INTRODUCTION
Building Partnerships: Health Centers & Supportive Housing

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.

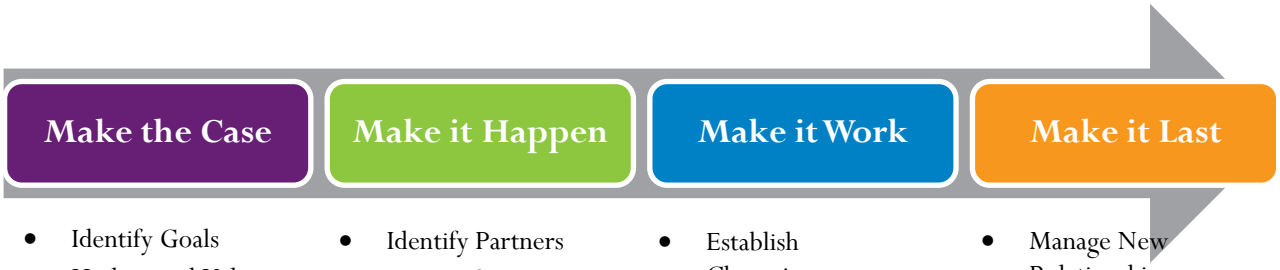
About This Guide

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.



- Identify Goals
- Understand Value of Potential Partners
- Assess Your Capacity
- Engage Leadership

- Identify Partners
- Approach Partners
- Assess Partners
- Select Partners

- Establish Champions
- Create a Shared Vision
- Build the Partnership Plan
- Launch Partnership Activities
- Create Short-Term Wins

- Manage New Relationships
- Demonstrate Flexibility
- Build Momentum
- Anticipate Changes
- Align Funding & Data

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

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/