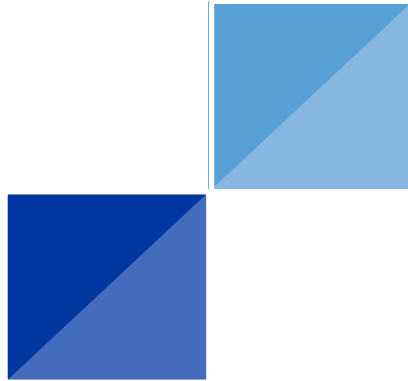# Community-Clinical Linkages

Implementing an Operational Structure with a Health Equity Lens

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About the Health Equity Guide

In the United States, people from different racial and ethnic groups have different rates of cardiovascular disease (CVD). They also have different rates of death from CVD. These differences are closely linked with unfair and unjust social, economic, and environmental disadvantages. Thus, CVD is a health equity issue with significant health, social, and economic consequences.

For definitions of terms related to health equity, see Resource 1.

To achieve health equity in CVD, we need evidence-based approaches designed with a health equity lens. Such approaches identify people who are at increased risk for CVD. They also acknowledge and address the historical and structural factors associated with CVD inequities.

Community-clinical linkages (CCLs) are connections between community and clinical sectors. CCLs strive to improve health within a community. CCLs are an effective, evidence-based approach to preventing and managing chronic diseases such as CVD. But little is known about how to implement CCLs with a health equity lens. The guide intends to fill that gap.

The guide is for practitioners in public health, community, and clinical sectors. It aims to help practitioners incorporate health equity when organizing a CCL's structure and supporting its operations, called an operational structure.

To produce the guide, we reviewed journal articles and publicly available information on CCLs, such as blogs, briefs, conference reports, and newsletters. We also spoke with CDC-funded recipients and health equity subject matter experts.

How to Use the Guide

The guide is not intended to serve as step-by-step instructions. Instead, you can use the guide to help decide what to adapt and use to start a new CCL or strengthen an existing one.

Introduction

Figure 1. Public Health Sector Linking Community and Clinical Sectors*

Community Sector

Composed of organizations that provide services, programs, or resources to community members in non-health care settings.

Public Health Sector

Composed of public health organizations that can lead efforts to build and improve linkages between community and clinical sectors.


Clinical Sector

Composed of organizations that provide services, programs, or resources directly related to medical diagnoses or treatment of community members by health care workers in health care settings.

* From Centers for Disease Control and Prevention. *Community-Clinical Linkages for the Prevention and Control of Chronic Diseases: A Practitioner's Guide.* Atlanta, GA: Centers for Disease Control and Prevention, U.S. Department of Health and Human Services; 2016.

The term "community-clinical linkages" highlights only community and clinical sectors. However, the public health sector is integral to CCLs. (**See Figure 1**.)

Public health organizations can play key roles in CCL efforts to address health equity. They can be leaders, facilitators, or partners. For example, they can:

- Use their relationships with organizations in community and clinical sectors to connect the sectors, such as barbershops or Federally Qualified Health Centers (FQHCs), respectively. It is especially important to work with organizations in "upstream" areas not typically within the purview of public health. Transportation and housing are examples of these areas.

- Collect, analyze, share, review, or use social determinants of health (SDOH) data at individual and population levels. They can also connect these data to CVD outcomes.

- Provide knowledge and technical assistance to help address structural and community factors that create and perpetuate CVD inequities.

- Highlight heterogeneity (e.g., different ethnicities and backgrounds within Black or Asian populations), chronic health conditions that occur together, and intersectionality among racial and ethnic groups. "Intersectionality" means overlapping social categories—such as race, class, and gender—that create interdependent systems of discrimination or disadvantage.

- Identify and share evidence-based approaches that can be reused or adapted for different racial and ethnic groups or settings.

- Provide infrastructure and support to increase capacity. For example, they can provide funding, staff, and expertise in areas such as evaluation.

- Link and align local and state efforts to national initiatives that explicitly address health equity, racial equity, or people who are at increased risk for CVD. Examples of initiatives include the Association of State and Territorial Health Organizations/Centers for Disease Control and Prevention Heart Disease and Stroke Prevention Learning Collaborative; the Centers for Medicare & Medicaid Services State Innovation Models Initiative; Million Hearts®; and the National Association of Chronic Disease Directors' President's Challenge FY 2021.
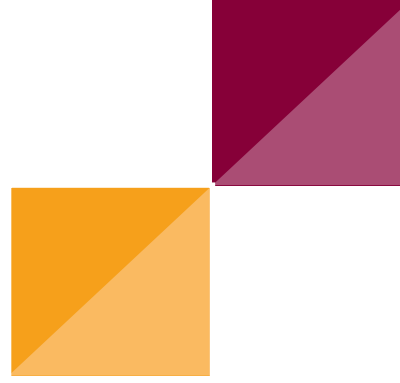
Components of a CCL's Operational Structure

Consider the following components when creating a CCL operational structure with a health equity lens. **See related action steps to each component below.**

Formal Commitment to Health Equity	**Communication and Decision-Making Processes**
Structural Considerations	**Staff (Workforce)**

You do not need to address these components in order. In some cases, you may need to revisit a component as you go, or you may be able to address multiple components at the same time. In other cases, it may make more sense to skip a component and come back to it later. Every CCL will have different needs and resources.

Formal Commitment to Health Equity

Potential Action Steps	✓
1. Include health equity and related concepts—such as social justice and structural racism—in formal statements and/or documents that describe and guide the CCL. These concepts could be included in vision and mission statements or strategic plans. Make sure community members most affected by health inequities and partners from community and clinical sectors are equitably involved in defining, writing, reviewing, and carrying out these documents. Resource 2 provides examples of partner organizations in each sector.	☐
2. Designate conveners and coordinators to attend to the CCL's basic organizational functions. They can strive to build trust among community members disproportionately affected by CVD inequities. They also can build trust among partners in both sectors. Resource 3 provides examples of their functions. Engaging racial and ethnic minority groups in ways that build or enhance trust is especially important as they may distrust health care systems. They also may have experienced public health efforts that were not sustained.	☐
3. Check that the CCL includes community members most affected by health inequities. Also make sure it includes traditional and nontraditional partners. CVD inequities are the result of complex, interrelated factors. That means it is important to include partners who can help improve social conditions such as food security, transportation, housing, and broadband access. Including these partners also recognizes that the groups most affected by CVD often face challenges and social conditions that they may view as more urgent than preventing or managing CVD.	☐
4. Develop formal agreements among partners which: • Outline a health equity–focused vision or mission. • Provide a timeline. • Describe each entity's commitment and support for the CCL's purpose in assuring health equity. • List roles and responsibilities. See Resource 4 for examples. Agreements might include memoranda of agreement, action plans, or contracts.	☐
5. Encourage partners to incorporate principles of health equity and the CCL into their initiatives. This step ensures that the CCL is not addressing health equity in isolation. Health care organizations have often used evidence-based health equity approaches independently of quality improvement and other efforts. Community-based organizations have found that implementing these approaches is challenging when those approaches are not part of the organizational structure and culture.	☐

Communication and Decision-Making Processes

Potential Action Steps	✓
1. **Have a formal mechanism to involve community members most affected by health inequities in the development and implementation of your CCL.** Engaging community members can make strategies work better and last longer. Initiative organizers often overlook people who are at increased risk for CVD. Organizers may also ask them only to provide input, serve as advisors, or endorse information. Instead, engage them as integral and equal partners in all phases of CCLs.	☐
2. **Establish a formal mechanism, such as a leadership committee, to continually engage champions and community leaders from both sectors.** Champions and leaders can influence the speed, scope, scale, and success of a new CCL. Their influence can be positive or negative. For example, if a leader feels that a CCL is not aligned with their organizational interests, they may not support it.	☐
3. **Hire a facilitator.** The facilitator can help obtain buy-in from community members most affected by inequities as well as traditional and nontraditional partners. Having a facilitator who can convey the purpose of the CCL can build participant support for a common vision. This step is important for a few reasons: • Addressing health equity involves judging what is avoidable, fair, and just. • Health equity topics include implicit bias, privilege, and racism. Confronting these topics can make some people feel uncomfortable or defensive. • A few doctors do not believe their patients are affected by health inequities or do not support addressing SDOH.	☐
4. **Make it as easy as possible for people who are at increased risk for CVD to be involved with all phases of CCLs.** Some CCL participants may not be able to commit to attending meetings at certain times. They may have competing priorities. Consider flexible and nontraditional meeting times and venues.	☐
5. **Check that community members and partners have a shared understanding of key health equity terms and concepts.** Use these terms and concepts often and consistently in documents, meetings, presentations, and other forums. (See Resource 1 for examples.) Like every discipline, public health has its own jargon and acronyms. There are also wide variations in how terms are used. For instance, doctors may use the term "obesogenic environments" for what community advocates call "food deserts" and "food swamps."	☐

Potential Action Steps	✓
6. **Convene a small team to help with implementation.** Engaging all community members and partners in all implementation stages will likely be unmanageable. Instead, create a small advisory group or committee to help with many aspects of implementation. The group can solicit the larger group's input when needed.	☐
7. **Use health equity data to continuously adapt, improve, and communicate about the CCL.** *Using* health equity data is harder than *collecting* it. Many initiatives have formal meetings to discuss and guide their ongoing use of data. These meetings promote smooth implementation and process improvement. They also can help build trust, support collaborative learning, improve transparency, and foster positive relationships. Resource 5 presents example data sources for national, state, and local disparities in CVD. CCLs can use the data to inform decision making.	☐
8. **Build systematic and formal processes that encourage partners in both sectors to learn how changes in community and health care landscapes may affect people at increased risk for CVD.** For example, the shift from fee-for-service to value-based payment may discourage health care organizations from working with people who are more affected by adverse SDOH (e.g., people who experience homelessness) to avoid penalties for higher hospital readmission rates.	☐
9. **Use formal dissemination plans to share promising practice- and evidence-based information with community members and CCL partners.** Make sure that the information is relevant to them, and share it in appropriate formats. Partners in both sectors who focus on health equity often do not adopt evidence-based strategies and practices because they feel that the evidence is not applicable to their specific populations. These partners may feel that it is easier to create their own programs. Other reasons for not adopting evidence-based strategies and practices include limited ability to assess published research, information overload, and limited time to keep abreast of the latest research. For example, implementers of a CCL working with FQHCs lacked the time to train staff on new clinical guidelines.	☐
10. **Include health equity language and concepts in the CCL's financial processes and procedures.** Processes and procedures include requests for proposals/applications, hiring practices, contracts, and budget and resource allocation. Including health equity language and concepts helps build a shared understanding and appreciation of health equity across sectors. This shared understanding provides guidance and clarity about health inequities and the CCL's health equity focus. Health equity terms and concepts include discrimination, health care disparity, and structural racism.	☐

Structural Considerations

Potential Action Steps	✓
1. **Design every aspect of the CCL to reflect the needs and assets of patients and community members who have been economically or socially marginalized.** Implement the CCL with the aim of helping these patients and community members receive health care that is equitable, effective, efficient, patient-centered, safe, and timely. The CCL can help remove obstacles and increase opportunities to receive care.	☐
2. **Include strategies and activities that explicitly address structural inequities.** Such approaches are more likely to address the contributors to CVD inequities. However, approaches aimed at reducing disparities or inequities in CVD tend to focus on individual and interpersonal factors. For example, efforts might include addressing health literacy among patients with limited or no English proficiency and conducting cultural sensitivity trainings with health care providers. Consider approaches that focus on organizational, community, and public policy factors. Such efforts could include enacting policies in organizations in both sectors.	☐
3. **Check that the CCL builds on the strengths of the priority populations and SDOH-related assets of the organizations in both sectors.** For example, in the clinical sector, FQHCs are located in high-need areas and accept all patients regardless of insurance status or ability to pay. They provide services that aim to increase health care access and improve health outcomes. Such services may include on-site interpretation or translation, transportation, or eligibility assistance for public programs. In the community sector, a CCL might draw on a no-cost gym or the YMCA. The YMCA provides financial assistance to support use of YMCA resources and participation.	☐
4. **Set up structures that balance perceptions of power among community members most affected by health inequities and partners from distinct sectors.** For example, a CCL could have two co-chairs from each sector and include representatives from both sectors as equal voting members on an advisory board. Some advisory groups stipulate that community members, patients, or clients make up at least 50% of their membership. This practice aims to ensure that community voices are heard. It also aims to include the priorities, knowledge, and experiences of people receiving services.	☐
5. **Consider a structure that increases availability of and access to comprehensive care for people at increased risk for CVD.** For example, establish clinical and community services in one facility. That way, different services related to health care and SDOH are available in one visit. It is important to differentiate between merely physically locating community and clinical services close to each other and fully integrating the services to achieve quality care. Quality care is safe, effective, efficient, patient-centered, timely, and equitable. This action step is especially pertinent for priority populations, because they often have multiple chronic conditions. Resource 6 describes one program in which public health professionals used this approach.	☐

Structural Considerations (cont.)

Potential Action Steps	✓
6. Choose procedures and health technology that partners in both sectors can use to respond to individual-level adverse SDOH. These are some approaches that partners can use to address patients' SDOH: • Collect quantitative and qualitative SDOH data. • Review SDOH data and identify needs. • Identify referral options. • Process referrals. • Provide feedback to each other about people at increased risk for CVD. • Coordinate follow-up. • Track CVD inequities. • Develop processes for continuous quality improvement.	☐
7. Allow flexibility in the CCL's structure. Help organizations in both sectors remain true to their mission and vision while adapting to changing or challenging environments. Changing environments could involve new or emerging practice- and evidence-based information or policy changes. Challenging environments could include public health crises, such as the COVID-19 pandemic.	☐
8. Connect trainings and continuing education opportunities to the CCL's ongoing operations. This practice will help make sure that these opportunities are not one-time events. Foster a safe and respectful learning environment. Avoid stereotyping. Set aside enough time and resources for staff from multiple layers of organizations in both sectors to participate in these opportunities.	☐

Staff (Workforce)

Potential Action Steps	✓
1. **Include "boundary spanners" or "spanning personnel" as a formal position in the CCL.** Spanning personnel are people who act as the glue that bonds the community and clinical systems. Of particular importance are those who have expertise in working with community members, especially those most affected by SDOH (e.g., people experiencing homelessness), and addressing health inequities. For example, community health workers (CHWs) are frontline public health workers who are trusted community members. They have a deep understanding of the populations they serve. This trusting relationship enables CHWs to serve as liaisons between health and social services and communities. They can facilitate access to services, improve the quality and cultural competence of service delivery, and build individual and community capacity.	☐
2. **Recruit and hire staff, including community members, who reflect populations affected by CVD inequities or have experience working with them.** These staff members can be familiar with speaking up for the needs of community members who are at increased risk for CVD. They can have experience addressing the structures and systems that create these inequities. Offer staff members who come from the communities they serve fair compensation and training with potential for advancement.	☐
3. **Offer regular trainings on health equity to staff.** Training can help improve staff members' ability to implement the CCL and to integrate the CCL's activities into each organization's structure and operations. Frontline staff in both the clinical and community sectors can be trained. Doctors, managers, data collectors, evaluators, and others can also receive training. Staff in the clinical sector could include nurses, medical assistants, and physician assistants. Staff in the community sector might include program coordinators, field staff, and CHWs. In the public health sector, CCLs can train leadership, implementation, and communications staff. Training can boost knowledge, skills, and competency.	☐

Resources

Resource 1: Terms related to health equity*

Discrimination

The unjust or prejudicial treatment of groups of people based on age, disability, ethnicity, gender, national origin, race, religion, sexual orientation, or other characteristics. Discrimination exists in systems meant to protect well-being or health. For example, it exists in health care, housing, education, criminal justice, and finance. Discrimination can lead to chronic and toxic stress. It shapes social and economic factors that put some people at increased risk for poor health. Types of discrimination include ableism, ageism, homophobia, racism, and sexism.

Health care disparity

A difference between groups of people in health care quality that is not due to access-related factors or clinical needs, preferences, and appropriateness of intervention.

Health disparity or health inequality

A type of health difference that is linked with social, economic, and/or environmental disadvantage and other characteristics that are linked to discrimination or exclusion. Health disparities adversely affect groups of people who have systematically faced greater obstacles to health based on certain characteristics. These could include their racial or ethnic group, religion, socioeconomic status, gender, age, mental health, disability, sexual orientation or gender identity, or geographic location. "Health disparity" and "health inequality" mean the same thing. The United States uses "health disparity," while other countries use "health inequality."

Health equity

An ethical, human rights, and social justice principle that calls for ensuring that all people can attain their highest level of health. Reaching health equity requires valuing everyone equally. It requires focused and ongoing societal efforts to address avoidable inequalities, injustices, and disparities in health and health care. Achieving health equity requires addressing obstacles to health, such as poverty, discrimination, and their consequences. These include lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care. For the purposes of measurement, it is important to recognize that health equity means reducing and ultimately eliminating disparities in health and its determinants that adversely affect groups that have been excluded or marginalized. It is also important to recognize that these groups are not static.

Health equity lens
The perspective through which one seeks to identify and understand social, economic, and structural factors associated with health

Health inequity
A health difference or disparity that is unfair, unjust, and avoidable.

Implicit bias
The positive or negative attitudes and stereotypes that affect people's actions and decisions without their awareness.

Inclusion/Inclusivity
A set of behaviors that helps people feel valued for their unique qualities and have a sense of belonging and shared power. Inclusive diversity is a set of behaviors that promotes collaboration within a diverse group.

Intersectionality
The interconnected nature of social categories such as race, class, and gender as they apply to a given individual or group, creating overlapping and interdependent systems of discrimination or disadvantage.

Priority populations
Groups that have been economically or socially marginalized and that are prioritized for health-related resources and efforts.

Privilege
Unearned advantage, immunity, and social power held by members of a dominant group.

Terms related to health equity (cont.)

Racism

A system of structuring opportunity and assigning value based on the social interpretation of how one looks. This interpretation is what we call "race." The system unfairly disadvantages some people and communities and unfairly benefits others. By wasting human resources, it keeps our society from reaching its full potential. Racism can be expressed on three levels:

Interpersonal/personally mediated racism

Prejudice and discrimination. Prejudice is making assumptions about the abilities, motives, and intents of others based on their race. Discrmination is acting differently toward others based on their race. These can be intentional or unintentional.

Systemic/institutionalized/structural racism

Structures, policies, practices, and norms that result in different access to goods, services, and opportunities based on race. For example, major systems—such as the economy, politics, education, criminal justice, and health care—perpetuate unfair advantage.

Internalized racism

Acceptance by members of stigmatized races of negative messages about their own abilities and worth.

Social determinants of health

Conditions in the settings where people are born, live, learn, work, play, worship, and age that affect health, functioning, and quality of life.

Social exclusion or marginalization

When certain groups have barriers to full participation in society, affecting equity and social cohesion. Places where these groups live often lack opportunities, access to resources, or respect for rights. These conditions damage health. Examples include inadequate schools and lack of access to jobs.

Stigma

Discrimination against group of people, a place, or a nation. Stigma is associated with a lack of knowledge, a need to blame someone, fears about disease and death, and gossip that spreads rumors and myths.

Resource 2: Examples of partner organizations within each sector

Public Health Sector

- Health departments (state and local)

Clinical Sector

- Cardiac rehabilitation clinics
- Community clinics and free clinics
- Community mental health centers
- Emergency departments and urgent care clinics
- Emergency medical services (EMS)
- Federally Qualified Health Centers (FQHCs) (e.g., community health centers, migrant health centers, public housing primary care programs)

- Hospitals, including safety net hospitals
- Pharmacy-based clinics
- Private physicians who accept uninsured or Medicaid patients or provide pro bono services
- Rural clinics

Community Sector

For-profit Organizations

- Barbershops and hair salons
- Chambers of commerce
- Grocery stores
- Pharmacies
- Restaurants

Nonprofit Organizations

- Clothing charities
- Civic clubs (e.g., sororities/fraternities)
- Military and veteran service organizations
- Voluntary health associations
- Head Start

Education

- Public elementary, middle, and high schools
- State and local Area Health Education Center (AHEC) programs
- Universities, colleges, and technical schools

Community Sector

Food Access

- Farmers' markets
- Food banks or pantries
- Hunger and outreach organizations
- Meal delivery organizations

Housing

- Fair housing organizations
- Homeless and violence protection shelters
- Housing agencies that provide rent subsidies and/or affordable housing

Law Enforcement/ Criminal Justice

- Crime prevention task forces (state, county, or local)
- Legal Aid
- Police (state and local)
- Prisons and jails
- Victim assistance programs

Media and Communication

- Radio stations
- Public relations and marketing professionals or consultants
- Television stations

Payers

- Children's Health Insurance Program (CHIP)
- Commercial insurance (e.g., Blue Cross, Aetna)
- Medicaid
- Medicare
- Self-insured plans (e.g., large employers)

Policy

- Boards of directors in for-profit and nonprofit organizations
- Elected officials (state and local)
- Policy analysts and lawyers

Faith/Belief Communities

- Churches
- Mosques
- Synagogues

Social Service Programs

- Area Agencies on Aging
- Supplemental Nutrition Assistance Program (SNAP)
- Supplemental Security Income (SSI)
- Temporary Assistance for Needy Families (TANF) Program

Transportation

- City and regional planning commissions, including urban planners
- Public transportation (e.g., trains, buses, paratransit vehicles) providers
- Departments of transportation (state and local)

Resource 3: Examples of functions of a CCL convener or coordinator

Examples of Functions	✓
1. Is a trusted and accountable leader.	☐
2. Builds relationships among community members and representatives from community and clinical sectors to foster trust and respect.	☐
3. Creates focus and urgency around the CCL's mission and vision.	☐
4. Facilitates agreement among the CCL's partners on health equity goals and metrics.	☐
5. Emphasizes linking health care and social services to address upstream determinants of health.	☐
6. Assesses infrastructure and resources, including workforce capabilities, that are available to help the CCL fulfill its mission. Works with partners to make adjustments as needed.	☐
7. Puts processes in place for partners to share resources and track their contributions. Attends to potential power imbalances.	☐
8. Pursues financial sustainability. Methods could include: • Reallocating funding • Using new and existing funding sources • Developing innovative uses of current funding sources • Using multiple funding streams, such as Medicaid and public health and population health promotion programs • Testing payment reforms that promote value and incentivize disease prevention and healthy development	☐
9. Supports development of practices and policies at the local, community, and state levels to reach sufficient scale and sustain change.	☐
10. Develops a system of ongoing, intentional, and varied communication strategies to engage partners. Examples include: • Engaging communities at the grassroots level to build public will • Sharing local best practices and outcomes to engage and educate decision makers	☐
11. Coordinates training for staff in organizations from both sectors. Training covers how the CCL will be structured, roles and responsibilities, and the processes for providing referrals and feedback and sharing medical records and patient information.	☐
12. Convenes regular, frequent face-to-face meetings for staff from community and clinical organizations. At the meetings, staff can review information, discuss challenges, and develop solutions. These meetings promote smooth implementation and process improvement. They also help build trust and positive relationships.	☐

Adapted from:

• Centers for Disease Control and Prevention. *A Practitioner's Guide for Advancing Health Equity: Community Strategies for Preventing Chronic Disease*. Atlanta, GA: U.S. Department of Health and Human Services; 2013.

• Nemours. Integrator Role and Functions in Population Health Improvement Initiatives website. Accessed March 22, 2021.

Resource 4: Examples of partners, interests, and roles and responsibilities

Partners	Interests	Roles & Responsibilities
Administrators in community and clinical organizations	Financial obligations and return on investment	Establish infrastructure and provide resources to support the CCL
Businesses and nonprofit organizations	• Promotion of products and services • Positive community relations	• Donate supplies (e.g., blood pressure monitors) • Conduct screening and follow-up of high blood pressure in trusted community institutions (e.g., barbershops and hair salons)
Community health workers	Empowerment of community members experiencing disadvantage and disproportionate impact from CVD and its risk factors	• Serve as cultural brokers and mediators among individuals, communities, and health and social service systems • Advocate for individuals and communities • Build individual and community capacity
Community members, including former and current patients, experiencing disadvantage and disproportionate impact from CVD and its risk factors	• Improved health and quality of life • Reduced complications due to CVD and its risk factors	Identify needs, potential program successes, and barriers or challenges
Community pharmacists	Improvement of patients' medication adherence, health, and quality of life	Improve health care access and efficiency in the community
Decision-makers	Support from constituents	Support policies that address health care and SDOH
Employers	• Improvement of employees' work-related productivity • Reduction of employee absences and health care costs	Promote the CCL to employees
Faith-based organizations	• Health promotion and improvement of adverse SDOH in places of worship and throughout communities • Increased recognition that religion is a SDOH	Leverage access to and trusting relationships with populations often not reached by formal health care and public health systems

Examples of partners, interests, and roles and responsibilities (cont.)

Partners	Interests	Roles & Responsibilities
Farmers markets and food banks	• Reduction of food insecurity • Increase in access to and consumption of healthy foods	Work with both sectors (e.g., food pantries, FQHCs) to provide access to healthy foods tailored for specific health conditions
Health care professionals (e.g., dentists, doctors, nurses)	Improvement of patients' health and quality of life	Provide culturally responsive clinical care for patients
Health plans and insurers	• Appropriate use of benefits and reduction in costs of health care services among their members • Improved health of the population served	Market the CCL to their members
Homelessness or housing organizations and coalitions	• Decreased homelessness • Increased housing stability • Improved health among people experiencing homelessness	Use a trauma-informed approach to facilitate access to appropriate care for people experiencing homelessness and connect them to supportive housing and assistance programs
Lawyers	Improved patient access to legal services to address their adverse SDOH	Address patients' legal needs that can exacerbate adverse SDOH with remedies found in laws, regulations, or policies
Leaders, organizations, and coalitions that serve people who were formerly incarcerated	Increased responsiveness to the cultural, social, and economic needs of people who were formerly incarcerated	Facilitate continuity of health care and access to community resources among people returning to the community from incarceration
Media and communication organizations	Coverage of local or state issues	Help frame discussion and the CCL for community acceptance
Transportation network companies (e.g., Uber, Lyft) and public transportation providers	• Increased ridership of transportation services • Improved availability and safety of transportation options that support health	• Address issues related to transportation needs and barriers • Support access to health care and healthy lifestyles
Voluntary organizations	• Improved public health • Fulfillment of the organizational mission	Identify local needs of and emerging issues among community members most affected by health inequities

Resource 5: Data sources for CVD-related disparities

Behavioral Risk Factor Surveillance System (BRFSS)

Provides descriptive data on health-related risk behaviors and events, chronic conditions, and use of preventive services. The questionnaire has had optional modules on topics such as caregiving, health literacy, industry and occupation, social context, and SDOH.

Centers for Medicare & Medicaid Services Office of Minority Health's Mapping Medicare Disparities Tool

Identifies disparities between subgroups of Medicare beneficiaries in health outcomes, health care use, and spending.

CDC Chronic Disease GIS Exchange

Provides a forum for sharing examples, ideas, and techniques for using geographic information system (GIS) mapping to record geographic disparities, inform policy and program development, and build partnerships.

CDC Data Set Directory of Social Determinants of Health at the Local Level

Improves conceptualization and availability of data on the impact of SDOH on populations.

CDC Interactive Atlas of Heart Disease and Stroke

Provides county maps showing information on heart disease and stroke. Also provides maps of social environmental conditions and health services for the entire United States or for a chosen state or territory.

CDC's State Cardiovascular Health Examination Survey

- Provides information on priority populations to guide states in the development, implementation, and evaluation of strategies to promote cardiovascular health and control risk factors to end health disparities.

- Guides states in developing hypertension and cholesterol control strategies to promote cardiovascular health.

Compendium of Federal Datasets Addressing Health Disparities

- Provides publicly available data resources that address reducing health disparities. These resources are from federal agencies within the U.S. Department of Health and Human Services (HHS).

- Describes and links to 132 public datasets and resources with information on factors that affect the health of minority populations.

Health and Retirement Study

- Monitors the health and well-being of people age 50 or older in the United States.

- Explores the changes in how much people work and the health transitions that they go through toward the end of their work lives and in the years that follow.

HHS Office of Minority Health Native Hawaiian and Pacific Islander Population Health Data

- Provides a detailed look at the health status of Native Hawaiian and Pacific Islander (NHPI) populations. Includes data on factors such as access to and use of health services, health insurance coverage, and risk factors.

- Highlights differences in the prevalence of selected health conditions between the NHPI population and the Asian population, which data sources have often combined.

PLACES: Local Data for Better Health

Provides city and census tract estimates for chronic disease risk factors, health outcomes, and clinical preventive service use for the largest 500 cities in the United States. These estimates allow cities and local health departments to better understand the prevalence and geographic distribution of health-related variables in their areas. They can use this information to plan public health interventions.

Surveillance and Evaluation Data Resource Guide for Heart Disease and Stroke Prevention Programs

- Provides a compilation of most cardiovascular health data sources. The guide is useful for conducting policy or data surveillance or evaluation. For each data source, basic information is provided to help state heart disease and stroke prevention programs find data that are relevant to planning, monitoring, and evaluation. Data from these sources can be used to compare program impact and outcomes with those of other states and the nation.

- Includes GIS surveillance tools and performance measures for hypertension. Also provides updated tools essential to planning, implementation, and evaluation in heart disease prevention and control.

- Includes an updated media tools table for tracking and reporting media metrics.

This story is an example of how public health practitioners implemented a CCL operational structure. It is adapted from the following source:

O'Toole TP, Johnson EE, Aiello R, Kane V, Pape L. Tailoring care to vulnerable populations by incorporating social determinants of health: the Veterans Health Administration's "Homeless Patient Aligned Care Team" program. Prev Chronic Dis 2016;13:150567.
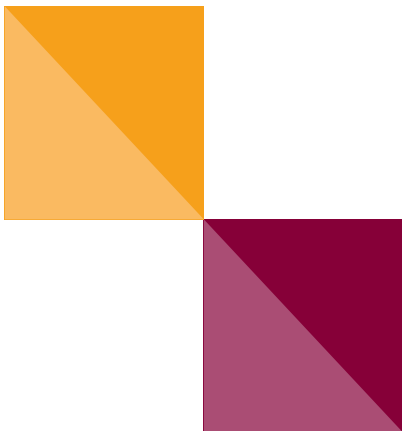
Example of Co-Location

The Veterans Health Administration created the Homeless Patient Aligned Care Team (H-PACT) to integrate health and social services for veterans experiencing homelessness. H-PACT serves veterans who have multiple chronic conditions and face barriers to getting primary care. These barriers include lack of transportation, trouble scheduling or keeping appointments, the stigma of homelessness, social isolation, and lack of appropriate support systems. Without good primary care, people experiencing homelessness have high rates of hospitalization and emergency department visits.

H-PACT aims both to engage veterans in health care and to provide them with social services to keep them in housing. It stresses providing high-quality, evidence-based, and culturally sensitive care.

The structure of H-PACT is different from traditional primary care. The program emphasizes the integration of services. Mental health and primary care services are co-located with community programs and social services to create a continuum of care. H-PACT provides housing assistance, food, clothing, hygiene items, showers, and laundry facilities. To reduce barriers to care, it provides open-access, walk-in care, and community outreach.

Researchers found that patients experiencing homelessness who were enrolled in the H-PACT program had more primary care visits and social work visits than did those in traditional primary care. They also had fewer emergency department visits. The cost of care per patient per year was $9,379 less with the H-PACT program.

The success of H-PACT was in integrating medical care with social services to address SDOH.

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