To Go Far, Go Together:

The Importance of **Community** in Patient Health Management

Community Health Management Task Force

The **Community Health Management Task Force** (Task Force), composed of 13 National Training and Technical Assistance Partner (NTTAP) organizations, engages health centers, Primary Care Associations (PCAs), and Health Center Controlled Networks (HCCNs) to address critical issues to improve the prevention, treatment, and management of chronic conditions among health center patient populations nationally.

Part 1: Introduction

Health centers serve as a cornerstone of chronic disease management in the U.S., providing comprehensive, integrated primary care to more than 32.5 million patients—many of whom face significant challenges to accessing care. According to 2023 Uniform Data System (UDS) data, 28.3% of health center adults have been diagnosed with hypertension, 16.6% are living with diabetes, more than 11% were diagnosed with anxiety disorders, and over 9.3% are diagnosed with depression or other mood disorders.[1] For many health center patients, managing a chronic condition is complicated by non-medical factors that influence health outcomes, like housing instability, food insecurity, and transportation challenges. Yet, despite the complexity of patient needs, health centers demonstrate measurable success in delivering high-quality care; for example, more than 65% of patients with hypertension had their blood pressure controlled (<140/90 mmHg), 77% of patients at high risk of cardiovascular events were prescribed statin therapy, and nearly 80% of patients with a new HIV diagnosis were linked to care within 30 days.[1]

Health centers are uniquely positioned to address chronic disease because they emphasize integrated, team-based care that includes enabling services such as

mental health care and substance use disorder treatment, dental, pharmacy, and case management—often co-located within a single site. This model enables care teams to meet patients where they are, literally and figuratively, and tailor services to their lives' specific realities. Over 98% of health centers offer mental health or substance use treatment services, reflecting how health centers are reimagining chronic disease care to address the full spectrum of physical and mental health needs. In recent years, health centers[1] have shown particular success in managing care for populations with complex needs, including people with HIV, diabetes, and co-occurring mental health or substance use disorders. These gains result from health centers' deep understanding that community health is about more than managing diseases—rather, community health is about patient-provider relationships, continuity of care, and building trust within the populations served.

Frontline Perspectives

The 2024 Health Center Training and Technical Assistance Needs Assessment identified the national health center workforce's desire for information and resources to:[2]

- Learn about emerging clinical topics and best practices for working with specific groups of patients **(72%)**
- Build programs and partnerships to address health-related needs and improve community health outcomes **(68%)**

To address this need, the Task Force hosted a series of conversations with community leaders who work with health center patients across the U.S. in both urban and rural areas. The purpose of these conversations was to identify key community health management strategies from those who have inspired change at a local level.

Interviewees included a range of roles, specialties, and modalities, including:

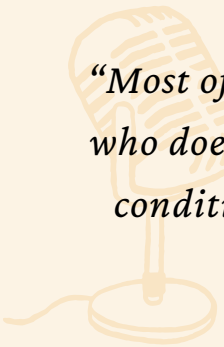
- **Substance Use and Mental Health Coordinator**
- **Dental Community Health Worker**
- **Family Medicine Provider**
- **Registered Nurse**
- **Medical Director**
- **Quality Improvement Coach**
- **ACE Certified Health Coach**

Based on these conversations, the Task Force identified key themes and promising practices that health centers can leverage to improve the prevention, treatment, and management of chronic conditions among health center patient populations nationally. In Parts 2-4 of this publication, you will find strategies, lessons learned, and resources gleaned from these conversations with community leaders.

Part 2: Management of Chronic Diseases that Impact Health Center Patients

A growing number of people are living with two or more chronic conditions. Living with and caring for a chronic condition is complex. There is no one single cause of each condition, nor a one-size-fits-all approach to treatment.

"As clinicians, we're trained to treat diabetes, but we forget that a person doesn't just come with diabetes. They're coming with all of these other health conditions, plus the additional stress of being diagnosed with a chronic health condition and then the stress of having to learn how to manage it."



"Most of these conditions go hand in hand. I don't think I've ever seen somebody who doesn't have at least two of them together because navigating these types of conditions is pretty challenging, but you add these extra layers of complexity, and it just makes it that much more difficult."

A mismatch between heavily disease-specific care delivery and patients' unique needs can result in lower-quality care and increased fragmentation. Poor outcomes include avoidable hospitalizations, increased healthcare costs, and other adverse events. Improving care for health center patients, therefore, requires health center providers to understand the complete context of patients' lives, and to address each patient's needs accordingly.

Key Takeaways:

- Stress rooted in the conditions experienced by health center populations compounds the negative health impacts of chronic diseases.
- Due to competing priorities, many patients may not be aware of their illness or even their symptoms.
- Patient-centered medical homes (PCMH) can help meet patients where they are and provide holistic care coordination and co-located services.

Integrated and Co-Located Services

People with chronic health conditions like diabetes or hypertension may struggle to manage their conditions over time. They often have to make hard choices to afford prescriptions, and may not have access to ongoing care, adequate transportation, or time off to attend multiple appointments in different locations. These circumstances can cause a good deal of stress for both patients and clinicians.

"... clinicians get very stressed when they begin to look at numbers. For example, you have a very elevated A1C, there's this pressure to fix it at that visit."

Patients need to be able to access a variety of health services in one location. Co-locating services helps to facilitate continuity of care, give access to all or most services patients need, and minimize transportation and other barriers.

"If we're to optimize chronic illness like HIV or diabetes, we really have to address the [multiple] conditions that [patients] face, and having an integrated healthcare team with behavioral health is essential."

Success Story: The Value of Co-Located Services

"The patient was at the health department here for a completely different reason, but then he saw a sign saying that our clinic was in the back and we offered wellness screenings, so he just walked over there and wanted to see what it was that we had available.

So I talk to him and find out that he had recently lost insurance and he's diabetic. He's about to run out of his medications. I did his health screening. His A1C was out of control, and so I was like, 'Yeah, we definitely need to get you back on track and make sure that you don't have a gap between your medications.'

...He came seeking, and not very many people do that, to do the work. He really wanted to change. ***He's managing his diabetes and he's still incorporating that healthier lifestyle.****"*

Strengthening Connections to Address Needs

To receive the highest benefits of medical interventions for treating and preventing chronic diseases, patients need to be consistently engaged in care. This level of engagement can be challenging for many reasons, including a patient's competing life priorities, readiness to accept care, access to a care team equipped to provide the best medical practices, and ability to follow through on referrals to non-primary care services. For these reasons, it is important to assess all patients with chronic disease for needs related to housing, food, substance use disorder treatment, mental health care, safety at home, etc.

"Rooting [into] people's lived experience helps you see… What are real life challenges people have."

"We have to learn to take it slow and really be able to wait for the patient to signal to us that they're ready. And in the meantime, we're still exploring and asking questions and trying to see if we can help them address some of those [other] factors that might be driving their inability to manage their health conditions."

To best manage the care of people with chronic conditions, and address their needs, health centers are best served by forming partnerships both within their health center and in the community.

"Community-based organizations…have met needs around food security and housing instability for decades. [They] were silent partners in people's wellness for a very long time…if we look at those organizations and institutions as guides, the systems can help their providers by linking those [services] together."

Utilizing a multidisciplinary group of partners not only helps the person who is navigating their medical care, but assists the care team as a whole.

"There's not enough time and [one person] can't have expertise, you know, in all of those domains. Partnerships support our patients, but I think they also support providers and clinicians. It helps you provide care that you feel good about, and that, you know, is really going to help this person and combat [provider] burnout."

Key Takeaways:

- Conflicting disease-specific guidelines, personal factors that impact the ability to self-manage, and preferences and values of the individual all influence care. To optimize care and improve health outcomes, health centers must look to the interconnectedness of disease management with whole-person care.
- Trust and communication between patients and providers are critical to complex care management. Limitations of time, resources, and referrals can significantly impact rapport with patients and the likelihood that they will adhere to a care plan.
- Partnerships, community supports, and integrated care approaches not only support patients, but can also prevent provider burnout.

Part 3: Responding to Needs as a Community

Improving health outcomes for patients living with chronic conditions depends on understanding a specific patient's needs and health in the context of their

community. Health centers can offer a powerful example of this work in practice by bolstering non-medical case management programs staffed with individuals who possess a deep knowledge of community strengths and challenges. For these efforts to succeed, stakeholders—patients, providers, leadership, and partners—must have a shared understanding of goals and opportunities.

Key Takeaways:

- Whole-person care means looking at the collective health of our communities.
- Patients benefit when health centers understand and uplift the unique strengths and assets of a community.
- Health centers must support staff by prioritizing clear communication, continuous learning opportunities, and seeking regular feedback.

Community Health Workers

Community Health Workers (CHWs) can make a substantial difference in helping health center patients manage chronic disease. CHWs reach beyond the clinic walls and meet people where they are - at churches, food banks, and farms - breaking down barriers to care.

"Community health workers really can have an important role because they are our key partners in helping us build trust with the community."

At one health center, CHWs are funded by the Ryan White HIV/AIDS Program to support people living with HIV. Many of these patients struggle with taking their medications consistently, which puts their health at risk. Instead of waiting for patients to come to them, CHWs go out into the community, offering support, medication adherence education, and a familiar face. They help people navigate the healthcare system in a way that feels approachable and accessible.

"[The] impact of community health workers has really been transformative…and [have] helped people in a way that the…clinic on its own and the clinicians on their own had really not been able to…"

Across health centers, CHWs often play a significant role not just in HIV care, but also in managing chronic conditions like diabetes and oral health. Increasingly, health centers are recognizing that CHWs bring something invaluable to the table: they understand their communities, they know how to connect with people, and most importantly, they do not represent the conventional healthcare system. Ultimately, CHWs demonstrate that good healthcare is not just about what happens in an exam room. It's about relationships, trust, and meeting people where they are.

Community Supports

Health management often extends beyond the health center walls to include community healing and connection. Strengthening familial and communal relationships helps to foster a sense of belonging for patients and improve overall health.

"…when you are part of a community, and you feel like you're valued and that you belong, that also contributes to well-being and better health…."

Conditions, customs, and norms in a community all impact patient care. To enhance overall health, we must transform healthcare systems to look beyond individual patients and symptoms, and to examine and address the root causes and conditions of disease.

"Teamwork and community partnerships are key… There's not enough time, and you can't have expertise… in all of those domains. I'm a big supporter of partners, having one foot in the clinic and one foot in the community."

In a healthy community, all systems are connected, tended to, and able to thrive. This concept applies not only to the patient populations that health centers serve, but also to the staff that health centers employ. Health centers are uniquely set up to serve the community because the workforce often has lived experiences similar to those of patients. Health centers can create opportunities for connection and community through partnerships with local agencies and community-based and faith-based organizations.

"Partnerships support our patients, but they also support providers… It helps you provide care that you feel good about, and…is really going to help this person."

"There is so much for me to do in a clinical encounter, and that number of things only has been increasing. … There's not enough time. … And so you have to work as a team in order to have time to think, time to talk, and time to build trust."

Key Takeaways:

- Health centers should adopt robust non-medical case management programs and teams of enabling services staff, like CHWs, who understand community needs.
- Care work that centers community and person-centered healing can be challenging, as many people working in these fields have similar lived experiences.
- Community and connection are integral to healing and enhancing the health of medically-underserved populations.

Part 4: Conclusion

These conversations with community leaders provided tremendous insights for all those working to improve the prevention, treatment, and management of chronic conditions in health center populations. It is vital to acknowledge both the complexity of these conditions and the needs of the patients living with them. Establishing trust and maintaining long-term relationships with patients allows us to fully understand their stories. Strengthening connections benefits everyone-patients, staff, and community partners alike. Each health center should define its top priorities and tailor its multidisciplinary approach to meet the unique needs of its community and improve overall patient health management.

Recommended Action Steps

→ **Conduct needs assessments to understand your patient population's historical, social, and community contexts**

→ **Co-locate services (physical, mental, dental, behavioral, etc.) and create pathways for integrated care teams to support patients beyond clinic walls**

→ **Meet patients where they are (literally and figuratively)**

- **Simplify processes to receiving in-person services**
- **Use clear communication and shared decision-making**

Prioritize hiring and retaining staff who are from the communities you serve

Identify available community resources and build working relationships with local service providers for more effective referrals for patient assistance

Tools & Resources

- Health Needs Assessment Toolkit
- National Association of Community Health Workers Networks and Training Programs Catalogue
- Community Health Workers in Enhanced Care Management and In Lieu of Services: A Model of Care Resource
- Promoting Chronic Disease Management: A guide for behavioral health care teams
- Evidence-Based Chronic Disease Self-Management Education Programs
- Available Care and Services for People Living with HIV
- AIDS Education and Training Center
- My Health Is My Treasure: A Guide for Living Well With Diabetes | COMIC
- Health Network | Migrant Clinicians Network
- Smiles for Life: Front Line Health Workers Curriculum

For more information on the Community Health Management Task Force, visit bit.ly/communityhealthtaskforce.

References

1. Health Resources and Services Administration (2024). National Health Center Program Uniform Data System (UDS) 2023 Awardee Data. https://data.hrsa.gov/tools/data-reporting/program-data/national
2. National Association of Community Health Centers (2025). 2024 National Health Center Training and Technical Assistance (T/TA) Needs Assessment Findings. https://www.nachc.org/resource/national-training-and-technical-assistance-needs-assessment/

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