developing a park
- Victims of domestic violence asking their local CHC leadership to develop programs that would end the violence at home without separating the family
- A board member requesting that the CHC open a "clothing attic" for new and slightly used clothing for needy families to dress better for school and work

A grant opportunity that matches a problem the CHC recognizes in the communities it serves, e.g.:

- A CHC learning of a Request for Proposals issued by a Federal grant-making program and taking the initiative to create a coalition of community-based organizations, to apply for the grant, and to work together in addressing youth violence and promoting a safe, healthy, and nurturing environment for students and families
- A CHC, aware of the high rate of unemployment in its community, responding to a Federal stimulus program to provide skills training and subsidized job employment

Highly publicized events in the community that inspire attention, e.g.:

- A violent beating of an immigrant in the community
- An event that gets national attention such as the Columbine High School shooting or the terrorist attacks of 9/11
- The high incidence of parasitic infections in local children due to poor sanitation
- A potential hurricane disaster
- High levels of mercury and PCB in local fish
- Local stores' selling of tobacco products to minors

A non-CHC organization that approaches the CHC, e.g.:

- Establishing a shelter for abused spouses and children after the CHC was approached by the director of services at a local public housing project
- Participating in a project to clean up several brownfields in the area after the CHC was approached by a state agency

A CHC stepping in to enable the survival of existing programs or efforts by other organizations that the CHC deems too important for the community to lose, e.g.:

- Creating a Culture and Technology Center to fill the void when art programs in local public schools became subject to budget cuts
- Taking the lead in creating a band program for public elementary school students to fill the gap left by state cuts to school funding
- Incorporating the Latino Educational Achievement Project (LEAP), which had been created as an independent non-profit more than a decade earlier

CHCs do conduct general community needs assessments, both initially to determine the local need for a new site and periodically thereafter (e.g., once every decade) to identify changes in needs and priorities. CHCs may also use community assessments conducted by other organizations, as well as electronic health records, in their decision-making, or – less frequently – conduct additional, more targeted assessments, focus groups, or workshops. Based on the 10 case studies, however, CHCs most often use the resulting data to test hypotheses and as supportive rationale for a program or effort idea, rather than as a prompt or a source of inspiration. For example, La Maestra Community Health Centers was already well aware of the high unemployment, poverty, and crime rates within its mostly immigrant and refugee community, and used county statistics reports to confirm some of its knowledge before establishing its Microcredit Program for Women to help newly arrived families build their own businesses and expand employment opportunities.

Furthermore, CHCs may not necessarily treat such data as the final say in whether or not to pursue or sustain an SDH effort, or may not treat it as such consistently. For example, at Hudson River HealthCare the idea for a childhood obesity prevention program was sparked by a clinical staff member and developed into an actual program after the CHC confirmed that the community had one of the highest rates of childhood obesity in the state. In contrast, youth participating in the CHC's intergenerational Health Unites Generations program proposed a Senior Prom program component for elders, which was incorporated for the benefit of program participants rather than based on community data.

Design and Strategy of Efforts

The actual design and strategy of SDH efforts varies, and most efforts are designed by CHCs themselves although they often do so with input from community members, staff and CHC departments, and organizations from within and outside the community, including universities. In some cases, CHCs use one-, two-, or three-year grants to innovate and test program design and demand. Other efforts are based on existing curricula such as the WE CAN! curriculum to improve nutrition and physical activity, or originate from non-profit (e.g., Reach Out and Read, Health Leads, Medical-Legal Partnership) or Federal and state (e.g., WIC, charter schools) programs. Among published efforts that were reviewed in the CDN literature review, interventions ranged from those targeted at the home environment to city-wide and multi-county efforts.[50] CDN also notes that "Community Based Participatory Research" was the most frequent theoretical approach used (5 projects). In any case, CHCs take care to design and tailor their efforts to be culturally sensitive to the target group and community.

The following principles for effort strategy and design emerged from IAF's interviews with CHC leaders and case study development:

- Target education, literacy, and youth development, which can have powerful follow-on effects across a wide range of SDH, including job placement, health literacy, social relationships, teen pregnancy, and gang activity.
- Involve all of the CHC staff and leadership in the process of leveraging the SDH.
- Use evidence-based practices whenever possible.
- Whenever possible, design programs to address multiple community needs concurrently.
- Coordinate new CHC efforts with existing ones.
- From the very beginning, ensure that program development addresses community commitment, the creation of broad networks, clear deliverables, a pathway to sustainability, and a monitoring and evaluation strategy.
- Help the target community take ownership of the effort. Engage them in the development of programs and efforts, including having them define their perception of barriers to care, health, and wellbeing in terms of the SDH, and provide opportunities to collaborate on the actual design and implementation of the effort.
- Avoid an all-or-nothing attitude in program development: if it is not possible to immediately implement a particular program in its entirety, go ahead and start working in the desired direction at least by taking little steps.

CHCs often address multiple community needs concurrently, as with this health fair held as part of a community gardening program. Photo credit: La Maestra Community Health Centers.

- Start with a series of smaller efforts to develop expertise and strong partnerships before tackling larger efforts.
- Consider promotores or community health workers from a target population as the most effective change agents, because they have successfully struggled with the same issues as the people with whom they are working.
- Build on the insights and experiences of patients, staff, and leadership who come from the community served. Have staff constantly work on getting to know patients and the community. Periodic systematic assessments are necessary, useful, and required, but they are not sufficient.
- Have one individual or team specialize in the management and finance of SDH efforts and have that unit work with the other CHC divisions, rather than expanding the scope of responsibilities of existing staff.
- Grow programs with intentionality. Consider articulating a clear vision for the community's future, and aligning SDH efforts with that vision.
- Remain open to adapting the design of an SDH effort based on community interest and support both before and throughout program implementation. Also, some relevant and important needs may not come to light until after an SDH effort is well underway.
- Consider that SDH efforts do not necessarily have to remain under CHC-only management; CHCs can jump-start efforts and eventually transfer them to other organizations, or turn efforts into small businesses.
- Know that community organizing, legislation, and dealing with public officials (i.e., advocating for changes), can be a valuable, but time- and effort-intensive process and can get stuck. Before committing to persist in such a case, clarify whether there are other pathways or community needs of greater priority that may be more "doable."

Nationwide Programs

As noted, CHCs do not always need to invent ways to leverage the SDH from scratch. There are a number of national programs that help CHCs leverage the SDH and in which CHCs take part. They include:

Special Supplemental Food Program for Women, Infants, and Children (WIC) (*http://www.fns.usda.gov/wic*) – As noted, 94.8 percent of CHCs provided or made referrals for WIC services in 2007. This federally funded program of the U.S. Department of Agriculture (USDA) provides grants to states for supplemental foods, health care referrals, and nutrition education for low-income pregnant, breastfeeding, and non-breastfeeding postpartum women, and to infants and children up to age five who are found to be at nutritional risk.

AmeriCorps (*http://www.americorps.gov*) – CHCs often cite AmeriCorps members as part of their staffing for SDH efforts. AmeriCorps is a national network of programs that engages more than 70,000 Americans each year in intensive service to meet critical needs in communities throughout the nation. An AmeriCorps program specific to community health centers, begun in 1995, is the NACHC **Community HealthCorps** (*http://www.communityhealthcorps.org*). In 2010 there were almost 500 Community HealthCorps members performing service projects for patients and community, often by functioning as community health workers. CHCs use these programs to develop or staff their efforts that leverage the SDH. For example, one of the CHCs described in an IAF case study developed an intergenerational program with the help of AmeriCorps volunteers, and a preparatory school program of another CHC uses AmeriCorps members to tutor children at the school.

Reach Out and Read (*http://www.reachoutandread.org*) – These programs encourage early literacy by having CHC clinical providers in pediatric exam rooms provide new books to children and advice to parents about the importance of reading aloud. According to the Reach Out and Read organization, about 1,480 sites or about 18 percent of the approximately 8,100 CHC clinic sites offered the program in 2010.[51]

National Center for Medical-Legal Partnership (*http://www.medical-legalpartnership.org*) – According to the National Center for Medical-Legal Partnership, there are over 150 health centers in the U.S. with a medical-legal partnership as of 2011, representing approximately 13 percent of HRSA-grantee CHCs. The Medical-Legal Partnership (MLP) is a health care and legal services delivery model that aims to improve the health and wellbeing of vulnerable individuals, children, and families by integrating legal assistance into the medical setting. MLPs address SDH and seek to eliminate barriers to health care, family stability, education, and housing in order to help vulnerable populations meet their basic needs and stay healthy.

Health Leads (*http://www.healthleadsusa.org*) – There are a number of models that focus on connecting low-income families to resources (e.g., Single Stop USA, LIFT). Health Leads, however, deploys its volunteers directly in a health care setting. As of 2011, Health Leads contracts in six cities with five CHCs and other health care sites. The non-profit trains college volunteers to expand the capacity of clinics to connect their patients with the resources they need to be healthy, such as food, housing, and heating assistance. Doctors "prescribe" food, housing, or other critical resources, just as they would prescribe medication, and patients take their prescriptions to Health Leads' college volunteers, who connect them to these resources. The Health Leads model complements services provided by social workers, case managers, and lawyers in a health care setting, and allows providers to take into account the diagnosis and treatment of non-medical but health-critical conditions (i.e., leveraging the SDH) as a standard part of patient care. In Fiscal Year 2011, Health Leads trained and deployed more than 950 college volunteers to connect approximately 9,000 low-income patients and their families to the resources they needed to be healthy. The organization estimates that it impacted about 27,000 children and adults that year.

Nearly all CHCs provide or make referrals for WIC, a federally funded nutrition program for women, infants, and children. Photo credit: Sixteenth Street Community Health Center.

Other programs with which CHCs may partner to leverage the SDH include:

– **United Way**, a worldwide network of community-based organizations that partner with CHCs and others to address local issues, including helping children and youth succeed through engagement, strengthening and supporting families, improving access to health care, and promoting financial stability.

– **Canyon Ranch Institute**, a nationally recognized spa/alternative health provider, which has partnered with CHCs to transfer the best practices of the Canyon Ranch approach to underserved communities to prevent, diagnose, and address chronic diseases, including the provision of exercise equipment.

– **Corporation for National and Community Service**, Senior Companion Program, which brings together volunteers age 55 and over with adults in their community who have difficulty with the simple tasks of day-to-day living. Companions help out on a personal level by assisting with shopping and light chores, interacting with doctors, or just making a friendly visit.

– **TimeBanks USA**, which promotes equality and builds caring community economies through inclusive exchange of time and talent.

– **State departments of education** or state agencies serving the same function, which may assist with planning, designing, or implementing new charter schools.

– **Migrant Head Start programs**, which improve nutrition for children from migrant families.

– **The national Green and Healthy Homes Initiative**, which provides housing intervention benefits.

– **USDA**, which offers Electronic Benefits Transfer (EBT) system services in collaboration with vendors and subcontractors in all states. CHCs may obtain and provide the equipment for EBT transactions to enable recipients of supplemental nutrition assistance to use their government benefits in purchasing healthy foods at a farmers' market.

Leadership Role

SDH work can only happen and be sustained over the long-term in a CHC setting where the executive leadership "gets it"; their buy-in and commitment is critical for the development and sustaining of efforts in leveraging the SDH, especially if funds are drawn from the CHC operating budget.

The CHC leaders interviewed by IAF were often a driving force behind their organization's consistent efforts to leverage the SDH. Although leaders are typically responsible for vision and direction together with the Board of Directors, some CEOs or executive directors go as far as to personally look for opportunities and to initiate new efforts regardless of whether or not their organization already includes specialized departments or subsidiaries tasked with developing and managing SDH efforts.

Not surprisingly, then, leaders of CHCs that leverage the SDH are open to change and innovation, and believe strongly in the benefits of leveraging the SDH, including the potential of these efforts to help break the poverty cycle in their low-income communities. Their personal commitment and vision is key to creating an organizational culture that supports and inspires staff at all levels to look for opportunities and to generate ideas, as well as to raise donations for programs, and to donate their time and even their own money to enthusiastically support SDH programs. At La Maestra Community Health Centers, for example, the CEO's leadership on the "Circle of Care" philosophy has created an organizational environment in which all staff work to identify barriers and to assist or connect resources to meet needs. Similarly, the leadership at La Clínica de La Raza inspired nearly all of its staff (97 percent) to participate in the 2010 employee donation drive to support efforts that leverage the SDH and provide health care.

Staffing

Staffing SDH initiatives does not appear to be a challenge for CHCs. Among the 10 case studies, CHCs most often preferred to hire their own permanent staff from the community as an opportunity to provide employment and to ensure that program staff speak languages of the community, can easily relate to the experiences of community members, and are familiar with the respective cultures. However, it is often a challenge to keep the staff after funding runs out for a particular program. CHCs must determine whether to release those personnel or reassign them to funded positions in other CHC programs, if available. CHC teams or departments that specialize in leveraging the SDH are most often composed of staff members with non-clinician backgrounds. CHCs also often draw on AmeriCorps volunteers who may assist as tutors, program design researchers, and leaders in the development of an SDH effort after the opportunity has been identified.

Primary care providers (physicians, nurse practitioners, and physician's assistants) generally do not lead SDH programs but instead support SDH efforts by identifying SDH needs of their clients, teaching health information and prevention, and instigating or referring their clients to SDH programs and services. Specific clinical provider involvement can include, for example, speaking to patients on the importance of childhood literacy and distributing books in the Reach Out and Read program to pediatric patients and their parents; writing prescriptions for SDH-related items (e.g., food, septic systems, deep wells, wheelchair ramps, other home repair, or exercise); and assisting with program monitoring and evaluation particularly when these efforts are linked to clinical problems (e.g., diabetes, asthma, and obesity).

Grant Development

The task of researching grant opportunities may be distributed among personnel at all levels or limited to certain departments or senior staff only. Although CHCs may use one or more strategy to actually develop and manage grant proposals for leveraging the SDH, they most often rely on a set of key individuals who "wear many hats," typically senior staff who also work as grant writers, developing grants in collaboration with leaders of any of the CHC departments. Altogether, CHCs may use one or more of the following ways to develop and manage grants for SDH efforts:

CHCs may designate a set of key individuals, who may also hold other responsibilities, as primary grant-writers who work with other department heads or program area directors based on the project or program to be proposed.

- Centro de Salud Familiar La Fe relies on several senior staff members to write and manage grant proposals in addition to their other responsibilities. Based on the grant opportunity and program to be proposed, these senior staff members may work with other staff members and directors from any of La Fe's departments or subsidiaries.
- Hudson River HealthCare employs two staff members to manage grant proposals with support from program area directors.
- Kokua Kalihi Valley Comprehensive Family Services employs a community development coordinator who is tasked with monitoring trends and happenings in the community, supporting the development of programs in keeping with the CHC's mission, determining how to finance and sustain program ideas, and working with other program coordinators to document and communicate project proposals and experiences for a variety of audiences.
- Sea Mar Community Health Centers has designated two individuals among its administrative staff to develop and manage grant proposals in collaboration with Sea Mar's 10 department heads.

CHCs may develop and manage grants through a formal division that works with all program areas within the organization.

- La Clínica de La Raza's Planning Department collaboratively works with the Community Health Education Department (Casa CHE) to develop and manage proposals for Casa CHE programs.
- La Maestra Community Health Centers' Fund Development Unit works with La Maestra subsidiaries – La Maestra Foundation and the La Maestra Housing and Community Development Center – to develop and manage proposals for their respective SDH programs.

CHCs may develop and manage grants through a department or unit that specializes in SDH efforts.

- At Community Health Partners, the department head of Learning Partners writes and monitors grants for Learning Partners programs.
- At Sixteenth Street Community Health Center, the head of the Environmental Health Department also functions as the chief grant writer who develops proposals and manages them with support from other department staff.

CHCs may create project-based teams for grant proposal and management, with those teams composed of personnel from various CHC divisions that would be engaged directly in the effort.

- Joseph P. Addabbo Family Health Center does not have a program planning department or a grant writing department, but instead designates these functions to the staff members who will be most involved with the effort, as determined by the CEO with support from the executive board.
- Sea Mar Community Health Centers includes the Preventive Services and the Behavioral Health divisions, which often draft and develop grant applications and proposals for themselves to be later reviewed by other CHC personnel and by the organization's grant writers.

CHCs may choose to develop grant proposals and program designs in collaboration with community partners as part of coalitions or consortiums.

- Beaufort-Jasper-Hampton Comprehensive Health Services identifies the appropriate people both within the health center and among community partners, and requests their support once a funding opportunity has been identified. Upon proceeding towards a proposal, a consortium is formed with appropriate community partners to create the proposal and manage it when it gets funded.
- The Joseph P. Addabbo Family Health Center gathered the support and commitment of 10 subcontracting and funded partners, more than 25 volunteer partners, and 12 legislators and their representatives to propose a comprehensive effort that would deal with youth violence in the Rockaways community and promote a safe, healthy, and nurturing environment for students and families.

Program Management

CHCs use various configurations to manage SDH programs depending on the mission of the CHC, the size, longevity, and business model of the program, and how the program relates to clinical operations as well as how much expertise is available in-house. Most frequently, however, CHCs manage their SDH efforts through specialized staff members or entities (e.g., team, department, or subsidiary). Altogether, CHCs may use one or more of the following organizational structures to manage SDH efforts:

A specialized, formal staff member or division with dedicated staff. Organizational set ups for managing SDH efforts range from an individual Director of Special Programs, coordinators for specific program areas, and specialized CHC departments to subsidiary organizations with their own funding streams and offices to oversee staff and manage SDH activities. Selected examples include:

- Community Health Education (Casa CHE) Department for educational programs (La Clínica de La Raza).
- Learning Partners Department for education- and job-related programs (Community Health Partners).
- Program Area coordinators who may manage, for example, a shelter for abused spouses and children, or a nature preserve (Kokua Kalihi Valley Comprehensive Family Services).

- Environmental Health Department to work on environmental health initiatives (Sixteenth Street Community Health Centers).
- A Director of Special Programs who assists in defining and guiding the goals and objectives for SDH programs. In the past, the CHC also included a team or department specializing in implementing environmental interventions such as septic systems and wells, as prescribed by physicians (Beaufort Jasper Hampton Comprehensive Health Services).
- La Maestra Foundation and La Maestra Housing and Community Development Center, which are subsidiaries that in part direct management of many SDH programs, including the CHC's microcredit program and a program to help clients navigate the housing market (La Maestra Community Health Centers).
- The Culture and Technology Center and the Montana Vista Community and Satellite Resource Center, which are both treated as internal divisions, whereas the La Fe Policy, Research, and Education Center, La Fe Preparatory School, MPV Inc. (to build and operate housing), and the La Fe Community Development Corporation are subsidiaries with their own staff, offices, and funding streams (Centro de Salud Familiar La Fe).
- A Department of Community Initiatives with various programmatic areas, including youth development, and The Preservation Company subsidiary for addressing housing needs (Hudson River HealthCare).
- A Director of Housing and an affiliate LLC of the CHC that owns housing projects (Sea Mar Community Health Centers).

Distributed among several existing divisions or departments, to whichever they most closely relate:

- Many SDH programs are managed by the Department of Community Initiatives. Some of the SDH programs with a clinical focus (e.g., addressing childhood obesity through nutrition education and physical activity), however, are managed by the Operations Department (Hudson River HealthCare).
- The management of SDH programs being divided among several departments or divisions, including the Preventive Health Services, Community Services, and Communications and Education. The Child Development Center and Intergenerational Program is under the management of the skilled nursing department head, and the housing projects are owned by an affiliate LLC and overseen by the Director of Housing (Sea Mar Community Health Centers).

Seamlessly integrated with clinic operations, as in the case of:

- Doctors prescribing and referring patients to services and resources to address critical needs such as food and housing (e.g., Health Leads operating at five CHCs; referring eligible patients to the Green and Healthy Homes Initiative as is done at Baltimore Medical System, or to the Healthy Homes, Healthy Kids initiative as it is done at St. John's Well Child & Family Center).
- Providing books to pediatric clients and discussing the importance of early childhood literacy (e.g., Reach Out and Read programs).
- CHC outreach workers providing support for safe and healthy environments in the home and the community – e.g., the Community Lead Outreach Project to address lead poisoning (Sixteenth Street Community Health Center), the Rural Geriatric Care Case Management Program to prevent falls in the homes of seniors (Beaufort-Jasper-Hampton Comprehensive Health Services), and domestic violence prevention services (La Clínica de La Raza).
- Food pantries that distribute groceries that cater to those with medically restricted diets (e.g., due to diabetes or hypertension) with options that are culturally appropriate (La Maestra Community Health Centers).
- How CHCs operate in general, such as directly employing community members and otherwise promoting economic development in their communities by directly purchasing goods and services from local businesses to maintain operations.

Project-based teams that form and disband according to funding opportunities, and cut across the CHC and partner organizations, as in the case of:

- A multi-year youth safety and education project where the coalition was led and primarily managed by a handful of CHC personnel from across the organization (Joseph P. Addabbo Family Health Center).

Separate, independent SDH-addressing organizations or semi-independent coalitions, which CHCs have played an instrumental role in establishing but with which they are no longer directly involved on a daily basis. For example:

- Beaufort-Jasper-Hampton Comprehensive Health Services awards grants to a small business created by former employees of its environmental department to conduct SDH efforts in the community.
- Community Health Partners initiated a dialogue with community partners about providing affordable housing commensurate with living wages. The dialogue eventually evolved into a coalition of local social service agencies, businesses, and community members working on solutions to homelessness in the area. The same CHC was also an instrumental collaborator in creating a local, independent foundation that identifies and monitors the community health and wellbeing drivers and then supports dynamic community action.
- Joseph P. Addabbo Family Health Center provided its director of mental health to act as the project manager for the Project for Rockaway Youth in Safety and Education, a coalition of more than 20 partners to address youth violence in the community and to promote a safe, healthy, and nurturing environment for students and families. While the project manager had primary responsibility for organizing and administering the project on a day-to-day basis, activities conducted by partners were managed by the respective organizations, who would in turn work with and report to the project manager.
- Kokua Kalihi Comprehensive Family Services established Hawaii's first domestic abuse shelter, and eventually transferred it to the management of a private non-profit organization.
- La Clínica de La Raza provides a network coordinator for the East Bay Coalition Against Gender and Domestic Violence, a network of providers who assist in the coordination of all types of referral services (housing/legal/psychiatric counseling) and education for Spanish-speaking immigrants who suffer from isolation and do not know how to navigate the system in order to access domestic violence institutions if needed.
- Sixteenth Street Community Health Center established a non-profit organization to take the lead in the Menomonee Valley Sustainable Development Project to develop brownfields.

Partnerships

Many SDH efforts require multiple partners with diverse but complementary skill sets, resources, goals, and strengths to successfully conduct a project. For example, community garden programs may require partners that can provide supplies such as seeds and tools, negotiate a land agreement, teach farming or gardening practices, and provide knowledge of business and accounting to those who wish to sell their produce. Even if CHC staff possess the skills needed for a particular SDH effort, partnerships are key to extending the reach of the effort and promoting CHC efforts and services. For that purpose, CHC personnel at multiple levels are often tasked with keeping an eye out for partnership opportunities, which may arise anywhere, including in the everyday interactions between CHC staff and community members.

CHCs partner with a wide variety of organizations, networks, and coalitions, either through the CHCs directly or through their subsidiaries. IAF's research and the CDN literature review have both found that CHCs tend to take

the lead in collaborative SDH efforts. Partners may include public housing, churches, community centers, YMCAs, libraries, public health departments, hospitals, local social agencies, local police, politicians, educational institutions and public school systems, for-profit and non-profit entities, local governments, government agencies, builders and developers, volunteer organizations, and existing coalitions. For successful collaborations among such diverse partners, several CHCs recommend designing efforts in a way that permits partners to participate most actively in the parts of an effort that leverage their strengths. Depending on the effort, partners may not need to be continuously active for the duration of an effort.

Financing

Funding is often a challenge. CHCs most often choose to launch programs with support from external – and often multiple – funding sources, and most often this funding is provided through time-limited, one- to three-year grants. For larger projects it can take several years to secure the funding. Grant opportunities may also stipulate partnering requirements (e.g., partnership must include a community-based health care agency that serves needy populations, or the grant recipient must be a local education agency). Funders may also prefer programs or efforts that are evidence-based and that demonstrate impact, though it is a challenge to demonstrate the impact of SDH efforts (see Results and Evaluation discussion below). Accordingly, several CHCs recommend that funding should be provided for a minimum of three years in order to create and demonstrate genuine impact.

Out of the 176 efforts in the IAF database, 64 or more rely primarily on grants, and another 10 or more include income-generating activities by which the effort is largely, if not entirely, self-sustaining, such as low-income housing that produces adequate rental income and farmers' markets that collect a fee to participate or a percentage of the profits earned by participating farmers. Farmers' markets also provide community gardening participants with the opportunity to sell extra produce. Financial support for SDH programs may come from private and community foundations, foundation "arms" of CHCs that operate as separate non-profits, other health care organizations, corporations and small businesses, charities, donations, public funds (Federal or state), and state providers of low-interest loans for housing. Most frequently, private funding for SDH efforts comes from foundations: 27 or more out of the efforts in IAF's database are funded at least in part by foundations, including 20 efforts that received funding from local foundations and 12 efforts that received funding from national foundations.

Operating Budgets and Donations

Given the difficulties with obtaining and sustaining funding and depending on the type of effort, CHCs may choose to rely on their organizational operating funds for an SDH effort. Leadership may also frame the use of operating funds to leverage the SDH as an appropriate and cost-effective marketing opportunity for the CHC, with community-focused SDH activities bringing additional patients to the CHC. Many CHCs also supplement their income stream with large annual fundraising events – e.g., an annual celebrity roast, auctions, golf tournaments, or dinner dances – to diversify revenue sources and enhance financial stability for programs. These fundraising efforts may bring in anywhere from $10,000 to $250,000 in additional funds.

Some types of resources such as free legal aid, donated goods and services, and voter registration forms, as well as AmeriCorps members, college student volunteers, and community resident volunteers, are free or sufficiently low-cost for the CHC to support using its operating budget. However, CHCs may also use their operating budget to get larger, more costly efforts going and then leverage early accomplishments and successes to attract additional and future funding and engagement. Alternatively, CHCs may use one- to three-year grants to test an effort

and demonstrate its value to staff and to the community; in such a case, a CHC may be more comfortable with using operating funds to sustain what has been shown to be a successful effort, if the original grant funding is discontinued. In all, 28 or more of the 176 efforts in the IAF database rely on internal funding (including general support and program area-specific donations to the CHC) to some degree.

Estimating the share of a CHC's total operating funds that go toward leveraging the SDH is a challenge. Sixteenth Street Community Health Centers estimates that 1.7 percent of its total operating budget in 2010 was directed toward its Department of Environmental Health programs, and Community Health Partners estimates that 3.4 percent of its operating budget for that year was directed towards its Learning Partners programs. La Clínica de La Raza and the Joseph P. Addabbo Family Health Center estimate that 5.5 and 6.7 percent of their respective budgets went toward leveraging the SDH. In contrast, Sea Mar Community Health Centers estimates that an astounding 28 percent of its total budget is directed to programs that address the physical, social, and/or economic conditions in the communities served.

Leveraging the SDH, however, is often built into ongoing operations, including hiring practices, referral systems, the supply and service needs of CHCs as community businesses, and the organizational mindset. At La Maestra Community Health Centers in San Diego, for example, the organization's "Circle of Care" philosophy applies a holistic view to patients' health and includes training all CHC staff to take part in the process of leveraging the SDH by identifying the total needs of patients and working together to address them through referrals or through the creation of new SDH efforts. Accordingly, the CEO of La Maestra has suggested, "If we are doing our job right, everyone is contributing to leveraging the SDH," and therefore a portion of every dollar is spent on leveraging the SDH.

Community gardening efforts provide opportunities for better nutrition, physical activity, and income generation. Photo credit: La Maestra Community Health Centers.

Sustainability

Among SDH activities, program sustainability comes in various forms. Some programs are sustained through government sponsorship as long as performance requirements are met at each renewal, as in the case of charter schools, WIC, and government subsidies for low-income housing. Some efforts that require relatively heavy investment in the early phase of the initiative become self-sustaining when paired with income-generating opportunities. Examples include housing (with rental income) and community gardening programs (in conjunction with farmers' markets), both of which take some funds or resources to initially establish but thereafter can become self-sustaining.

Programs may also be considered sustainable if their cost is small enough to be funded through donations and/or the CHC's operating budget, or if no funds are required at all. This is true in the case of providing the opportunity for students to shadow health professionals (Community Health Center of Buffalo's partnership with Health Sciences Charter School) and providing nonpartisan voter registration forms to encourage civic engagement among eligible patients (St. John's Well Child & Family Center's Voter Engagement Program).

Most programs are not self-sustaining, and their funding varies over their lifetimes. SDH efforts often require outside funds and may simply cease to function if follow-on funding is not obtained in time. In response, CHC may

- Resurrect previous programs when funding does become available;
- Pare the effort down into practices or components that can be continued with or without funding through the operating budget;
- Apply to renew the same grant; or
- Move a program every one to five years from one grant to another to sustain the effort, including temporarily covering the cost of the program through the operating budget and modifying the design of the program to fit the funder's interests.

Results and Evaluation

CHCs often monitor their efforts in terms of, for example, the number of program participants, septic systems installed, or books distributed. But most CHC efforts in leveraging the SDH have not been formally evaluated, much less written up and published in scientific or academic literature. Of the 176 efforts in our database, we were able to obtain monitoring and evaluation results for only a few programs.

Monitoring and evaluation of these programs is challenging for a number of reasons. CHCs recognize that their SDH efforts tackle complex problems where the true program impact may not be evident until several years after a one-, two-, or three-year grant ends. In addition, it may be that not all of the individuals involved in the effort are patients of the CHC; therefore, the CHC may not have any documentation on individuals benefiting from the program. Furthermore, the CHC's population may be transient; some beneficiaries may leave the community before results can be observed or obtained. In addition, the CHC may have neither the resources nor the access to people with the skills needed to perform advanced monitoring and evaluation of projects and therefore may need to collaborate with an outside agency to complete these types of studies. In our database, we can identify 5 out of 176 efforts that have been evaluated either in part or in their entirety by a third-party evaluator with support from the CHC and the original funder. The CHC and evaluator for these are:

- Project for Rockaway Youth in Safety and Education – Joseph P. Addabbo Family Health Center and Baruch College, City University of New York (CUNY)[52]
- Menomonee Valley Sustainable Development Project – Sixteenth Street Community Health Center and the University of Wisconsin[53]
- Community gardening component of Ho'oulu 'Aina/The Kalihi Valley Nature Preserve – Kokua Kalihi Valley Comprehensive Family Services and the University of Hawaii[54]
- Raíces/Roots Youth Development Program – Centro Cultural Chicano and the University of Minnesota[55]
- Adult Basic Literacy Education program of the Learning Partners department – Community Health Partners and the University of Arizona[56]

This paucity of formal evaluations is reinforced by the findings of the CDN literature review for this project. Among the articles and websites reviewed by CDN, only three articles reported measured health outcomes. CDN also notes the 2004 review by Yancey and colleagues, who reviewed 23 "ethnically inclusive community level intervention studies" on promoting healthy eating and active living and state that less than half of of these studies included outcome evaluations.[57]

Notes

[46] "Physicians Highlight Overlooked Connection Between Social Needs and Health". Robert Wood Johnson Foundation, Vulnerable Populations Portfolio. December 8, 2011. *http://www.rwjf.org/vulnerablepopulations/product.jsp?id=73646&cid=XEM_2809280*.

[47] Consumer-directed boards do not, however, automatically guarantee commitment to addressing the social determinants of health. Some boards may be relatively more conservative and cautious, with financial concerns cited as a reason the CHC should not step beyond the traditional role of a health care provider.

[48] "Bureau of Primary Health Care, Section 330 Grantees Uniform Data System (UDS): National Rollup Report." Calendar Year 2007 Data. Available at *http://bphc.hrsa.gov/healthcenterdatastatistics/nationaldata/2007/2007_nat_uds_summary.pdf*.

[49] "Community Health Centers, Health Care Providers and Leveraging the Social Determinants of Health: A Representative Review of the Literature." Prepared by the Clinical Directors Network for the Institute for Alternative Futures Project on Community Health Centers Leveraging the Social Determinants of Health. Available at *http://www.altfutures.org/pubs/leveragingSDH/CDN-LiteratureReview.pdf*.

[50] Ibid.

[51] Per communications with the Reach Out and Read National Center, July 2011.

[52] Van Ryzin G, Weikart L, and Ronda M. "Evaluation Report: Project for Rockaway Youth in Safety and Education". Baruch College/CUNY School of Public Affairs. February 2004. *http://www.sshs.samhsa.gov/media/sshs_media/pdf/PRYSE_Final_Evaluation_Report.pdf*

[53] "2005 State of the Valley Report: Evaluating Change in Milwaukee's Menomonee Valley". Menomonee Valley Benchmarking Initiative. *http://epic.cuir.uwm.edu/mvbi/05_report.htm*.

[54] Hsu et al. "Pathophysiologic differences among Asians, Native Hawaiians, and Other Pacific Islanders and Treatment Implications". *Diabetes Care*. Forthcoming 2012; and Look, M. A., Usagawa, T., Yoshimura, S., & Rothfus, N. (2009). "Diabetes self-management using culture-based education: Land, food & health." Presented at the 11th Campus-Community Partnership for Health Conference Portland, Oregon. *http://www3.jabsom.hawaii.edu/native/docs/community/Ulu_Reports_4%28Land_Food_and_Health%29.pdf*.

[55] Allen M, Svetaz M, Hurtado GA, Yon KJ, Okuyemi K, and Marczak M. "Utilizing CBPR to Develop and Pilot a Parent-Based Substance Use Prevention Program for Latino Youth". 2010. *Journal of Adolescent Health*, 46(2), S60; and Allen M, Hurtado GA, Goldade K, Lewallen L, Stoppa P, and Svetaz M. "157. Parenting Values and Practices of Immigrant Latino Parents of Youth: A Qualitative Study". 2011. *Journal of Adolescent Health*, 48(2), S99-S99.

[56] Weiss BD, Francis L, Senf JH, Heist K, Hargraves R. "Literacy Education as Treatment for Depression in Patients with Limited Literacy and Depression: A Randomized Controlled Trial". *J Gen Intern Med.* 2006 Aug;21(8):823-8. *http://www.ncbi.nlm.nih.gov/pubmed/16881941*.

[57] Yancey AK, et al. "Population-based interventions engaging communities of color in healthy eating and active living". *Preventing Chronic Disease*. 2004; 1(1):1-12. Accessed at *http://www.cdc.gov/pcd/issues/2004/jan/03_0012.htm*.

Recommendations

A draft version of the above observations and insights were reviewed and enhanced by CHC leaders and relevant experts at a National Workshop on September 26-27, 2011, in Alexandria, Virginia. The workshop participants (identified in the Appendix) also considered what CHCs, national leaders, funders, and others should do to expand, support, and enhance the work of CHCs in leveraging the SDH. The following are the recommendations these workshop participants developed for the field, as well as the principles that guided their development.

Making leveraging the SDH more common among CHCs

1. **Develop and implement a systematic process for identifying community strengths and needs, beyond clinical and basic demographic information, to identify and map the SDH.** Doing so will help CHCs engage communities as a whole in a dialogue about their priorities in addressing the SDH. Community mapping, needs assessments, and polls provide avenues for such a systematic process. Specifically:
    a. The community should manage the needs assessment process.
    b. The assessments should go beyond health care needs; community strengths and weaknesses in terms of the SDH can be mapped.
        – Look for the "positive deviants" in communities (i.e., those who have achieved superior outcomes with the same resources) and try to figure out how to scale the approaches that have made them successful relative to others in their communities.
    c. The assessment should seek to identify opportunities that connect various community stakeholders, including CHCs.
        – Conduct or piggy-back on community assessments and polls to identify high-priority issues around which to start a local, cross-sectoral dialogue. Polls provide an opportunity to create political will, test messages, and learn which sectors are interested in the topic. CHCs can approach local newspapers or others for a nominal fee to add questions to surveys that may already be planned or ongoing.
    d. Improve coordination and reduce redundancy among CHCs, hospitals, school systems, and public health departments in conducting community needs assessments. Different frequency requirements exist for different types of organizations, and there is an opportunity to consolidate the process to some degree and to allocate resources that would emerge out of this change to leveraging the SDH.
        – Be aware that as communities change rapidly, these assessments should be conducted periodically and frequently enough to recognize change in community needs and priorities in a timely manner.
2. **Create and promote the use of a standardized health risk assessment for each patient that goes beyond conventional physical or behavioral health conditions to include the SDH.** HRSA, NACHC, or other relevant organizations should enhance existing assessments or develop an appropriate assessment to increase the availability, quality, and use of data on SDH affecting patients and communities served. Such

an assessment should become a routine part of patient assessment and care, and should be integrated into the patient intake questionnaire, electronic health records, and CHC registries.

3. **Recognize leveraging the SDH as an important component of case management, and provide support accordingly.**
    a. Expand the Patient-Centered Medical Home (PCMH) to be a collaborative model for patient-centered justice including access to services such as educational support, housing, food advocacy, and legal services. Doing so requires including leveraging the SDH in the case management model.
        – For models related to PCMH, whether a CHC has or has not yet implemented the Chronic Care Model, the Comprehensive Health Home, or the Community-Centered Health Home, incremental advancement of case management at the point of service will necessarily include leveraging the SDH.
    b. CHCs are required by HRSA to provide enabling services (e.g., case management, health education, and supportive counseling), and they are expected to customize their design to fit the needs of their communities as long as it serves the core purpose: to provide comprehensive patient care and facilitate access to social services and health care. However, CHCs are often not adequately reimbursed or funded for enabling services. With funding, this existing system offers a platform for including services that foster increased access to educational support, housing, food advocacy, and legal services.

4. **Enhance CHCs' position as role models of socially just workplaces and health-promoting organizations.** NACHC and BPHC should support FQHCs and PCAs in looking at how their own staffs are impacted by the SDH. CHCs should set an example as inclusive and fair organizations in terms of power distribution and pay (with all employees making at least a "housing wage"). NACHC and BPHC can also encourage CHCs to integrate healthy workplace practices such as providing access to healthy foods (either free-of-charge or in vending machines), places to store and prepare fresh foods, and spaces suitable for exercise or walking.

5. **Recognize and raise awareness that leveraging the SDH is integral to the work of CHCs and other health care providers.** For this purpose:
    a. CHCs and others need to understand and communicate that work in leveraging the SDH is part of the CHC movement, and part of improving health outcomes and the quality of the center's work.
    b. CHC staff at all levels should be trained and knowledgeable about the SDH.
    c. NACHC should support this effort by raising these issues and building awareness among CHCs and PCAs through NACHC Policy and Issues Forums.
    d. BPHC should support these efforts by making it easier for CHCs to report the nature and scope of their SDH efforts to the Uniform Data System and Electronic Handbook. Discussions on this should be initiated as soon as possible.
    e. HRSA should create a Program Assistance Letter or similar document to provide encouragement and tools or approaches for CHCs to assess and respond to the impact of the SDH on their patients and their communities.

Developing an evidence base for leveraging the SDH, and identifying and disseminating best practices

6. **Pilot learning communities should test ideas and interventions for CHCs and other organizations engaged in leveraging the SDH.** Led by NACHC, CMMI, and BPHC, doing so will help to:

a. More quickly move from promising activities to evidence-based practices on which FQHCs and others can draw for leveraging the SDH.

b. Demonstrate economic implications of leveraging the SDH for the community, the CHC, and the health care system.

Opportunities to implement this recommendation include the CDC Community Transformation Grants Program, CMMI Health Care Innovation Challenge, and other related efforts such as Healthy Cities/Healthy Communities, and Transition Initiatives or community efforts to promote sustainability.

Building the SDH into existing breakthrough collaboratives

7. **To create a national learning community, HRSA should include the leveraging of the SDH in *existing* national breakthrough collaboratives**, e.g., the Patient Safety and Clinical Pharmacy Services collaborative and the Healthy Weight collaborative.

    a. CHCs have numerous examples of best practices, and need opportunities to share these practices and to learn from others. They learn best from peer learning, and have already demonstrated success with the chronic disease breakthrough collaboratives where participants create story boards and registries to broadcast and report the information exchange. Including leveraging of the SDH in existing national breakthrough collaboratives will facilitate greater acceptance and more rapid progress in improving population health.

Incentivizing engagement of the SDH

8. **HRSA, CMMI, and CDC should reward action steps taken toward addressing the SDH as part of relevant payments and non-economic recognition available to all CHCs.** To change the outcomes of the current health care system, it is necessary to align resources and create a cultural shift supportive of engaging the SDH. Tactics to implement this recommendation include:

    a. Using Requests for Proposals as opportunities to encourage leveraging the SDH and in the scoring process reward collaborative efforts that span across CHCs, health departments, places of worship, housing authorities, and others. This was already a successful strategy with the breakthrough collaboratives to elicit participation among CHCs.

    b. Combining or enhancing reimbursement for types of enabling services that leverage the SDH.

9. **National organizations relevant to leveraging the SDH, including NACHC, the Prevention Institute, ASTHO, NACCHO, TFAH, and APHA, should work to create and shape research and a Request For Proposals for CMMI's Population Health Models Group, which includes representatives from other sectors (e.g., education, housing, agriculture).** This collaboration should inform funding streams from CMMI by helping them define and address population health. Some principles that would support these efforts include:

    a. Expanding the scope of eligible organizations (beyond those that directly focus on health, such as housing organizations or educational institutions) to lead local population health efforts;

    b. Focusing on Medicare and Medicaid together, not separately; and

    c. Having a focus on services broadened, integrating health care services into services of other sectors as well as integrating other services into traditional health care settings (education, literacy, legal support, housing support).

10. **Driven by the HHS secretary, HRSA should lead a formal interagency group that systematically comes together to promote, advance, and support efforts addressing the SDH within communities.** HRSA is already a leader in integrating primary care, behavioral health, and public health through the enabling services program, which includes leveraging the SDH. Taking the lead on organizing a formal interagency group will allow HRSA to take ownership on addressing the SDH and give it a "home" within the Federal structure.
    a. The Affordable Care Act (ACA) asks for this type of interagency effort, and HRSA is already working in partnership with CMS, CDC, USDA, the Environmental Protection Agency (EPA), the U.S. Department of Housing and Urban Development (HUD), and others within and outside of HHS, including national, state, and regional cooperative agreements with partners that work directly with CHCs. HRSA has the opportunity to link common program activities across different agencies. Partnerships are currently conducted in a fairly ad hoc manner and a more systematic process is needed.
    b. Possible candidates for taking on the function recommended here may be the Federal Interagency Health Equity Team (FIHET) and the National Prevention, Health Promotion, and Public Health Council (National Prevention Council). FIHET seeks to facilitate activities of the National Partnership for Action to End Health Disparities between federal agencies. This team includes representatives of USDA, DOC, DOD, ED, EPA, HUD, DOJ, DOL, DOT, VA, HHS, and the U.S. Consumer Product Safety Commission, and can collectively address the broad range of SDH. The National Prevention Council, called for by the ACA, provides coordination and leadership at the Federal level and among all executive agencies regarding prevention, wellness, and health promotion practices. It is composed of the heads of 17 federal agencies and chaired by U.S. Surgeon General Regina Benjamin.

11. **Cross-sectoral dialogues on leveraging the SDH in multiple settings should be organized to build partnerships between health and other sectors**, including
    a. At the national level on the National Prevention Strategy;
    b. At the regional level with state offices of Medicaid, health departments, PCAs, departments of education, and school systems;
    c. At the local level with CHCs inserting themselves into local non-health forums and inviting non-health players to communities' tables. CHCs may consider inviting members of other sectors (e.g., housing, education, transportation, agriculture, or regional planning commissions) to join their boards or multi-sectoral advisory boards or subcommittees created by the CHC. Likewise, CHCs and other community health voices should be part of local sustainability and development discussions;
    d. Across all levels, organizations such as NACHC, PCAs, local clinic networks, foundations, and the Chamber of Commerce should involve clinic staff, patients, providers, public agencies, businesses, and the community to raise awareness of the SDH and help communities own the concept.

12. **Philanthropy should support building a bridge between the SDH and the clinical setting.** As leaders in their communities and as an important voice in the health and health care communities, funders and funder associations or partnerships (such as Grantmakers In Health and the Convergence Partnership, which are already funding efforts related to the built environment, healthy eating, and active living) should educate colleagues and other funders – particularly those that fund health care initiatives – in an ongoing fashion about:
    a. The role of the SDH in health and health outcomes; and
    b. Funding strategies and initiatives for supporting efforts that address the SDH.

Communication Strategies for Leveraging the SDH

13. **Those promoting efforts to leverage the SDH should frame them in ways that are intuitively meaningful to multiple sectors, the general public, and the entire community.** Rather than telling others that they need to be concerned about health, repackage health messages into ideas and language that take into account the concerns and priorities of other sectors, promoting cross-sectoral coalitions. Strategies to implement this recommendation include:
    a. Using terms or phrases that translate across sectors, such as "livability," "sustainability," "community resilience," "equal opportunity for health and wellbeing for all," "national strength," and "community health and wellbeing";
    b. Using media such as videos to share stories related to the SDH as told by non-clinicians, policymakers, politicians, and others; and
    c. Taking advantage of particular opportunities or apertures in messaging to heighten relevance and impact. For example, in discussions on the Federal Government and budget cuts, there is an opportunity for messaging about economic implications for communities, CHCs, and the health care system, as well as about how addressing social justice, disparities, and the workplace actually creates a vibrant, local economy that contributes to the national economy, thus presenting health as a vital economic input.

14. **CHCs and other health care providers should collaborate with community members to articulate a clear vision for the community's future, and align efforts to leverage the SDH with that vision.** The formulation of a community vision can help CHCs develop their efforts in leveraging the SDH with intentionality and promote community engagement, and can help CHC boards, staff, and executive teams promote the idea of the SDH and pass on community aspirations to future generations of staff and community members.

Principles Shaping the Recommendations

During the workshop and subsequent discussions, participants identified several principles that shaped their recommendations for leveraging the SDH, and should influence their implementation:

- There is a way forward using the strengths CHCs already have, and preference should be given to identifying, influencing, and leveraging existing resources within and outside the health sector rather than requesting new funds or changes in legislation. Existing regulations and program expectations allow for leveraging the SDH. For example, HRSA expectations for CHC programs covered under section 330 of the Public Health Service Act (i.e., CHCs, migrant health centers, health care for the homeless grantees, healthy schools, healthy communities grantees, health services for residents of public housing grantees, PCAs, and primary care offices) already allow much of what is being called for in these recommendations.
- CHCs have limited time and resources. Information must be pooled in order to bring out best practices and present them in formats that are easy for organizations of any size and resource level to use.
- The goal should be to integrate prevention more widely and promote social justice for all, in the community and within the CHC.
- CHCs should address the full spectrum of strengths and needs of their patients and communities.

- The SDH do not lend themselves to short-term interventions and measurable cost reductions. We need long-term attention to innovation in understanding the SDH and in documenting effective interventions.
- True community health requires an understanding of community dynamics. Metrics must be developed to capture community dynamics in order for interventions to be replicable.
- Clinical data systems must be adjusted to include information on the SDH. Innovation is needed here.
- As innovators in leveraging the SDH, CHCs only affect a small percentage of the potential levers for improving community and population health. A more ambitious agenda is needed – one that goes well beyond health care. The agenda must move *beyond the medical model* and health care system, seeking expertise from other sectors (e.g., housing, transportation, education) for addressing population health.

CHCs may promote early childhood development and school readiness by offering or making referrals for childcare and preschool programs. Photo by Chieko Horn, courtesy of Community Health Partners.

Conclusion

IAF's approach to understanding and creating the future calls for communities and organizations to identify what they think is likely and more importantly what they prefer. Deeply shared aspirations should guide planning, strategies, and actions taken today so they then move toward preferred futures. Otherwise planning is overly biased by reactions to past and current problems and a suboptimal future that people in organizations often implicitly assume is likely. Instead, Community Health Centers Leveraging the Social Determinants of Health offers IAF's commitment to identify the most promising advances for bringing health gains to the poor and underserved and to accelerate the development and deployment of these advances to reduce disparities. This report thus offers an implicitly hopeful future emerging from NACHC's partnership and the support of the Kresge Foundation. We have created this unique look at the potential for improving population health along with our analysis and recommendations to help health care providers and communities work toward their preferred future. The results of this project lead us to believe strongly that CHCs and other health care providers leveraging the SDH will make important contributions to health equity. We encourage CHCs, the health care community, policy makers and funders to consider and adopt these recommendations.

Page 53 –Many CHCs encourage physical exercise, as in the case of this program that provides bicycle-related activities for elementary and middle school students. Photo credit: Kalihi Valley Instructional Bicycle Exchange.

Appendix: Acknowledgements

Advisory Committee

This project has been guided by an Advisory Committee, the members of which repeatedly and generously provided input and feedback on the design and details of project activities and deliverables. Their support has proven invaluable. Members of the Advisory Committee are:

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Experts Providing Input and Interviews

We also would like to truly thank the following individuals, who participated in interviews that helped IAF understand the significance and the circumstances of CHCs' efforts to leverage the SDH, and supported the development of in-depth case studies of several of these efforts:

- **Antoinette Angulo**, Sea Mar Community Health Centers
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Workshop Participants

On September 26-27, 2011, CHC leaders and relevant experts met in Alexandria, Virginia to review and enhance the findings of the project, share their insights, and develop the recommendations in this report. IAF is grateful for their time, enthusiasm, and contributions. Participants include:

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Virtually all CHCs seek to improve nutrition and often do so through community gardening programs, nutrition classes, farmers' markets, and food pantries. Photo credit: La Maestra Community Health Centers.

Workshop Advisors

The IAF project team would also like to acknowledge the following individuals for their role as technical advisors to the workshop:

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Some CHCs provide childcare as an "enabling service." Photo by Chieko Horn, courtesy of Community Health Partners.

Beaufort-Jasper-Hampton Comprehensive Health Services

Ridgeland, South Carolina

Beaufort-Jasper-Hampton Comprehensive Health Services (BJHCHS) is one of the country's oldest CHCs. BJHCHS opened in 1969 to address the health needs and improve the living conditions of residents in South Carolina's Lowcountry community, and has grown into a Federally Qualified Health Center with more than 200 personnel and 16 sites. With a budget of around $13.9 million, BJHCHS served approximately 17,900 rural residents through 80,900 patient visits in 2010. The CHC predominantly serves African-Americans, but also provides services to many Caucasians and Hispanics. Slightly over half of BJHCHS's patients are uninsured, one-fifth have Medicaid coverage, and the remaining are split between Medicare and private insurance. Virtually all fall at or below twice the Federal Poverty Level.

With the philosophy that "health is a right, not a privilege," as well as an understanding of health as the product of a patient's total environment, BJHCHS addresses the SDH by improving lunch programs at local schools, encouraging healthy cooking, promoting accessible opportunities for physical activity, providing substance abuse and behavioral health services to help residents obtain and hold jobs and to encourage youth to pursue post-secondary education, and working with county agencies that define policy and control local resources, such as land for community gardens and walking trails. A past BJHCHS effort to inspect the homes of elderly patients for safety and providing assistance to prevent falls is an example of an SDH effort that was seamlessly integrated into clinic operations. BJHCHS has also been successful in improving water quality and environmental health and safety. The CHC has eliminated parasitic worm infections among local children by prescribing and providing septic tanks and deep wells, has helped organize water systems and fire protection for two counties, and has worked with state government to change policy and mandate better sanitary services.

In general, BJHCHS relies on clinical observations, ongoing community interactions, and continual evaluations of community health disparities by CHC leadership to identify SDH opportunities. BJHCHS' Director of Special Programs assists in defining and guiding the goals and objectives for SDH programs, and in the past the CHC included a department specializing in implementing environmental interventions such as septic systems and wells. When BJHCHS lost funding for this unit, its former employees created their own small business and today continue their work by competing for contracts awarded by the CHC with support from United Way.

For grant development and program management, BJHCHS tends to create project-based teams – that is, the CHC identifies the appropriate people both within the health center and among community partners, and requests their support once a funding opportunity has been identified. A consortium is then formed with appropriate community partners to create the proposal and manage it once it receives funding. The CHC's Pathways in STEP (Sheldon Township Empowerment Program) Recapturing the Legacy effort is an example of a project-based team that collaborates with community residents and organizations to design the effort.

The full case study is available at *http://www.altfutures.org/pubs/leveragingSDH/IAF-BJHCHS-CaseStudy.pdf*.

Centro de Salud Familiar La Fe

El Paso, Texas

In 1967, a group of women in Segundo Barrio in El Paso, TX, banded together to take action against the poverty, unemployment, lack of health care, and gang activity that were rampant in their community. They envisioned a social-justice organization that would address Total Wellness – a holistic approach to making the community healthy and strong that ensured the right to quality health care, job access, education, affordable and decent housing, preservation of cultural traditions, respect for family values, and a vibrant and flourishing arts and cultural environment. With partners they created a one-room clinic that has grown into Centro de Salud Familiar La Fe (La Fe), a Federally Qualified Health Center with nearly 500 personnel that leads 23 diverse medical and social-service sites serving the entire West Texas region. In 2010, with a budget of more than $25 million, La Fe served more than 30,000 urban residents, largely of Latino origin, through over 300,000 patient visits. Two-thirds of patients were uninsured, one-quarter had Medicaid, and 82 percent lived at or below the Federal Poverty Level (FPL). Only one percent had incomes above twice the FPL.

La Fe works to "improve the quality of life of those we serve by continuously enhancing the health and human services provided." The CHC has been leveraging the SDH particularly in youth development, employment, and education. La Fe's many efforts include providing adult education classes and youth arts and culture classes; supporting entrepreneurialism through a culinary academy; fostering pride and a sense of responsibility among Latino men for their children; bringing together volunteers age 55 and over with seniors in the community to support families or professional caregivers, or simply to be a friend; developing a mixed-income housing complex; creating a dual language immersion program for students in pre-K through 5th grade; promoting civic involvement in system changes in health and social policies; providing job training and free legal aid; and creating a neighbor-to-neighbor network for providing medical care in exchange for community service, thus building and strengthening the bonds of trust and caring among residents.

The executive director is a direct and driving force behind La Fe's consistent efforts to leverage the SDH, as in the case of the La Fe Policy, Research, and Education Center (La Fe PREC), which grew out of a long-held interest shared between the La Fe executive director and the person that would eventually lead La Fe PREC. Many efforts, such as the culinary academy, have grown out of monthly meetings among senior staff to discuss their work, to identify opportunities, and to collaborate. The La Fe Culture and Technology Center in particular came about when art programs in local public schools were getting cut and the CHC deemed that type of education too important for the community to lose. Several senior staff members develop grant proposals in addition to their other responsibilities within La Fe, in collaboration with staff and directors from La Fe departments or subsidiaries. Most of La Fe's SDH work is managed through specialized internal departments that may be physically separate from the clinics or subsidiary non-profit entities with their own staff, offices, and funding streams. These entities in turn often partner with one another.

The full case study is available at *http://www.altfutures.org/pubs/leveragingSDH/IAF-LaFe-CaseStudy.pdf*.

Community Health Partners

Livingston, Montana

Community Health Partners of Montana (CHP) is a Federally Qualified Health Center serving low-income rural community residents in Park and Gallatin Counties since 1998. With just over 100 personnel, a budget of $5.8 million, and seven sites, including medical and dental clinics and an educational site, CHP served about 10,600 community residents through 39,000 patient visits in 2010. The CHC predominantly serves Caucasians but also provides services to many Latinos, Native Americans, and others. Two-thirds of patients are uninsured, 13 percent have Medicaid coverage, 14 percent have private insurance, and 65 percent fall at or below twice the Federal Poverty Level (FPL).

CHP works "to enhance community health and wellbeing through innovative programming, strong partnerships, and improved outcomes with a vision for 100% access and zero disparity." CHP's efforts to leverage the SDH focus on providing educational programming within the clinic walls. To help adults and children reach their potential and to elevate them out of poverty, CHP founded Learning Partners (LP) to advance education and expand job preparedness. In 2010 alone, LP provided 26 affordable computers to families, helped 37 residents earn a GED (in a town that has an average graduating class of 110 students), and distributed 200 books each month through the Reach Out and Read program at CHP pediatric clinics. LP also placed 18 adults in subsidized employment and provided workplace training for 94 participants. The department also manages teen and adult parenting classes as well as an Even Start preschool program. In 2010, 44 families participated in the preschool program and an average of 45 parents and children attend CHP's weekly Open Gym. CHP's adult literacy program has been formally evaluated with support from the University of Arizona and found to significantly increase self-efficacy and significantly decrease depression symptoms among participants. Furthermore, CHP has played an instrumental role in establishing SDH-addressing organizations or coalitions that work semi-independently of the CHC. For example, CHP initiated a dialogue with community partners about providing affordable housing commensurate with living wages, and this dialogue led to the creation of a coalition of local social service agencies, businesses, and community members working on solutions to homelessness in the area. CHP was also instrumental in creating a local foundation to identify and monitor the community health and wellbeing drivers and to then support dynamic community action.

Most of CHP's efforts to leverage the SDH have resulted from clinical observations and interactions with community members. For example, clinical staff noted that parents were visibly uncomfortable when asked to read to their children, leading to the development of adult literacy classes. It was a patient who proposed the affordable computers program. LP is an example of a formal CHC division that specializes in leveraging the SDH with dedicated staff, and CHP estimates that 3.4 percent of its 2010 operating budget was directed towards LP programs. These activities are often funded through grants prepared and monitored by the LP department head. Some, however, are self-sustaining, such as the computer recycling and rebuilding program described above.

The full case study is available at *http://www.altfutures.org/pubs/leveragingSDH/IAF-CHP-CaseStudy.pdf*.

Hudson River HealthCare

Peekskill, New York

Hudson River HealthCare (HRHCare) began in 1975 as a single clinic located in an old department store, based on a community effort spearheaded by a group of four women to bring affordable health care to the people of Peekskill. Since then, HRHCare has grown into a Federally Qualified Health Center with a network of 18 sites serving 65,000 urban and rural community residents in 2010. HRHCare predominantly serves Latinos but also provides services to many African-Americans and Caucasians. Approximately one-third of patients are uninsured, one-third are enrolled in Medicaid, and 14 percent have private insurance.

The CHC works "to increase access to comprehensive primary and preventive health care and to improve the health status of our community, especially for the underserved and vulnerable." HRHCare's efforts in leveraging the SDH frequently concentrate on helping clients modify lifestyle choices (nutrition and physical activity) and supporting youth development. SDH efforts to date include improving opportunities for physical exercise, such as creating a paved path for local children and providing donated bikes and helmets; offering WIC services; promoting childhood literacy through Reach Out and Read; addressing housing needs through assistance with home purchases and necessary home improvements; lobbying the county bus system to improve mobility; providing leadership and employment programs for teens; and promoting social inclusion among seniors by providing activities to remain active and mentor youth. The Health Unites Generations program in particular boasts a 50-60 percent retention rate among participating youth and seniors. HRHCare also took the lead in working with local Migrant Head Start programs to improve nutrition and collaborated with the New York State Migrant Program Parent Advisory Committee to successfully change the kind of milk that was served in Migrant Head Start centers across the state to be low-fat milk.

Generally, two HRHCare staff members work with program area directors to develop grant proposals, and most SDH programs are managed by the Department of Community Initiatives, though housing-related activities are carried out through a specialized HRHCare subsidiary, The Preservation Company. To identify opportunities for leveraging the SDH, HRHCare maintains an open dialogue and briefings among its board of directors and staff for cross-pollination among program areas as well as community members and organizations. Staff may then consult electronic health records and community surveys to confirm the need for a program. For example, the idea for a childhood obesity prevention program was sparked by a clinical staff member and developed into an actual program after it was confirmed that the community had one of the highest rates of childhood obesity in the state. SDH efforts have also been prompted by anecdotal observations of CHC staff, such as a social worker noting that seniors living in a public housing project were looking for opportunities to socialize and venture out, or by a highly publicized event such as the violent beating of an immigrant in the community, which inspired HRHCare to develop an additional youth development program.

The full case study is available at *http://www.altfutures.org/pubs/leveragingSDH/IAF-HRHCare-CaseStudy.pdf*.

Joseph P. Addabbo Family Health Center

New York, New York

The Joseph P. Addabbo Family Health Center (Addabbo) started out as a free pediatric clinic in 1981 and has developed into a Federally Qualified Health Center that will soon open its seventh site. The CHC has approximately 230 personnel. In 2010, with a budget of nearly $25 million, Addabbo served about 27,200 urban community residents through 152,100 patient visits. This CHC predominantly serves African-Americans and Hispanics, but also provides services to many Caucasians, Native Americans, and Asian or Pacific Islanders. Sixty-five percent of patients are covered under Medicaid, 17 percent self-pay, and 14 percent have third-party insurance. Almost nine out of 10 fall at or below 200 percent of the Federal Poverty Level (FPL).

With a mission "to be the leading preventive and comprehensive primary health care center in New York," Addabbo addresses the SDH based on grant opportunities that fit the needs of the community, as determined by the CEO and medical advisors who have ongoing interactions with the community, and through clinic observation. SDH efforts to date have mainly focused on youth intervention and family socioeconomic stability to break the poverty cycle, but have also included planting trees in the city to improve air quality and livability, offering WIC services, creating a community garden, partnering with a local jail to facilitate re-integration of inmates into the community, and fostering a coalition to teach residents about emergency preparedness. The CHC has also organized a farmers' market that provides farmers and community garden participants with an opportunity to sell their crops.

Prompted by the Federal Safe Schools/Healthy Students (SS/HS) initiative, Addabbo has also led a three-year comprehensive multimillion dollar effort with more than 20 partners to deal with youth violence in the Rockaways and to promote a safe, healthy, and nurturing environment for students and families. Under this effort, the Project for Rockaway Youth in Safety and Education, the CHC organized open houses to share employment and career opportunities with youth; invited and trained clergy members in crisis counseling, signs and symptom recognition, and general health education; trained local adult and youth residents to serve as sources of reliable information; and operated a Community Resource Center to provide assistance with a wide range of needs, including after-school teen and family programs, counseling, and parenting classes. Baruch College CUNY evaluated the project and found positive trends in crime rate, parent involvement in schools, reading scores, and trust among neighbors.

Addabbo does not have a program planning department or a grant writing department, but instead designates these functions to the staff members who will be most involved with the effort, as determined by the CEO with support from the executive board. The health center estimates that approximately 6.7 percent of its 2010 operating budget was directed toward SDH programs, which are typically under the management of one staff member or of a project-based team of the staff members most directly involved with the effort. For example, Addabbo's director of mental health acted as the project manager for Project for Rockaway Youth in Safety and Education, together with a handful of CHC personnel.

The full case study is available at *http://www.altfutures.org/pubs/leveragingSDH/IAF-Addabbo-CaseStudy.pdf*.

Kokua Kalihi Valley Comprehensive Family Services

Honolulu, Hawaii

In 1972 leaders from local churches and the community formed Kokua Kalihi Valley Comprehensive Family Services (KKV) to address the unmet health and social service needs of residents in Kalihi Valley, Honolulu, Hawaii. The organization began with a staff of five to connect residents to existing agency resources. Eventually KKV began to provide health care services directly and has grown into a Federally Qualified Health Center with nine sites and 160 personnel. In 2010, KKV served over 10,000 urban community residents through approximately 40,000 visits. The CHC predominantly serves residents of Asian or Pacific Island descent, particularly Filipino, Micronesian, and Samoan community members, as well many other Asian and Native Hawaiian patients. Forty-three percent of patients are enrolled in Medicaid, 37 percent are uninsured, 15 percent are covered by third party insurance, and 96 percent or more live at or below 200 percent of the Federal Poverty Level.

With a mission to work "toward healing, reconciliation and the alleviation of suffering in Kalihi Valley, by serving communities, families and individuals through strong relationships that honor culture and foster health and harmony," KKV leverages the SDH through a variety of efforts while linking residents with one another, with the land, and with Hawaiian culture. Examples include establishing Hawaii's first domestic abuse shelter, which was eventually transferred to the management of a private non-profit organization; integrating legal assistance into the medical setting to help eliminate barriers to family stability, education, housing, and child care; providing social services, cultural orientation, crisis intervention, ESL classes, and health care to Laotian refugees; connecting people with a source of gently used clothing; offering sewing classes for middle and high school girls that live in public housing projects to develop job skills and their self-esteem; providing access to loans to encourage community development; taking the lead in creating a band program for public elementary school students; and nurturing trust and relationships among residents through "talk story" (a Hawaiian expression used as a noun or verb to mean "an informal chat") and the growing, preparing, and sharing of food.

KKV has also partnered with the community to develop a nature preserve, including community gardens and reforestation efforts which make exercise a natural part of the daily life for residents. The community gardening component of this particular effort has been evaluated with support from the University of Hawaii and found to be especially effective in helping patients lose weight. KKV has also supported the successful passage of a formal commitment make Honolulu a bicycle- and pedestrian-friendly city, and developed a youth bicycle exchange program that refurbished and provided nearly 2,000 bicycles to and installed 20 bike racks in the community over the course of four years.

Program ideas at KKV are primarily driven by staff and leadership through ongoing community interactions and clinical observations, though efforts have also been prompted by patients (e.g., the nature preserve), by the director of services at a local public housing project (e.g., the shelter for abused spouses and children), and by state cuts to school funding (band program). Program area coordinators at KKV manage SDH efforts and collaborate with a community development coordinator on grant proposals and funding, monitoring, and sustainability.

The full case study is available at *http://www.altfutures.org/pubs/leveragingSDH/IAF-KKV-CaseStudy.pdf*.

La Clínica de La Raza

Oakland, California

In 1971 a group of medical students opened a free clinic, La Clínica de La Raza, to provide affordable clinical care for low-income urban residents of Oakland, California. La Clínica has grown to become a Federally Qualified Health Center and is now among the largest of the state's CHCs with 800 personnel and 26 sites across three counties. In 2010, with a budget of $68.5 million, La Clínica served about 68,100 community residents through 328,200 patient visits. This CHC predominantly serves Latinos, but also provides services to many African-Americans, Caucasians, and Asian or Pacific Islanders. Forty-four percent of patients are uninsured, 43 percent are enrolled in Medi-Cal, and 96 percent live at or below 200 percent of the Federal Poverty Level.

The mission of La Clínica is to "improve the quality of life for the diverse communities it serves by providing culturally appropriate, affordable, high quality and accessible health care." Their efforts to leverage the SDH are inspired for the most part by their clinical experience as well as by listening to the communities served. Most SDH efforts at La Clínica have a foundation in education and advocacy and are primarily developed and managed within the Community Health Education Department, also referred to as Casa CHE. SDH programs include training community members as promotores; providing opportunities for youth to learn leadership and community action skills; providing pregnant and parenting teens and their children with safe opportunities, support, and relationships with caring adults; helping Latino men explore better adaptive ways to be a man, a husband and a parent; organizing a diabetes walking group, and a supervised group for planning nutritious affordable meals and shopping strategies; having health educators perform "puppet plays" in local school classrooms to prompt discussions on violence and what the child or teen could do when a violent situation arises; coordinating a network of culturally and linguistically sensitive domestic violence services and education for immigrants; and offering WIC services and classes on managing stress. In addition to these formal efforts, CHC staff often volunteer their own time with other agencies to improve the SDH, confront significant problems such as childhood obesity, and support health through active living.

In the development of a particular SDH program, La Clínica may conduct community surveys or focus groups to identify and better understand the issues to be addressed. However, efforts have also been prompted by observations, such as finding out that local stores were selling tobacco products to minors, or hearing community members at Casa CHE speaking about "difficulties" in their homes. To develop and manage proposals for SDH efforts under the purview of Casa CHE, the department collaborates with La Clínica's Planning Department. Though the CHC pursues most of its SDH efforts through Casa CHE, a specialized division with dedicated staff, La Clínica also leverages the SDH by integrating domestic violence prevention services seamlessly into its clinic operations and by providing a coordinator for a community network (e.g., East Bay Coalition Against Gender and Domestic Violence). In all, La Clínica estimates that 5.5 percent of its 2010 operating budget went toward leveraging the SDH.

The full case study is available at *http://www.altfutures.org/pubs/leveragingSDH/IAF-LaClinica-CaseStudy.pdf*.

La Maestra Community Health Centers

San Diego, California

In 1990 La Maestra Amnesty Center (LMAC) of San Diego, California opened La Maestra Family Clinic to meet the medical needs of immigrants, refugees, and low-income residents. Soon the clinic developed into an independent non-profit, eventually absorbing many of the social service programs performed at LMAC and changing its name to La Maestra Community Health Centers (La Maestra). The organization has grown into a Federally Qualified Health Center with more than 240 personnel and 15 sites, including four school-based medical and dental clinics. In 2010, with a budget of $15 million, La Maestra served about 37,800 urban residents through 110,800 visits. This CHC predominantly serves Latinos, but also provides services to many Caucasians, African-Americans, Asian or Pacific Islanders, and Native Americans. Sixty-three percent of patients are enrolled in Medi-Cal, 29 percent are uninsured, and 98 percent fall at or below 200 percent of the Federal Poverty Level (FPL).

La Maestra works "to provide quality health care and education, improve the overall wellbeing of the family, bringing the underserved, ethnically diverse communities into the mainstream of our society, through a caring, effective, culturally and linguistically competent manner, respecting the dignity of all patients." Every staff member is trained in identifying and addressing the patient's total needs, i.e., leveraging the SDH, as part of the organization's "Circle of Care" model. The CHC particularly believes in tailored and educational programs such as financial, language, and environmental literacy classes as the basis for any social change and effective health care outcomes, but is also involved in a variety of SDH efforts such as providing referrals and educational programs for first-time home buyers, promoting childhood literacy and offering childcare, creating a community garden, operating a food pantry, collaborating to organize a farmers' market, and developing an emergency and disaster plan in collaboration with other first-responders in the community. The CHC also provides micro-enterprise assistance and job training and placement. For example, from 1998 to 2003, the CHC trained over 560 community members to work as medical assistants, pharmacy technicians, eligibility workers, outreach workers, and referral clerks; six months later, 70% of these participants had remained at their jobs. La Maestra also noted the international success of microcredit programs in developing countries, and used county statistics reports to confirm its awareness of the high unemployment, poverty, and crime rate within the community. Today, more than 500 women are participating in the La Maestra Microcredit Program for Women, with a 98 percent repayment rate. The CHC also created a transitional housing program, where 60 percent of residents successfully recover from a variety of issues, including alcohol and substance abuse, and become and remain employed.

Although ideas for SDH programs may originate at any level of the CHC, most of these efforts are conducted through La Maestra's two specialized subsidiaries, La Maestra Foundation and the La Maestra Housing and Community Development Center. The CHC's general Fund Development Unit works with these subsidiaries to develop and manage proposals for their respective SDH programs. Some efforts, however, are seamlessly integrated with clinic operations, such as Reach Out and Read and a food pantry that caters to diabetic and other patients.

The full case study is available at *http://www.altfutures.org/pubs/leveragingSDH/IAF-LaMaestra-CaseStudy.pdf*.

Sea Mar Community Health Centers

Seattle, Washington

In 1977, a group of community leaders established a free clinic staffed by volunteers to address the health care needs of the Spanish-speaking community in western Washington. Since then, the clinic has grown into Sea Mar Community Health Centers (Sea Mar), a Federally Qualified Health Center and one of the largest community-based health providers in Washington, with more than 1,500 personnel and more than 60 diverse medical, dental, behavioral, and social-service sites. In 2010, with a budget of $125.7 million, Sea Mar served about 143,700 urban and rural community residents through 581,100 patient visits. This CHC predominantly serves Latinos and Caucasians, but also provides services to African-Americans, Native Americans, and Asians or Pacific Islanders. Forty-four percent of patients have Medicaid coverage, 41 percent are uninsured, and nearly 92 percent fall at or below 200 percent of the Federal Poverty Level (FPL).

Sea Mar works to provide "quality, comprehensive health and human services to diverse communities, specializing in service to Latinos," and leverages the SDH most frequently in youth development, social mobility (jobs and education), and housing. Sea Mar's many SDH efforts include helping youth pursue healthy alternatives to risky behaviors, develop leadership skills, and attend college with the help of a Sea Mar scholarship; providing adequate, safe, and affordable housing; offering citizenship preparation assistance; providing child care and early childhood education, including the Reach Out and Read program; offering WIC services, operating a community kitchen, and providing food literacy, nutrition, and meal planning education; helping increase healthy menu options at a local restaurant and inspiring a similar initiative in a nearby town; providing opportunities for children and elderly residents to socialize and to learn from each other; supporting employment and academic achievement among adults, youth who are behind in school, and youth who have dropped out of high school; and helping residents advocate for healthy eating and active living opportunities.

Beside suggestions from clients, staff, and members of the Sea Mar Board of Directors, the directors of each Sea Mar division meet regularly as a formal interdisciplinary team to develop and coordinate SDH programs and services. However, the Latino Educational Achievement Project to promote youth development and policies for improving the academic achievement of Latino students in the state began as a separate non-profit and was adopted by the CHC in 2010. Electronic health records and community surveys may be used to help decide whether or not to pursue a particular program idea, and most grant proposals are written and managed by two administrative staff members in collaboration with department heads, who are responsible for researching grants and sometimes may draft grant applications themselves to review with others. Each developed SDH program is then managed by the CHC department to which the effort is most closely related, though housing efforts are conducted through an affiliate LLC that is managed by a Director of Housing. In all, Sea Mar estimates that 28 percent of its total 2010 budget was directed to leveraging the SDH.

The full case study is available at *http://www.altfutures.org/pubs/leveragingSDH/IAF-SeaMar-CaseStudy.pdf*.

Sixteenth Street Community Health Center

Milwaukee, Wisconsin

In 1969, a group of community activists opened a free clinic to serve the urban, low-income, and multicultural residents of Milwaukee, Wisconsin. The clinic, eventually named Sixteenth Street Community Health Center (SSCHC), has grown into a Federally Qualified Health Center with more than 280 personnel and that is now in the process of establishing its fifth site. In 2011, with a budget of about $27 million, SSCHC served about 30,900 community residents through 155,200 patient visits. This CHC predominantly serves Hispanics, but also provides services to many Caucasians, African-Americans, Asians, and others. Fifty-nine percent of patients are enrolled in Medicaid, 11 percent have third-party insurance, 26 percent are uninsured, and 60 percent fall at or below 200 percent of the Federal Poverty Level (FPL).

SSCHC works to "improve the health and wellbeing of Milwaukee and surrounding communities, by providing quality, patient-centered, family-based health care, health education and social services, free from linguistic, cultural and economic barriers." Its biggest efforts to leverage the SDH are in addressing environmental conditions, though other programs and services are also provided, such as parenting skills classes, WIC services, Reach Out and Read, and social services. The environmental efforts grew out of a 1994 assessment that linked local factors including deteriorating lead paint in housing and poor air and water quality to the acute and chronic medical conditions of SSCHC clients. In response, the CHC established its Department of Environmental Health (DEH) to bring about positive change in the community, and in part to extend the reach of the Milwaukee Health Department. DEH trained and fielded a team of community health outreach workers who helped to successfully drop the prevalence of lead poisoning among children from 34 percent in 1996 to 1.8 percent in 2011.

Other efforts include the cleanup of several smaller brownfields, and a larger effort which was evaluated with support from the University of Wisconsin and which, after a decade, boasts the development of 300 acres of brownfields, 28 businesses, 4,200 family-supporting local jobs, over seven miles of trails, and 45 acres of native plants, leading to improved wildlife habitat and water quality. DEH has helped to establish "benchmarks" for monitoring local community, environmental, and economic conditions, and is now working on the rehabilitation and revival of another brownfield area and the development a more coherent set of policies and programs that will lead to improved water quality and the protection of the Great Lakes.

DEH program ideas usually grow out of inter-departmental networking within the CHC to identify opportunities and nurture innovative ideas and solutions. DEH has also led visioning and design exercises on ways to bring high-quality investors and family-supporting jobs back to the community, and works directly with community partners and other SSCHC divisions for many of its efforts. DEH established a separate non-profit organization to take the lead in the effort to redevelop the brownfields, including office and apartment construction. DEH raises its own funds through grants and donations, where the department lead is the chief grant-writer for DEH efforts, and the CHC estimates that 1.7 percent of its total 2010 operating budget was directed towards DEH efforts.

The full case study is available at *http://www.altfutures.org/pubs/leveragingSDH/IAF-SSCHC-CaseStudy.pdf*.

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