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Health & Housing Partnerships

Strategic Guidance for Health Centers and Supportive Housing Providers

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INTRODUCTION
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A Call to Partner

The past few years have brought new regulations, funding opportunities and priority shifts that have been game changers for the health, housing and supportive services systems that serve communities' most vulnerable people. The Affordable Care Act has expanded programs to improve access to care and in many states, extends medical insurance coverage to include more low-income individuals, many of whom are frequent users of costly emergency systems and have complex mental health and/or substance use issues along with serious physical health conditions. Moreover, expansion and non-expansion states[i] (those that have elected to expand Medicaid eligibility) alike have implemented Medicaid waivers[ii] that allow for more flexibility in how services are paid for in housing, among other benefits.

Supportive housing[iii] leads to improved health outcomes for tenants[iv] and is a more efficient use of public resources. Health systems realize significant cost savings per patient from reduced use of emergency services and inpatient care once a patient is housed in permanent housing,[v] as they seek recommended care and engage in preventative and primary care at much higher participation rates and lower costs than those who are unstably housed. Effectively and efficiently meeting the needs of the most vulnerable frequent users of these systems requires collaboration across health and housing systems to coordinate and integrate care, interventions and services.

Health and supportive housing partnerships are collaborations between providers of primary, mental health, substance use services and providers of housing and supportive services for formerly homeless tenants. These relationships can be referral based, structured partnerships with integrated operations, or larger community initiatives and coalitions involving multiple partners. Here are the key elements and examples of partnership types, from low to higher levels of collaboration:

Referrals	Care Coordination	Co-Location	Full Service Integration
• Client referrals to preferred services • Client initiated • Partners retain autonomy and operations are independent; resources generally not shared • Low collaboration	• Client-centered joint care plans • May include centralized intake • Client initiated with strong transiton supports • Organizations operate independently but may share resources and funding • Moderate to high collaboration, with cross-training and frequent communication	• Health center operates satellite or full center on-site at supportive housing or shelter • Wrap-arround care housed in a site that tenants access for various services • Partners operate jointly, but may retain autonomy • Can be incorporated into existing site, mobile services or new joint site • High collaboration	• Single point of entry, integrated assessment • Joint case planning/mgmt • Wrap-around care that may be brought to where it is most accessible to the client • Partners may have independent or joint operations • Can blend with co-location • Very high collaboration, with integrated resources, service delivery and sometimes funding

Many organizations readily see the benefits of partnership and want to partner, but are not quite sure where to begin**.** Most supportive housing providers already partner with other service providers, yet partnerships with health centers have been less frequent and can be more complex. There is no one-size-fits-all approach or partnership model across communities, as successful partnerships are developed to meet needs specific to a community. Thus, it is essential to define the purpose, scope and approach of a potential collaboration that will fit the needs of your community and target population. Two key

considerations are to maximize the capacity and expertise of each of the partner organizations, and create opportunities that leverage resources to fill gaps in community services.

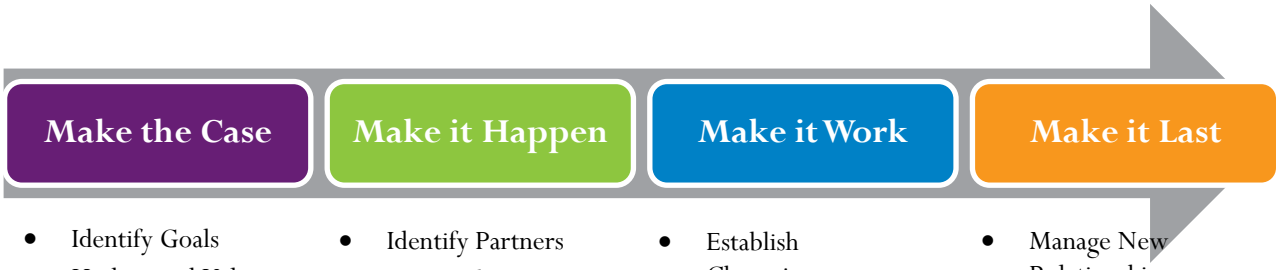
About This Guide

This paper offers strategic guidance in building, assessing and/or strengthening various types of partnerships between Health Center Program Grantees, behavioral health providers and supportive housing providers. Whether you represent one of these types of organizations or you are merely curious about health and housing partnerships, you can use this guide as your roadmap.

- ***Are You Curious About Healthcare and Housing Partnerships?*** *This guide will give you the basics and will help you frame whether or not pursuing a partnership is for you.*
- ***Are You Ready to Explore Partnering?*** *This guide will take you step-by-step through the process of understanding, assessing and identifying partners.*
- ***Do You Want to Strengthen or Improve a Partnership?*** *This guide offers insight on breaking barriers to partnership and provides community examples and strategies for successful partnerships.*

This guide is divided into four stages that lead you from determining why health center and supportive housing collaborations might work for you, how to build them and make them last.

- **Stage I: Make the Case** starts with your awareness and capacity to lead a partnership, being very realistic about the commitment and value a partnership or collaboration would bring.
- **Stage II: Make it Happen** guides you in exploring your community to identify and assess organizations that might fit with your needs and goals.
- **Stage III: Make it Work** challenges you to start the conversations and connect with potential partners, share information, and design and implement a plan with the partners who are a fit.
- **Stage IV: Make it Last** ensures you take steps to make a collaboration that can be sustained.



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STAGE I: MAKE THE CASE

Before taking the steps to create any type of healthcare and housing partnership, it is important to understand the value of these collaborations, the primary needs for partnering, and your capacity to lead and implement the type of collaboration that meets those needs.[vi] This analysis may seem arduous, but it will lay the foundation for a strong partnership. An initially successful partnership in Washington State realized the mistake in not building this foundation. The collaboration dissolved after two years because the partners were not clear about their reasons for partnering, did not align partnership goals with the goals of their organizations and did not assess the capacity for each partner to implement new ways of doing things.[vii] Due diligence is key, and it starts with understanding the value a partnership could bring.

1. Understand Your Partners

About Health Centers

Health Center Program Grantees[viii] are community-based, patient-directed healthcare organizations that serve populations with limited access to health care. About one out of every fifteen people in the U.S. relies on HRSA-funded health centers for their preventative and primary care[ix] and the numbers served continue to grow as more people enroll in Medicaid. The Health Centers that serve those in supportive housing are generally community health centers, Public Housing Primary Care programs and Healthcare for the Homeless[x] programs.[xi] Health Centers, particularly those funded under Health Care for the Homeless (330h) grants from HRSA, have certain funding requirements from HRSA (see Table 1 below) that could be met through community partnerships. Integration of primary and behavioral health care is an important goal, as is consideration of housing status and recognition of the importance of housing stability for health outcomes. Most health centers strive for coordinated primary and preventative services to offer a "patient-centered medical home" for patients.

Partner Value

Health centers funded under HRSA are encouraged to collaborate. Integration is built into the framework of those centers operating under Section 330, as it is recognized that centers may not be able to provide all required services directly and therefore, grantees can provide services through contracts or cooperative arrangements.[xii] Section 330 also explicitly encourages health centers to "make every reasonable effort to establish and maintain collaborative relationships with other health care providers in the service area of the center."[xiii] While collaboration is encouraged, Section 330 funding also establishes requirements for health center governance structure and health center autonomy.

Partnerships must bring value to all involved organizations and their target populations. Supportive housing and behavioral health providers have qualities and expertise that align well with HRSA's health center requirements – a highly motivating factor in taking steps to build a partnership. Table 1 below highlights the areas of opportunity.

Table 1: How Health Centers Can Benefit From Supportive Housing Service Providers

Current HRSA Framework & Requirements[xiv]	How Supportive Housing (SH) Service Providers Can Help
Health center demonstrates and documents the needs of its target population, updating its service area, when appropriate	• Many SH providers conduct community needs assessments. • Opportunity for SH providers to help design a community health needs assessment and could help administer it
Health center provides all required primary, preventive, enabling health services and additional health services as appropriate and necessary, either directly or through established written arrangements and referrals	• SH Providers directly and indirectly provide enabling services with licensed staff – they are experts in many of these enabling services • SH providers are experts at providing or coordinating case management, often incorporating health system navigation, housing stability services, and education

	about a variety of topics into residents' case plans
Health centers requesting funding to serve homeless individuals and their families must provide substance abuse services among their required services (*only for HCH health centers*)	• Many SH providers are networked with substance use services providers, and some provide these services directly
Health center maintains a core staff as necessary to carry out all required primary, preventive, enabling health services and additional health services as appropriate and necessary, either directly or through established arrangements and referrals. Staff must be appropriately licensed, credentialed, and privileged	• SH Providers directly and indirectly provide enabling services with licensed staff – they are experts in many of these enabling services • SH providers are experts at providing or coordinating case management, often incorporating health system navigation, housing stability services, and education about a variety of topics into residents' case plans
Health center provides services at times and locations that assure accessibility and meet the needs of the population to be served	• SH Providers serve many residents in the community, both homeless and housed, at times 24-hours per day • In Medicaid expansion states many homeless and low income clients are likely to be newly enrolled in Medicaid • Partnership could focus on co-located services, collaboration or referrals to make health services more accessible
Health center provides professional coverage for medical emergencies during hours when the center is closed	• SH Providers often provide 24-hour staff coverage and a partnership would ease access to clients needing after-hours care • Partnering with a SH Provider to develop or use space on their site for a clinic could allow 24-hour accessible coverage to residents
Health center has a system in place to determine eligibility for patient discounts adjusted on the basis of the patient's ability to pay • Full discount to individuals and families with annual incomes at or below 100% of the Federal poverty guidelines • Sliding discount otherwise	• Many more SH tenants are now Medicaid eligible, so services for them are reimbursable • With proper information sharing agreements, SH Providers can verify their tenants' incomes
Health center makes effort to establish and maintain collaborative relationships with other health care providers, including other health centers, in the service area of the center	• Many SH providers are already networked in the community to provide the supportive services, many of which are health/behavioral health services (especially providers of scattered site SH) • SH providers have developed collaborative systems and staff is accustomed to building and sustaining community relationships
The health center governing board is composed of individuals, a majority of whom are being served by the center and, this majority as a group, represent the individuals being served by the center in terms of demographic factors such as race, ethnicity, and sex	• Some SH providers have tenant councils and representatives on their boards who could be active in health center governance, as well
Pressure to limit the excessive use of	• Many frequent users are clients served in SH

emergency services in the community health system by frequent users[xv]	programs, or are eligible for such programs • SH partners could help to engage this population, assist in accessing health insurance, and can facilitate a "warm hand off" connection to the health center
Encouraged **to provide eligibility assistance to uninsured patients**[xvi]	• SH providers can promote health centers as enrollment assistance sites • Providers could support enrollment assistance, especially if there is on-site space with computer access

About Supportive Housing Providers[xvii]

Supportive housing is affordable housing without a time limit that offers voluntary supportive services that focus on stabilizing vulnerable individuals in a community. Supportive housing can be publically and/or privately funded housing units or vouchers offered in single-site, multi-site or scattered site housing projects.[xviii] Services, usually funded separately from "operating," or rental funding streams, may be offered directly onsite or through a network of service organizations, including health centers. Because of this range, supportive housing providers have varying levels of experience partnering and have different goals, restrictions and partnership needs.

Partner Value

Health centers can be critical players in linking primary care, behavioral health, and other services and supports to supportive housing tenants, many of whom have histories of chronic homelessness. Much like supportive housing services staff, Health Center staff is trained to understand and address the unique and complex needs of vulnerable populations. Here are just a few examples of the value Health Centers can bring to collaboration with supportive housing providers:

Table 2: How Supportive Housing Providers Can Benefit From Health Centers

Supportive Housing Goals Related to Health Needs of Target Population	How Health Centers Can Help
Identify potential residents, connecting them to services	• Many health centers have outreach workers or mobile clinics to connect with this population
Access and funding for health services	• Health centers provide these services directly and could be linked to supportive housing residents through referral, co-location, satellite services or mobile teams and home visits • Health centers can change their scope to include additional service sites which can include supportive housing sites • Medicaid could pay for health services under all of these options • Health Center grants support needed services that are traditionally not reimbursable (outreach, engagement)
Funding for enabling services	• Medicaid could fund enabling services that are required services for health centers • By definition, supportive housing providers also provide case management, but very few are set up to bill Medicaid for these services. Traditional Medicaid

	billing structures don't fit the "whatever it takes" approach embraced by most supportive housing providers
Improving health outcomes of a population that has co-occurring disorders, dual-diagnoses and chronic illnesses	• Health centers provide these services directly or through provider relationships, and could be linked to supportive housing residents through referral, co-location or satellite services or roving teams/home visits • Working with a health center to create health homes or other comprehensive health services for residents is an opportunity to improve health outcomes
Understanding target population's health needs	• Health centers are required to conduct annual assessments of health needs in the community. Participation in this annual assessment facilitates opportunity for supportive housing providers to advocate for their residents' health needs.
Improving resident recovery and increasing their stability	• Supportive housing providers can work with health centers to triage health issues when they arise to help decrease the likelihood of long-term inpatient stays. Supportive housing providers can also help manage residents' appointments, which increase use of preventive care and other quality measures, which can reduce use of emergency rooms and returns to the hospital.

2. Assess Your Capacity to Partner

Once you have gained a better understanding of how a partnership may be mutually beneficial, it is time to determine your own readiness and capacity to partner. You are the champion of the partnership you are considering, and your leadership, due diligence and willingness to take informed risks will drive its success. It is important to assess your organization's ability to build or improve a partnership and determine your primary needs and goals that a partnership could fulfill.

Use **Exhibit A– 'Assessing Partnership Fit'** to guide you in assessing your capacity. It is an assessment tool to help you synthesize information and build your organizational profile that can be aligned with potential partners, by answering questions related to your organization's mission, goals, resources, services, commitment and readiness to partner. Answers to the questions can be inserted directly into the tool along with detailed information about your organization as it relates to partnering with a health center, behavioral health or supportive housing provider.

By completing **Column #1** of the assessment, you will be able to determine your organization's:

1. **Reasons for building a partnership and whether there is urgency to partner**
2. **Commitment from leadership**
3. **Financial buy-in and resources related to partnering**
4. **Readiness to lead a change process**

Your capacity for partnership by type

If your organization does not have the capacity or goal to coordinate efforts beyond giving clients information on available services, and your clients are low-acuity, referrals would be a likely starting place for your organization. On the other hand, if there are urgent or complex needs not being met for your target population and you readily see how a partnership could meet these needs, consider pursuing more integrated approaches like care coordination and service integration. Partners should choose a partnership type that works best for all parties involved, after needs and goals have been identified. Further guidance for this determination is provided below in Stage III: Make It Work.

3. Engage Leadership

The most successful partnerships involve support and buy-in from senior leadership. It is necessary that key decision makers be on board early in the process. If you are not part of senior leadership in your organization, but you are driving the partnership process, find a way to engage these leaders. One way to do this is to schedule a strategy meeting with leadership where you would pitch the idea to partner, solicit input and ideas, address questions and concerns and determine your next steps. This is also an opportunity to identify champions, and to involve those who seem most interested or excited to join you in the next phases of establishing the partnership.

STAGE II: MAKE IT HAPPEN

1. Identify Potential Partners

In Stage I, you explored the needs of your organization, the people you serve, and how a health/housing partnership might be of value. The next step is to identify organizations with similar missions, target populations, and goals that would align with your organization's profile, and provide services that complement and hopefully do not duplicate the work of your organization. For some, it might be incredibly easy to identify with whom you might want to partner and what type of partnership you would like to pursue. Keep in mind, you may also find partnering with several organizations in a collaboration network may achieve the goals identified. Before you go through the process of approaching potential partners, it is important to make sure they are the right fit, not just those with whom it is easiest to connect.

Whom Should I Consider?

Ideally, you would approach potential partners that bring as much purpose, dedication and capacity as you. Both parties should stand to gain value. Here are some general tips for identifying the organizations:

- **Consider your existing networks.** Does your organization have a history of partnerships and building relationships? Determine any existing connections to your target organization type (health centers, behavioral health or supportive housing providers). These can be connections through staff, Board members, community meetings, or other affiliations. Determine if you have existing connections to leadership at any of those organizations.
- **Keep it Local.** The organizations in your community know the people you serve, better than anyone else. They are invested in and have missions to serve your community, and will understand your community's unique perspective. Partners should be accessible to clients, staff, and any other stakeholders as appropriate.
    - **Find a local health center**: To locate the nearest health center in your community visit http://findahealthcenter.hrsa.gov, or connect with the Primary Care Association in your state[xix]
    - **Find a local provider**: To locate a homeless service and housing provider, you can consult your local Continuum of Care, which can be found in the HUD portal by state: http://portal.hud.gov/hudportal/HUD?src=/states. You could also refer to your own patient intake data if it cross references with any local supportive housing residence or service provider information.
- **Find organizations that serve your clients.** Some of the most effective partnerships are formed around an overlap in clients served.[xx] Find out where your clients are referred to or where they seek health/supportive housing services. Where have your clients had positive experiences? Reach out to the umbrella networks in your community to learn about potential partners.
- **Identify complementary services.** Use knowledge and information you have on your population to identify what are the complementary services that are needed. Identify if these services are provided by potential partners, and how they could benefit both your clients and organization. What are your biggest gaps or issue areas right now? How might these be filled? Use insights gained from building your partnership profile.

2. Approach Potential Partners

Now that you have identified promising organizations, it is time to connect with them to start the vetting and planning process. Bringing the right people to the table when considering a partnership can avoid doubled efforts later in the process. It is important to think about who the stakeholders are and how best to approach. When approaching a supportive housing provider, consider whether you will be working with several stakeholders at once or whether you will be working mainly with staff from one organization. For example, scattered-site supportive housing projects may have a project owner, property manager, and various service providers, who work for different organizations. Consider starting conversations with the service providers then determine when you might need input from property managers or owners. Depending on your partnership needs and goals, you may want to consider partnering with various supportive housing providers or your community's Continuum of Care.

You can approach potential partners in a number of different ways, and various ways to do this face-to-face are outlined below:

Meeting One-on-One is a great way to engage potential partners if you have one or a few organizations you are considering partnering with, for a specific reason. Engaging and vetting partners may require several meetings before a decision is made or a plan is created with the right partner (see below on vetting).

Multi-Organizational Meetings are helpful when you have identified several targeted organizations with whom you would like to explore collaboration. This introduction can involve a meeting with your organization and several of your potential partners, or bringing organizations similar to yours together, with organizations you would like to partner with. For example, if you are a Health Center and you have identified several supportive housing organizations, you might include other Health Centers or current service partners in the initial exploratory meeting. In this process you may be able to scrutinize several organizations at once, or the meetings may result in more collective efforts like alliances and multi-organization collaborations.

Community Convening Meetings: These meetings can explore Health Center/behavioral/supportive housing partnerships at the systems level, and can take many forms: town hall meetings, symposiums, facilitated community discussions, action labs and other such convenings. This is a great way to take full stock of current relationships (formal or informal) already at play. This approach is especially useful if you're considering highly collaborative relationships or those with multiple partners, as it can accomplish many of the steps in identifying, vetting and soliciting stakeholder input in a short time, for several organizations at once.

Third-Party Facilitation: With any type of approach, it often helps to include an independent intermediary who can act as the convener and/or facilitator between potential partners. National Cooperative Agreements[xxi] (NCAs) are organizations specifically funded by HRSA to provide training, technical assistance and other resources to help Health Centers meet their requirements and improve performance. Some NCAs have the goal of connecting supportive housing, behavioral health and health centers, and could be useful resources to tap throughout the process of forming a partnership.

Success Through Collaboration:
Columbus Area Integrated Health & Columbus Continuum of Care

In Columbus, Ohio, Community Shelter Board and the Homeless Services Continuum of Care (CoC) created a Unified Supportive Housing System (USHS) after realizing the significant overlap of individuals experiencing homelessness and served in the mental health service system. The USHS is a broad partnership that includes the local Alcohol, Drug and Mental Health Board, the Columbus Metropolitan Housing Authority, and the Community Shelter Board. The partnership focuses on coordinating efforts to house and provide services for the community's most vulnerable. Facilitated discussions and meetings helped identify the partner organizations that had common goals and philosophies: commitment to partnering long-term, willingness to take risks, belief in Housing First and the willingness to prioritize the most vulnerable individuals.

Thanks to bonus funding from HUD under the Continuum of Care Program, a new scattered site housing project was developed. A unique partnership was formed with a mental health provider, Columbus Area Integrated Health Services, to serve as the housing provider and also deliver mental health services with Medicaid funding.

Choose a partnership initiation method that works best for you, keeping in mind how you will take steps to build relationships. If you don't know your potential partner organizations well, investing the time to become familiar with these organizations and their leadership will provide great insight and can help set the stage for a good working relationship well before you engage in an official planning process. Initiating relationships is more of an art than a science, but you may find the following tips to be helpful:

- Participate in site visits or tours of potential partners, and host site visits, tours of your own facility
- Invite a panel of shared clients to speak about their experiences
- Invite leaders and key staff of potential partners to engage in informal settings
- Join a community collaborative together or start one as joint founding members
- Jointly apply for a grant for a new or existing program that will meet your partnership goals

3. Assess Partners

Once you have connected with potential partners, take steps to assess potential fit before engaging in planning. Undergoing this process will minimize the risk for surprises or unintended consequences down the road that could derail your efforts. The vetting process is also beneficial even if you are attempting to improve an existing partnership. Again, you may not need to undergo extensive vetting if you plan to engage only in referrals initially; however, informal arrangements like referrals often evolve into larger-scale collaborations. If you have the capacity it may be valuable to engage in conversations with potential partners simultaneously as you roll out referral activities.

Go back and complete Column 2 of the assessment tool in **Exhibit A** to form a comprehensive overview of potential partners. If you prefer a more mathematical approach, an example of a partnership assessment tool with an integrated scoring feature is available from the Baltimore Museum of Art.[xxii] After the necessary information is in hand, **Exhibit B** provides guidance on how to analyze the data you have gathered. This guide facilitates the analysis of information gathered across relationship building considerations such as communication, work styles and trust that can be strengthened through meaningful discussion.

4. Select Partners

You may find in the vetting process that some or all of the organizations you are considering would be a good fit as potential partners. The right fit will have the strongest alignment of organizational values, goals, cultures and partnership "value-add." The right fit will also depend on similar capacities to collaborate. Select partners, who understand partnership value, are excited to work with you and are able to commit time and resources to build the foundation. Once you have made your decision, have leadership in your organization join you in inviting your selected partner(s) to establish a plan to partner together.

STAGE III: MAKE IT WORK

Now that partners are on board, it is time to build a plan together and make a partnership work. This requires identifying partnership champions, setting the vision and goals, creating a structure, devising a strategic partnership plan and addressing barriers.

1. Establish Champions or a Guiding Coalition/Committee

It is important to engage the right people in the partnership planning and implementation of any new systems or services. Large-scale collaborations may warrant establishing a steering committee at this point. Regardless, finding the champions of this change effort will drive it forward. Equally important is to engage organizational stakeholders in the planning process. Choose a team from both organizations of leadership staff, key partnership decision makers and key frontline staff and/or clients who are especially enthusiastic about this partnership opportunity, and who have influence over others in making this partnership a success. Consider case managers/residence managers, clinic intake staff, leadership staff who understand funding and legal considerations and clinic patients or supportive housing residents who are eager to provide insight and spread the word about the partnership.

Find a way for this guiding coalition to communicate regularly and engage in the planning process through ongoing meetings or collaboration tools. Include them throughout the planning and launch of the partnership. Stakeholder feedback is important early on and is something your champions or guiding coalition could solicit early in the planning process. Things to consider here would be focus groups, community forums and patient and resident surveys.

2. Create a Shared Vision

Hold planning meetings to envision what success would look like and create a shared vision with your partners. Become familiar with one another's worksites and cultures. The first decision point is the vision for this partnership. It is important that all partners are on the same page and realize the value this partnership will bring. Consider crafting a vision statement as a way to steer the planning process and motivate the guiding coalition or those engaged in this planning.

3. Determine the Partnership Type

Partnership types are varied, from loosely structured referrals to service integration and co-location. After a partnership vision is established and both parties understand the purpose of the partnership and primary needs it will meet, it will be helpful to set the structure and boundaries of your collaboration. Careful measures should be taken to ensure that a highly-integrated approach does not jeopardize the Health Center Program Grantee's designation. Important considerations follow that can guide you in determining which partnership type to adopt. Please note that some of these approaches may blend together, or you may choose to start with a low-intensity relationship through referrals, with the goal to expand your efforts in the future.

Referrals

Referrals are loosely structured and require a relatively low degree of collaboration. In this approach, one organization refers its clients to another organization for services it does not provide. Organizations often have information and resources of their referral agencies that they present to clients as needed. Referrals do not require a large-scale partnership plan or written agreements, but do involve collaboration. Successful referrals involve communication between direct service staff at all partner agencies to ensure a "warm hand-off" for clients as part of their referral. Referrals work well for low-acuity populations, as clients must initiate and access services without intensive supports.

It is important to consider that many referral relationships evolve into more collaborative partnerships as community systems become further integrated and providers are challenged to meet needs that span these systems. Although the limit of collaborating with another organization may be through referrals, oftentimes referrals are a way of "testing the waters" for future integrated collaborations.

Care Coordination

Care coordination is significantly more collaborative and integrated than referrals, and involves a concerted effort between health care and housing staff to work together to meet clients' needs with the right intervention, in the right place, at the right time. In this arrangement, housing and healthcare providers work together as a team with common goals to improve health outcomes for tenants/patients in the community. Written agreements such as a Memorandum of Understanding (MOU) or an Affiliation Agreement would be helpful for this type of partnership since it requires good communication and accountability.

To accomplish client care goals, a common infrastructure is established that is responsive to the client's needs in the moment. Warm hand-offs are supported with extended periods of transition and engagement that are delivered by staff who have been trained in best practices and have established care plans for serving the target population. This partnership type tends to work well for moderate-acuity clients, as more intensive supports are put in place to remove barriers to health and housing outcomes. In this approach, organizations stay autonomous with separate operations, but coordinate efforts around each client to remove barriers to services and ensure the progress of individualized care plans. Partners may also engage in cross-training and may elect to jointly pursue funding sources.

Collaborating for Care: Healthcare for the Homeless Houston

In Houston, SEARCH Homeless Project, a supportive housing and service provider and Healthcare for the Homeless Houston (HHH), a Health Center, have been coordinating care to serve the community for nearly two decades. HHH has located its largest primary care and dental clinic at the SEARCH transitional housing and multi-service center. With the support of a Medicaid 1115 Waiver Grant, "Integrated Care for the Chronically Homeless Initiative," the two organizations focused their efforts to expand clinical services and care coordination to serve chronically homeless clients. The program allowed HHH to implement the Primary Care Behavioral Health Consultant clinical model, thus moving HHH to a level 6 on the SAMHSA service scale 'Full Collaboration in A Transformed/Merged Practice.' The collaboration team includes: RN Case Manager providing nursing services (also serving as the staffing coordinator,) clinical case manager lead, social services lead, five clinical case managers and four community health workers, in addition to behavioral and primary health care staff. Some of the early lesson learned from this care collaboration partnership included: need to overcome conflicts in HUD and HRSA regulations; education and training for the use of evidence based practices, such as motivational interviewing, CBT and stages of change, was essential for all staff; RN staff was critical in 'interpreting' between medical and case management staff; and significant funding challenges exist as traditional Medicaid would not cover costs.

Co-Location

Co-location involves placing a Health Center Program Grantee clinic on the same site as a supportive housing project or vice versa. In this model, organizations can still retain their autonomy, and in some cases they must.[xxiii] One obvious benefit from this co-location model is that accessibility is greatly increased to services and to on-site staff who have already built trust with clients can bridge connections with partner staff. Another benefit is that the housing provider and clinic can share resources and have an advantage in forming strong working relationships, as they are together at the same site. Complications with payment structures for services can occur in the same spaces or those that appear to blend, but the benefits outweigh the risks.

Partners may choose to offer services in temporary spaces at partner sites or through mobile sites[xxiv] permanently create a clinic or residence at an existing partner site or create a new site all together. Partners that undergo a new joint venture to create a new clinic site with supportive housing will likely need to plan to engage in a very integrative and long-term partnership. This model requires a comprehensive planning process that addresses staffing, accountability, funding and funding restrictions, data considerations and change management. Written plans and agreements are essential, particularly if partners plan to share/integrate data or open a full-service health clinic. Start-up costs for new sites can be rather high, so it

is essential for partners to understand their total funding resources and how long it might take to fully fund ongoing operations (through grants, Medicaid, philanthropy, etc.)

Co-location works well for a target population with many complex needs, as it provides wrap-around services that are coordinated along a continuum, at one location. This model can assist to overcome barriers to services and focuses on meeting clients' short and long-term health needs. Organizations that wish to engage in this type of collaboration should ensure that all partners have the capacity, buy-in and enthusiasm to sustain the partnership.

Co-location Solves Problems: Health Works!

Health Works! began with a five year grant from the Substance Abuse Mental Health Services Administration (SAMHSA) in 2010, a supportive housing provider in Washington DC. Pathways reached out to Unity Health Care, a Health Center Program Grantee to begin to provide primary healthcare to complement Pathways' existing behavioral health services. The relationship grew from referrals of clients to care coordination, and ultimately to co-location.

Health Works! provides integrated behavioral health and primary care services to all Pathways DC clients through an on-site, walk-in Unity Health Care clinic, ACT peer health educators, and a RN nutrition specialist. Integrated health staff provides services in three ways, first through community outreach, second, in clients' homes, and lastly at medical appointments in the clinic. Health Works! and other service partners provide onsite wellness groups in diabetes education, nutrition, and healthy relationships and community wellness events, all of which partner with Unity Health Care's Nurse Practitioner to provide brief group education in preventive care and health management.

This partnership has helped the Health Center address a range of challenges including: low clinic volume, provider staffing, and follow-ups. Key rewards include expanded service area and coverage, reduced ER visits, care coordination, and increasing the volume of clients served that have Medicaid and other insurance.

Full Service Integration

Integrated supportive housing and healthcare models only exist on a rather small scale, generally due to siloed payment streams, but are becoming increasingly more common as payment delivery forms change. Full service integration is highly collaborative model that bridges community systems to provide holistic care along a continuum. In this approach, staff from the supportive housing provider, Health Center Program Grantee and behavioral health services provider (and managed care organizations) function together as one team and fully integrate their operations.[xxv] Organizations in this model may or may not be autonomous and funding and resources are often blended.

This model requires the highest degree of collaboration, as it involves integrated operational systems, shared data and bringing an integrated package of interventions that meet various needs of the target population at one time. It can involve larger community collaborations that span systems outside of housing and healthcare to better serve clients holistically. Full service integration tends to work rather well for highly vulnerable populations and frequent users of systems and institutions.

Service Integration Success: Project 25 San Diego

Project 25 in San Diego CA has built a comprehensive network of health and housing services targeted for the frequent users and high need clients in their community. The initial 'frequent user' pilot project initiated in 2010 under a Substance Abuse Mental Health Services Administration (SAMHSA) and funding from United Way of San Diego has grown both in the number of clients and residents served, as well as the network of community provider partners.

The primary health center partner St. Vincent de Paul is a Health Center Program Grantee with various locations both co-located and in the community to serve the target populations. Father Joe's Village is a supportive housing, child care and behavioral health care provider. A key goal was to focus on data sharing between and among the broad network of providers in the community. The Project 25 partnerships include two local hospitals, County mental health providers, and community 911 emergency and crisis care services. These partners have created a 'Community Information Exchange' that alerts and provides data across the partners to effectively target and serve clients with high needs.

The benefits of this extensive partnership include improved health outcomes resulting from stabilized housing, client care coordination (including appointment follow-up,) substance abuse and addiction counseling, medication management, and healthy food.

4. Build a Strategic Partnership Plan

Build your partnership plan by first identifying your partnership approach (formal/informal, structure, timeline) and how it would best be implemented to meet partner needs, add value and realize your vision. Documenting your strategies and activities as much as possible can prevent miscommunication and confusion down the road. You may also need to share pertinent information like budgets, data and other documents to determine the right structure for the partnership, and to address important funding considerations. Use the guidance provided in **Exhibit C** to assist you in developing a documented plan that addresses initial planning, implementation, and an ongoing services.

Written agreements: Written agreements can prove to be useful for any partnership, especially if there is a high level of collaboration and integration. The agreements serve to formalize and support a partnership by laying out key responsibilities and expectations of partners, and can also document justifications if data needs to be shared in the future. You may find that you need to create formal documents like contracts, partnership agreements or memorandums of understanding or affiliation agreements.[xxvi] In fact, these documents can often act as a partnership plan if they are detailed and clear. An example MOU between a health center and supportive housing provider can be found in **Exhibit D**.

5. Launch the Partnership

After you have developed a partnership plan or strategy, it may be useful to allow the partnership to start on a smaller scale and evaluate progress before rolling out significant operational changes or a large-scale collaboration. You likely will not have all of the answers up front and issues may arise that were not part of the original plan. Launching a pilot can be a very effective strategy in testing the waters.

Pilots may also bring unique funding opportunities to successfully plan and launch your partnership, especially if you can identify a funder who is interested in a particular community initiative, in solving an immediate community problem and/or in supporting a specified goal (i.e. house 100 chronically homeless individuals, create a new model for coordinated access to services). For example, the Chicago Housing for Health Partnership, a coalition of health and housing providers, secured philanthropic and public funding for a six-month pilot program to create a model for moving homeless individuals with chronic illnesses directly from the hospital to housing with support services.[xxvii] Funding covered the planning and design of the model, as well as its implemented pilot where funds and referrals were centralized then distributed throughout the new system. Having the crucial "start-up" funding played a large part in the successful design and launch of this new model. You

may also find special grant opportunities that help you realize the launch of your partnership, as illustrated in the featured partnership below:

Start-Up Success Attracts Additional Grant Funding:
Baltimore Healthcare For The Homeless Center and the Baltimore CoC

Baltimore's Healthcare for the Homeless health center has been connected with community homeless services providers since its inception in 1985. The linkage of health and homeless services began through a collaboration that sent nurses to provide convalescent care for people staying in shelters. HCH Baltimore branched into supportive housing partnerships during a 2005 City announcement to remove community encampments. HCH Baltimore persuaded the City to instead provide scattered site Section 8 vouchers while HCH provided their most accomplished social workers to provide case management, and 30 people were successfully housed as a result.

The success of this collaboration qualified for a large SAMHSA grant for purposes of housing 100 more vulnerable individuals. In collaboration with the CoC, HCH Baltimore applied for a grant for additional funding for housing and health services, which included funding for placing clients in hotels while they completed housing paperwork. The funding allowed for engaging in planning and implementation activities as well, which provided the momentum needed to jump-start this larger initiative.

The success of this second initiative led to additional funding from Blue Cross and Blue Shield affiliates to create co-located convalescent care and health services at shelters and housing sites.

6. Create short-term wins

As part of the partnership plan, incorporate short-term goals for the partnership and ways to celebrate successes, which will build trust and reinforce commitment. Here are a few examples others have found helpful:

- Draft new operations policies together
- Hold informational/engagement meetings for all staff – not just leadership and management
- Highlight success stories as the partnership ramps up such as achievement of a target number of clients placed in housing or served through partner health services
- Consider online partner forums or standing meetings (great for large-scale partnerships)
- Conduct in-person program reviews as part of pilot evaluation
- Communicate short-term wins together by writing case studies, speaking at conferences, applying for awards, highlighting wins in newsletters, etc.

Meeting the short-term goals will build long-term wins for the partnership. These wins will motivate partners, increase momentum and can even attract additional funding opportunities for ramping up or long-term operations. Effective programs communicate shared partnership successes to both internal and external stakeholders to show overall program impact and reinforcement of the partnership value to expand impact.

STAGE IV: MAKE IT LAST

1. Manage New Relationships

By now you have accomplished a great deal of work to identify, assess and build a plan with your partner(s). Establishing trust is key in building lasting, effective relationships. No matter how seemingly matched you are to your partner organization, building trust will take time, patience, motivation and accountability. Consider the following strategies to strengthen relationships:

- **Create Ways to Communicate**
  - Incorporate a mix of both formal and informal meetings between partners to continue to build understanding of each organization
  - Develop various channels for communication (meetings, ongoing updates to staff, incident support, and feedback)
  - Share lessons learned and solicit input from staff and clients for continuous improvement

- **Lead Joint Efforts in the Community**
  - Implement community needs assessments together
  - Start a community collaborative[xxviii] around health and housing partnerships
  - Present together at conferences to share your unique work and "get the word out"
  - Host special events/services together for national recognition days (Heart Month, Alcohol Awareness Month, Social Workers Month, etc.)
- **Celebrate**
  - Celebrate successes and share them with the community (milestone events, newsletter features, partnership success story highlights, client success highlights)
  - Engage in recognition activities (partnership anniversaries, create awards for your partner, recognize them at fundraising/media events, holiday gifts, etc.)

2. Demonstrate Flexibility

In an ever-changing landscape, flexibility is crucial. To ensure long-term partnership success, develop and utilize the contingency strategies addressing staffing/partnership representative turnover, funding changes, etc. Revisiting or changing processes, procedures and even goals could allow for continuous improvement of the partnership activities. Be prepared for changes that may result from leadership changes at the organizations. You may also at times need to give more resources or devote more time than your partner, depending on what the situation demands. You may also find that some tenants/patients are not ready for care at partner agencies or that you underestimated staff readiness to embrace new relationships and practices. Transitioning often takes time. Demonstrating your flexibility helps to build trust, which in turn makes a partnership last.

3. Build Momentum

Meeting initial goals is not enough and the partnership can stagnate if new goals and a long-term vision are not set. Build into the partnership plan the opportunity to keep it fresh with new objectives and goals that incorporate lessons learned and allow for anticipated future changes. Another way to sustain momentum is to constantly engage stakeholders throughout the process. Continue to gather input and allow staff, clients and leadership from all organizations the ability to give feedback and inform decision making. Communication is key in keeping the momentum going and to ensure partners stay active and committed. Finally, celebrating successes along the way will motivate those engaged in partnership.

4. Anticipate Future Changes

To the degree possible, try to anticipate what is on the horizon with your new partnership. Awareness of the nature and timing of new funding opportunities or restrictions, regulatory changes, and health care and service delivery trends will help set the right course in the long term. It will be helpful to read articles, attend conferences, and find opportunities for partners to stay abreast of changes in both health care and supportive housing.

5. Dive into the Data

A long-term plan will involve long-term data considerations. As your partnership grows, you may need to consider data more seriously or in a different way, as data informs understanding and justifies evaluations and successes of a program. It will likely be the case that you will have a higher need to share data with your partner as you engage in more coordinated efforts to serve your clients. Communities can create new data points together as part of their partnership success indicators. Examples can include cost reduction per client, tenant health indicators, percentage of tenant population engaged in preventative care, benefits enrollment rates, etc.

Know the data restrictions: There are various data restrictions both federal and local, mostly pertaining to health centers - namely, patient privacy and the requirement to maintain ownership of patient health records.[xxix] Homeless system data on the HMIS database is not as strict as HIPAA regulations, but it is protected information that is only shared with member providers who opt into the database system. Some communities have integrated written client release forms into their coordinated assessment intake process, which allows certain health center data to be shared with the supportive housing provider and vice versa. Data agreements between providers should be explored to determine the extent of sharing that can

be implemented, especially if the partnership focuses on frequent users of the health system.[xxx] Data sharing can be rather complex[xxxi] and continues to be a challenge, but more specific guidance to ease this tension is forthcoming from the Department of Health and Human Services (HHS).

6. Secure Long-term and Future Funding

Finding the resources and funding to plan and launch a partnership is a great accomplishment, but a lasting partnership requires ongoing and long-term funding strategies. Many grants that funded the initial innovations in health and housing partnerships do not cover ongoing operations.

Challenges: Current evidence-based practices for serving people experiencing chronic homelessness or living in supportive housing do not always align with the payment structures and requirements for health centers. It can be difficult to obtain reimbursement for providing "whatever-it-takes" wraparound services (e.g. motivational interviewing for mental health or substance abuse or including unlicensed staff such as peer support specialists into integrated patient care teams). Health Center grants may not cover some of these services. Further, HUD and HRSA regulations are not always alike. It will be beneficial to discuss potential funding challenges up front and develop solutions together, especially if your partnership will involve integrated services with the need for additional funding.

Opportunities: Many more supportive housing residents are either eligible for or are covered by Medicaid, and Medicaid expansion has led to increased funding for supportive housing services. This is especially true for services offered through supportive housing and health center partnerships.[xxxii] One first step is to ensure that eligible tenants and clients are enrolled in Medicaid.

Innovations: There may be creative funding opportunities for your community. Generally, the most recent innovations in funding involve organizations that partner. In Los Angeles, various representatives from homeless services, supportive housing, mental health services and health care came together in partnership to create a brand new housing subsidy focused on health. This allowed for the funding of health, supportive services and housing.[xxxiii]

Some Health Centers have been successful in coming to agreement with state policymakers and Medicaid program officials to ensure that ongoing funding is available to cover the costs of reaching, engaging, and serving people who are living in supportive housing, as well as those who are still experiencing chronic homelessness. It is important to continue to work with state Medicaid program leaders to develop solutions that can overcome specific challenges like billing structure, profitability of providing services located outside of the health center and multiple client visits on the same day.

CONCLUSION

There is no “one-size fits all” approach to partnering. Ultimately, the best approach will be what works for your organizational needs, resource gaps, goals, culture and capacity. It is important to view partnerships as long-term investments to serve your target population in the best way possible. Making partnerships last involves careful and thoughtful relationship management and continuous learning. As the housing and health care landscape continue to change, adopting a long-term view will allow partnerships to adapt to emerging opportunities and challenges. Equally important, a successful partnership must also be evaluated and updated regularly to realize impact for the target population. Taking this approach can position your organization as a partner-of-choice with a clear understanding of value, direction for the partnership and the ability to lead new projects or initiatives that solve community problems. It takes time, trust and work to partner, but when you and your partners are committed and take ownership in making collaboration successful, that collaboration can become a movement that builds healthy communities.

Exhibit A
Assessing Partnership Fit

Instructions:

1. Fill in the information under Your Organization first, and gather as much data as you can. Think about your answers in the context of partnering if something does not seem clear.
2. Have potential partners complete the information under Potential Partners. Again, think about answers in the context of partnering
3. You may instead choose to complete this tool together; remember, though, this tool asks for a good deal of information that could be gathered in advance of meeting.

Optional Data & Documents to Supplement This Process:

- Organizational strategic plans, agreement documents with other partners, policies and procedures manuals
- Services budgets, funding requirements, information on data collection and management
- Service program flow charts/overviews, client needs assessments

	1. Your Organization	2. Potential Partner
General		
Mission		
Target Population(s)		
Location		
Direct Service Staff Structure		
Approval/Decision Making Process & Key staff		
Top 3-5 Organizational Goals or Priorities		
This is what we do BEST:		
Current Services		
Committed to prioritizing homeless and chronically homeless individuals?		
Array of services offered		
Mental Health		
Who provides these services?		
How do clients access this service?		
Location of services		
Any funding restrictions?		
Current services needs or gaps		
Medical Health		
Who provides these services?		
How do clients access this service?		
Location of services		
Any funding restrictions?		
Current services needs or gaps		
Substance Abuse Services		
Who provides these services?		

How do clients access this service?		
Location of services		
Any funding restrictions?		
Current services needs or gaps		
Other Services		
Who provides these services?		
How do clients access this service?		
Location of services		
Any funding restrictions?		
Current services needs or gaps		
Data		
Current database(s) used for services data		
Is data shared with anyone outside of organization? If yes, what is shared? How is it shared?		
Data sharing restrictions		
Would client info release allow access to all data?		
Partnership Readiness		
Existing community collaborations or partnerships (of any kind)		
Existing partnerships or coordinated care efforts in health		
Capacity for partnership – staff champions? Resources?		
Partnership needs		
Partnership goals		
Leadership buy-in for partnerships of this kind?		
Who is driving this partnership effort? Role(s) at organization:		
Funding		
How are services currently funded?		
What are the major restrictions on funding?		
Do you receive funding for purposes of collaborating or partnering? If yes, what is required?		
Do you receive Medicaid? What does your funding structure look like around this?		
Do you help your clients		

enroll in Medicaid?		
Innovation Factor		
Are you willing to take risks? What is the most innovative program you've developed? How comfortable is your organization with ambiguity?		
Are you planning for future changes in health: MCOs, ACOs, system-wide collaborations?		
Do you see yourself as a community leader? In which ways?		

Exhibit B
Assessment Analysis Guide

Info area	Analysis
Mission	Missions should be similar or have some overlap.
Target Population(s)	Commitment to serve a similar target population
Location	Consider access to services, especially if service integration will be part of the partnership. Partners should be accessible to one other for staff and clients.
Direct Service Staffing	• **Structure**: This helps understand who would be interacting with the target population most – are there similarities in your structures? Are there key differences that could be of value or are potential issues? • **Roles**: There may already be overlap between supportive housing providers and Health Center Program Grantees with the following positons: o Practitioner or physician who delivers medical care to residents o Licensed clinical social worker who provides directly or links to mental health and substance use services o Medical assistant that provides medical support services (can factor into FQHC rate) o Benefits specialist who enrolls participants in Medicaid/Medi-Cal
Approval/Decision Making Process & Key staff	Who are the key staff at each organization that would make decisions related to this partnership? Are they in the room now? The partnership should have leadership participation from both organizations.
Top 3-5 Organizational Goals or Priorities	The top priorities at each organization should be similar in some way, or a health/housing partnership should fall in line with these priorities
This is what we do BEST:	The strengths of each organization should be complementary
Committed to prioritizing homeless and chronically homeless individuals?	Beyond target population, there should be a commitment specifically for prioritizing homeless and chronically homeless people. A bad fit would be partners who do not want to "deal with" this population.
Array of services offered	Do partners offer a narrow or wide array of services? It may be challenging for those that offer very narrow services with no other partners to forge this new partnership, as there will be a learning curve.
Services	
Mental Health **Medical Health** **Substance Abuse Services** **Other Services**	• Figure out **service gaps**, between the organizations • Note any **similar partners/referrals** that exist • Look for **common access points** for clients into these services. Are there common barriers to access? How can these be overcome together? • Are there specific **funding restrictions?** If so, what are they? How could each partner help meet these restrictions? Would any restrictions hinder partnering? How can these be addressed? • How can each organization bring **value** to the service gaps and needs of the other? • **Client engagement strategies:** How are they similar? How do they differ?
Data	• What are the client data needed for services at each partner site? Is there a lot of data overlap? • Determine which data is shareable. What are the data restrictions? Which organization(s) has the least restrictions? • Does either organization have experience sharing data with other organizations? Any experience in data sharing agreements or client information releases?
Partnership Readiness	• It is helpful if either or both organizations have experience with partnerships or collaborations in the community. If this is the case, who are the similar partners? What were lessons learned? What worked and why?

	• Both/all organizations should have staff that would commit to this partnership, with representation on both sides by leadership • Who would drive this partnership at each organization? How easy is it for them to make decisions and make things happen? • What are the hesitations to partner on either side, if any? How can these be addressed together? • The partnership goals should be similar if not the same • Staff members would follow directives from project managers who may be from the partner organization, are willing to learn about their partners and could take on new work • Staff are willing to integrate new practices that improve health outcomes for the target population
Funding	• Start with any organizational funding restrictions that may apply to a partnership with the organizations in question. How might partnering actually help meet these requirements? • Are there any funding opportunities that you could pursue as partners? • How would Medicaid funding impact this partnership? How would partnership meet these requirements? Would partnering result in additional funding for either partner?
Innovation	• Do partners match up in terms of their culture of risk? For example, a risk-averse partner may be too cautious or may be constrained by regulations that move more slowly for a risk-taking organization. • Are all partners innovators/early adopters in the community? There is not a very long history of these types of partnerships, so success may involve navigating ambiguity. • Have both organizations thought about how this partnership would fit in with the health/housing landscape as it develops in the future? Who else could be included in this partnership in the future?
Bottom Line	• **The value each of us can provide is complementary and fills service/resource gaps. There is equal value and effort.** • **We enjoy working with one another and are equally engaged in discussions and planning.** • **It's possible to back out if it's not a fit. The impacts to clients and funding resources are not too severe.**

Exhibit C
Components of a Partnership Plan

Component	Guidance
Partnership Purpose	Articulate your partnership vision and goals. Write it down in your plan or agreement and make sure the components are developed with equal input from all partners. Create both short-term and long-term goals.
Structure	Determine and document in writing the structure needed to meet the goals of your partnership. More formal structures may require an agreement that will serve as a contract.
Documented Agreement	Documented agreements will promote accountability and sustainability. In some cases, such agreements can serve as the partnership plan, and using the format of an agreement can help plan and organize partnership activities. **Examples:** • Partnership agreement • Memorandum of Understanding (samples in **Exhibit D**) • Affiliation Agreement • A more informal agreement of your choosing (viable for referral-based partnerships)
"Start-Up" Plan	Include your planning and implementation activities that will lead to the launch of the partnership. This can include a pilot for a new initiative, project, joint venture or campaign. Many of these can carry over into your ongoing plan, as appropriate.
Roles & Responsibilities	Spell out roles and responsibilities of each organization and of key staff to set collective expectations. Outlining the ownership of particular partnership activities and resources is considered a best practice.
Contact & Communication	**Contact**: Include contact information of key staff members, hours of operation, hours of new partner services (if applicable) **Communication**: Include a strategy for open and clear communication – ongoing meetings, referrals, problem-solving and crisis management avenues, information sharing. Also include strategies for marketing the partnership and successes – website updates, social media, online forum, newsletters, case studies, speaking at conferences, etc.
Operations	Develop an initial service operations plan that outlines the new partnership system and activities, step-by-step. You can choose to incorporate the sections above into this plan. Think about what systems must look like when your initial short-term goals are met. List the functions of your ideal system.
Data	Data is a key component of the operations of a new partnership, initiative, program, etc. Come to a decision on: • What data is collected and when • How does this data fold into each organization's current data processes? • Data sharing: information release forms, 'business affiliation,' merging data collection. Data sharing agreements are especially important when partnering with health care partners due to privacy restrictions under HIPAA[1] or state privacy laws.
Funding Strategy	When considering funding for partnerships you should think about both the resources to plan and launch the partnership, in addition to resources need to operationalize and sustain the services provided under the partnership. Determine what resources the program needs to meet the goals of planning and launch: staff, technology, facilities, service needs, supplies, equipment, etc. Develop a strategy to secure the funding. An informal budget could help organize.

[1] The text of the HIPAA Privacy Rule can be found here: http://www.hhs.gov/ocr/privacy/hipaa/administrative/privacyrule/

	Consider: • New grant opportunities or time-limited investments you can apply to together as partners • Can existing funding structures be re-configured to devote resources to the partnership? • Are there existing unrestricted funding resources that could be invested? Develop a strategy to secure funding for services delivery. The services included here may include both direct services and support services such as outreach, case management, and follow-up.
Personnel	In addition to the roles and responsibilities, determine which personnel will be involved in any part of the partnership, what training they might need, and how to keep them engaged throughout the launch and operational processes.
Ongoing Service Plan	
Roles & Responsibilities	Build on roles and responsibilities detailed in your start-up plan. Include any changes, new roles, future responsibilities. **Adapt from above as needed. Include responsibilities related to:** • Hiring, salaries, training • Purchasing, developing content • Who provides services and where, what client referrals or "hand-offs" look like • Communications on staffing, clinic hours, and protocols • Who manages data and who can share it • Who is responsible for client intake and billing • Partnership decision making
Policies & Procedures	Include rules for the new program/partnership, insurance, legal and compliance implications, and rights and obligations, if not already included in your documented agreement.
Contact & Communication	**Contact**: Include contact information of key staff members, hours of operation, hours of new partner services (if applicable) **Communication**: Include a strategy for open and clear communication – ongoing meetings, referrals, problem-solving and crisis management avenues, information sharing. Supply staff with key messaging. Also include strategies for marketing the partnership and successes – website updates, social media, online forum, newsletters, case studies, speaking at conferences, etc.
Operations	Develop an ongoing service operations plan that outlines the new partnership activities, step-by-step. You can choose to incorporate the sections above into this plan. Think about what would be happening if all partnership goals are met. List the functions of your ideal system.
Data	Adapt your data plan as needed from your start-up plan, considering ongoing and future data needs.
Funding Strategy	Determine what resources the program needs to meet the goals of ongoing partner operations: staff, technology, facilities, service needs, supplies, equipment, etc. Develop a strategy to secure the funding. An informal budget could help organize. Consider: • New grant opportunities to scale your partnership, highlighting existing successes • Can existing funding structures be re-configured to devote resources to the partnership? • Are there existing unrestricted funding resources that could be invested?
Personnel	Adapt your personnel strategy from your start-up plan as needed
Evaluation	Create short and long-term success indicators with benchmarks to measure

	progress against goals. These should be outcomes-related measures that include achievements within partnership activities. Many agencies have found that process measures (participation, number of meetings) are not as effective as progress measures.[2]
Change Management	It is important to remember that putting effective integrated care into place is not easy. It requires practice change on multiple levels, and it is nothing short of a new way of delivering care. Every team member is challenged to learn new skills and more importantly, to work together somewhat differently from the traditional way of doing his or her job. Addressing these issues upfront will help manage the changes as you implement phases of the partnership.
Contingency Plan	Unintended consequences can happen. Include contingency strategies, or know when it might be appropriate to dissolve your plan and agreement. Determine who might carry the torch if leadership or key staff turnover. Check in on how much intervention is needed to get things done. Evaluate your working relationship and make sure that all parties are driving the outcomes.

[2] CDC's structured approach to effective partnering:
http://www.cdc.gov/phpr/partnerships/documents/a_structured_approach_to_effective_partnering.pdf

Exhibit D
Health Center Program Grantee & Behavioral Health Organization or Supportive Housing Partnership Sample Agreement[3]

Memorandum of Understanding
Regarding Integrated Services

This Memorandum of Understanding ("MOU" or "Agreement") is entered into between --------, Inc. (Health Center) and ---- (Community Mental Health Center/Supportive Housing Agency (SHA)) effective [Date]. Each signatory to this MOU may be referred to as a "party," and collectively as "Parties."

WHEREAS, CMHC/SHA , a [NAME OF STATE] nonprofit corporation, is the community mental health (or SH) center that provides behavioral health services in ---- county, and

WHEREAS, Health Center, a [NAME OF STATE] nonprofit corporation, is a Health Center Program Grantee providing primary care in ------ county, and

WHEREAS, in the interest of collaborating for more effective treatment CMHC/SHA and Health Center will work together to serve patients whom they believe may have behavioral health problems and/or substance abuse issues that interfere with their ability to maintain good overall health.

WHEREAS the Parties desire to enter into an agreement that clearly identifies the roles and responsibilities of each party with respect to the development and implementation of an Integrated Health Services Program (list site here if there is a specific site where services will be).

ARTICLE I: TERM AND TERMINATION

- **1.1 Initial Term.** The initial term of this MOU shall be from DATE until DATE unless earlier terminated and in accordance with Section1.3.
- **1.2 Automatic Renewal**. Upon expiration of the Initial Term, this MOU shall be automatically renewed for successive one-year terms, each commencing on the first day following the date on which the preceding initial term or renewal term shall have expired. Each Party reserves the right not to elect to renew the MOU.
- **1.3. Termination.** Notwithstanding any other provision in this MOU, this MOU may be terminated on the first to occur of the following:
    - (a)Either Party may terminate this MOU, with or without cause and with or without providing reasons for termination, upon giving the other Party ninety (90) days' prior written notice.
    - (b)Either Party may terminate this MOU for breach upon giving the other Party thirty (30) days' prior written notice of intent to terminate and a description of the specific breach of the MOU. If the breaching Party has not cured the breach by the end of the 30 day notice period, this MOU shall terminate immediately at the expiration of the 30 day period.

ARTICLE II: RESPONSIBILITIES

- 2.1. **Responsibilities of CMHC/SHA**. CMHC/SHA shall:
    - Hire LIST NEEDED BH/SH STAFF POSITIONS through the standard hiring process
    - Provide new employee orientation
    - Pay a monthly base salary of -------
    - Provide standard benefits package with cost to be paid by ------
    - Provide laptop computer for work related functions, including documentation of encounters
    - Pay for any mileage, lodging, and incidental expenses incurred as a regular part of employment
    - Provide Health Center with a quarterly statement of one half the cost of salary and benefits

[3] Adapted from http://www.coloradohealthpartnerships.com/provider/integrated/Sample-FQHC-CMHC-MOU-Unabridged.pdf

- Provide training and supervision by the BH/SH Integration Coordinator to a 1 FTE BH/SH provider (Provider) following the agreed upon integrated service-delivery model. This person will also coordinate referral and communication with both CMHC/SHA and other specialty care services in the community. The Provider will be expected to participate in clinical training activities as time permits
- Providers providing services on Health Center premises will be appropriately licensed, certified, and/or otherwise qualified to furnish services as assigned
- CMHC/SHA shall provide all services pursuant to this MOU in accordance with applicable state and federal law and any performance standards established by Health Center and CMHC
- Not discriminate by payer source or patient's county of residence
- Document patient encounters in Health Center EMR only
- Bill for patient encounters utilizing Health Center Standard Operating Procedures for behavioral health billing

- **2.2. Responsibilities of Health Center Program Grantee**. Health Center shall:
  - Credential the Provider in full compliance with state regulations as described in [NAME OF STATUTE] Health Care Professional Credentials Application
  - Provide a furnished office for the Provider (if needed)
  - Provide organization orientation with required information confidentiality statements
  - Reimburse the CMHC/SHA one-half of the salary and benefit expenses as billed by a quarterly statement.
  - Provide a monthly encounter report to CMHC/SHA. This report can also be submitted directly to [_____]

ARTICLE III: LIABILITY AND INSURANCE

- **3.1 Liability**. Each Party shall be solely liable for any and all claims, costs, and expenses arising from or out of any act or omission in the performance of its obligations thereunder
- **3.2 Insurance.** Each Party shall maintain such policies of general and professional liability insurance as shall be necessary to insure it, its Board of Directors, and its employees against any claim or claims for damages arising by reason of an act or omission in the performance of its respective obligations hereunder. Such policies shall be carried in amounts of not less than $1,000,000 per occurrence. Each party shall further maintain worker's compensation and unemployment compensation policies for its employees
- **3.3. Coverage**. Health Center shall provide coverage under FTCA upon completion and approval of State Credentialing requirements as described in section 2.1

ARTICLE IV: CONFIDENTIALITY

The Health Center and the CMHC/SHA are covered entities for the purpose of Health Insurance Portability and Accountability Act (HIPAA)[4] and subject to 45 CFR and 164 of the HIPAA Privacy Regulation. To the Extent that employees are participating, employees shall:

1. Be considered part of the FQHC workforce for HIPAA compliance purposes in accordance with 45 CFR 164.103, but shall not be constructed to be employees of the Health Center.
2. Receive training by Health Center and CMHC/SHA on, subject to compliance with, all of the Health Center and CMHC/SHA privacy policies adopted pursuant to the Regulations, and
3. Not disclose any Protected Health Information, as the term is defined by 45 CRF 160.103, to which an Employee has access through program participation.

ARTICLE V: GENERAL PROVISIONS

IT IS MUTUALLY UNDERSTOOD AND AGREED BY AND BETWEEN THE PARTIES THAT:

1. **PARTICIPATION IN SIMILAR ACTIVITIES:** This instrument in no way restricts the CMHC/SHA or Health Center from participating in similar activities with other public or private agencies, organizations, and individuals.
2. **COMMENCEMENT/EXPIRATION /TERMINATION**: This MOU takes effect upon the signature of the CMHC/SHA and Health Center and shall remain in effect for 365 days from the date of execution. This MOU may be extended or amended upon written request of either the CMHC/SHA or Health Center and the subsequent written concurrence of the other(s). Either the CMHC/SHA or Health Center may terminate this MOU with a 30 day written notice to the other(s). Any remaining salary and benefit costs will be split by the agencies.

[4] Note: This might not be the case for a SHA.

3. RESPONSIBILITY OF PARTIES: The CMHC/SHA and Health Center and their respective agencies and office will handle their own activities and utilize their own resources, including the expenditure of their own funds, in pursing these objectives. Each party will carry out its separate activities in a coordinated and mutually beneficial manner.
4. PRINCIPAL CONTACTS: The principal contacts for this instrument are: CMHC/SHA Contact _____; Health Center Contact_____.

AUTHORIZED REPRESENTATIVES: By signature below, Health Center and CMHC/SHA certifies that the individuals listed in this document as representatives of the Parties are authorized to act in their respective areas for matters related to this agreement.

This agreement is for the time period of DATE to DATE and can be renewed or amended at that time upon the agreement of both parties.

_____
Chief Executive Officer
CMHC/SHA

_____
Chief Executive Officer
Health Center

References

[i] The Affordable Care Act allows states to expand their Medicaid programs to cover individuals with low incomes regardless of disability, family status and other characteristics. For more information: https://www.healthcare.gov/medicaid-chip/medicaid-expansion-and-you/

[ii] Medicaid waiver details: http://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/waivers_faceted.html

[iii] Supportive housing definition: " decent, safe, affordable, community-based housing that provides tenants with the rights of tenancy and links to voluntary and flexible supports and services for people with disabilities who are experiencing homelessness."

[iv] Supportive housing prevents onset of new injury/illness, improves access to coordinated care and promotes a healthier lifestyle. http://www.csh.org/wp-content/uploads/2015/02/HRSA-One-Pager.pdf

[v] Seattle's Housing First program reports roughly 60% per person savings after securing housing for six months, and a 75% savings after 12 months. Chicago reports over $6,000 savings per person after securing permanent housing.

[vi] Referral, care coordination, etc., as outlined on page three

[vii] Case study of a promising collaboration that went awry: http://aims.uw.edu/case-study-heartbreak-and-lessons-learned?utm_source=AIMS+Center+Newsletter&utm_campaign=0f148b5a1f-AIMSCenterNewsletter_April_2015&utm_medium=email&utm_term=0_5e264f9d0f-0f148b5a1f-352895369>

[viii] Partnering with a Health Center: http://www.hrsa.gov/affordablecareact/healthcenterpartner.pdf.

[ix] http://bphc.hrsa.gov/about/what-is-a-health-center/index.html

[x] Note: HRSA recently made supportive housing residents eligible to receive care in HCH clinics, along with individuals who are homeless.

[xi] These types of Health Center Program Grantees are awarded a grant under the Health Center Program within Section 330 of the Public Health Service Act.

[xii] Addressing Legal Barriers To The Clinical Integration Of Community Health Centers And Other Community Providers: http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2011/Jul/1525_Rosenbaum_assessing_barriers_clinical_integration_CHCs.pdf

[xiii] *Ibid.*

[xiv] These requirements are quoted or paraphrased directly from the HRSA Health Center Program Requirements: http://bphc.hrsa.gov/programrequirements/index.html. *Note: This list includes requirements where SH Providers could bring value. This is not an exhaustive list of the HRSA health center requirements.*

[xv] This is not an official requirement by the program, but is pressure that health centers face within the greater health and service provider field within a community

[xvi] While this is not a requirement, HRSA invests in outreach and enrollment, and health centers have a long history of providing this. http://www.hrsa.gov/affordablecareact/healthcenterpartner.pdf

[xvii] For a more detailed overview of the mechanics and funding of supportive housing, please refer to the following report: http://www.csh.org/wp-content/uploads/2011/11/IntegratingHealthReport_FINAL.pdf

[xviii] Please refer to the following for more information on supportive housing models: http://www.csh.org/toolkit/supportive-housing-quality-toolkit/getting-started/supportive-housing-models/

[xix] Your state's Primary Care Association can let you know what health centers are looking for new partners. http://bphc.hrsa.gov/technical assistance/partnerlinks/associations.html

[xx] Some communities have identified the most apparent overlap through a "frequent user" list of clients to target the highest system utilizers. An example: http://www.endveteranhomelessness.org/sites/default/files/Kuntz%20Creating%20a%20Comprehensive%20Frequent%20User%20List%20for%20Outreach%20Final.pdf

[xxi] More information on HRSA-funded NCAs can be found here: http://bphc.hrsa.gov/qualityimprovement/supportnetworks/ncapca/natlagreement.html

[xxii] There are also other partnership tools: http://naeaworkspace.org/naea14/Getting%20to%20a%20Better%20Yes%20Working%20Towards%20Impact%20in%20Challenging%20Times_Elizabeth%20Benskin_Anne%20Manning/BMA-Partnership%20Vetting%20Tool.pdf

[xxiii] There may be restrictions such as operating hours, storage and licensure requirements. http://www.csh.org/wp-content/uploads/2011/11/IntegratingHealthReport_FINAL.pdf

[xxiv] Usually via mobile clinics that move between supportive housing sites

[xxv] Definition and more details from a behavioral health and primary health perspective: https://www.sccgov.org/sites/mhd/Documents/Grand%20Rounds%20Newsletter-Vol%2016%20-%20Ron%20Manderscheid.pdf

[xxvi] An example of an Affiliation Agreement between a FQHC and a behavioral health provider can be found here: http://www.integration.samhsa.gov/an_affiliation_agreement.pdf

[xxvii] More details can be found here: www.huduser.org/portal/periodicals/em/summer12/highlight3.html

[xxviii] A Community collaborative is generally an organized planning and action body that is formed after representatives within or across systems come together to solve a community problem.

[xxix] The text of the HIPAA Privacy Rule can be found here: http://www.hhs.gov/ocr/privacy/hipaa/administrative/privacyrule/

[xxx] Additional information on data sharing for partnerships serving frequent users, please refer to CSH/HRSA's webinar, *Identifying Frequent Users and Data Sharing*: http://www.csh.org/about-csh/how-we-work/consulting-and-training/course-offerings/

[xxxi] Aside from HIPAA and HMIS protections, each State may have stricter protection laws surrounding patient/client information.

[xxxii] CMS Informational Bulletin June 26, 2015: http://www.medicaid.gov/federal-policy-guidance/downloads/CIB-06-26-2015.pdf

[xxxiii] Please refer to CSH/HRSA's *Health and Housing – Partnering at the Agency and Systems Levels* webinar for more details on this example and its funding methods: http://www.csh.org/about-csh/how-we-work/consulting-and-training/course-offerings/