



Strengthening Partnerships with Community Mental Health Centers



Introduction: Why Partner with Community Mental Health Providers?

Health Centers are more likely to serve persons with complex health and social needs than most primary care providers. Health Centers have been leaders nationally in the health equity movement, ensuring access to quality primary and integrated care for low-income communities. Those poorer communities are more likely to be communities of color due to our country's long history of structural racism.¹

The standard best practice for individuals with medical, behavioral health and health-related social needs is an integrated care model and/or team that addresses a person's complex needs in a holistic manner.² This best practice model is promoted by both the federal Health Resources and Services Administration (HRSA) and the Substance Abuse and Mental Health Services Administration (SAMHSA). However, access to integrated care teams, while growing remains limited due to the Fee for Service (FFS) financing models that include disincentives for health care providers who offer such teams.

For persons with the most serious behavioral health disorders, health centers have developed increasing capacity in these integrated care teams. Health centers have also created referral networks with Community Mental Health Centers (CMHCs) for the specialized behavioral health services (day programs, targeted case management, peer supports, recovery support services, supportive housing and supported employment services) that health centers may not offer.

A new model, based on the success of the Health Center movement is the Certified Community Behavioral Health Clinics or CCBHCs.³ CCBHCs are designed to offer a more comprehensive and easier to access behavioral health care model. Like Health Centers, CCBHCs are paid on a Prospective Payment System (PPS) and are required to accept all referrals regardless of ability to pay. There are emerging lessons from both CMHCs and CCBHCs that can help guide Health Centers looking to address community needs and partner effectively with these new and evolving models of behavioral health care. The paper will consider both partnerships needed to comprehensively address behavioral health and health-related social needs.

Common Behavioral Health Providers

Similarly, to how Health Centers refer out for highly specialized care, such as oncology, cardiology or rheumatology, health centers may also refer out to specialty behavioral health providers.

Health Centers are increasingly offering psychiatric care and consultation, mental health and substance abuse therapy services and Medication Assisted Treatment (MAT). For persons with more chronic or acute behavioral health conditions, such as Serious Mental Illness (SMI), Health Centers are still reliant on referrals to specialty behavioral health providers. Health Centers may refer out when a person would benefit from Targeted Case Management (TCM), Home and Community Based Services (HCBS), day programs, peer supports, recovery supports, supportive housing or supportive employment services. With these referrals comes a need for stronger partnerships between the referring entities, detailed referral processes, development of data sharing agreements, care platform collaborations and other cross agency efforts to ensure quality, integrated care for those individuals served by both agencies.

Many of these individuals may also have a variety of health-related social needs (HRSN) such as food insecurity, housing instability or homelessness, lack of individual safety in their homes or communities and other HRSNs. Both Health Centers and Health Care for the Homeless (HCH) programs see patients who are experiencing homelessness or housing instability as the housing crisis in our country worsens. Health Center patients may be living in a variety of settings some of which are permanent settings such as Permanent Supportive Housing (PSH) and other may be in shorter term options such as Rapid Rehousing (commonly 6-24 months) or emergency shelter and may need assistance with accessing a longer-term housing option.

Health Centers have embraced Social Determinants of Health screening using tools such as the **PRAPARE tool**.⁴ Health Centers have also expanded their partnerships with Community Based Organizations (CBOs) that address those needs. In those partnerships, they have developed tools and templates that can be adapted to the enhanced partnerships relationship growing between them and CMHCs and CCBHCs. The services that health centers offer or can connect their patients to can mean the difference between stable housing and homelessness or to other HRSNs. Without these services, connecting with primary care would be too difficult to navigate.

DEFINITIONS

1. **Federally Qualified Health Center (FQHCs)** – Primary care and other health care services provider who qualifies for funding under **Section 330 of the Public Health Services Act**.⁵
2. **Health Center Look Alike** – Health care provider that may offer similar services, and meet other qualifications, but is not funded by via Section 330.
3. **Community Mental Health Centers (CMHCs)** – Community Based Organization offering mental health services including specialty care for persons with serious mental illness.
4. **Certified Community Behavioral Health Clinics (CCBHCs)** – **SAMHSA supported program model**⁶ that meets federal standards. Similar to FQHCs they must serve all who ask for help regardless of ability to pay.
5. **Community Based Organizations (CBOs)** – Public or private not-for-profit resource hubs that provide specific services to the community or targeted population within the community.

Acuity in High Need Populations

When used in healthcare settings, acuity refers to an individual’s level of severity of illness or level of care needs. Acuity levels can be classified into high/medium/low groups (for example), to translate level of care needs and assessment findings into a classification system to help determine how to best serve clients with the right level of care provided in the best manner in the appropriate setting.

In particular, for patients experiencing homelessness or housing instability, acuity measures should include:

- + severity and chronicity of illness and/or disability;
- + presence of co-occurring mental health and substance use diagnoses;
- + level of care needed to support activities of daily living, including assessing assistance required to support communication, decision-making, mobility, and managing challenging behaviors; and
- + recognition of the exponential effects that multiple co-occurring chronic health and behavioral health conditions can have, particularly when coupled with the effects of systemic racism and historical trauma, adverse childhood experiences, isolation from family and friends, lack of safety net in times of crisis and disconnection from mainstream community health providers.

Finally, it is important to note that people’s acuity and service needs can fluctuate over time.

For FQHCs and Community Health Centers, patients with high acuity needs may require more intensive behavioral health services than are typically available—for example, it may be that these services need to be available “outside the four walls” of the clinic. It is for these patients that an established partnership(s) with CMHCs or CCBHCs would result in the best care. In particular, CCBHCs are able to expand care “beyond the four walls” of clinical settings to meet clients where they are at, such as in the community.

People with moderate or low acuity may not have any serious mental health diagnoses and while they may have substance use conditions, those are not co-occurring with mental health issues. People with moderate or low acuity may require more time-limited care such as counseling, group therapies, and assistance with benefits and access to housing.





Opportunities for Partnering

Assessing for Partners

Health Centers that are looking to develop partnerships and referral networks with local behavioral health providers have a number of places to start. SAMHSA has an online ***treatment locator***⁷ searchable by Zip Code to find providers who are serving the same geographic region as the health center. The community also likely has a ***Community Health Needs Assessment***⁸ highlighting issues facing the community. Reviewing the needs assessment for its analysis of behavioral health-related issues and system leaders in the community can assist the health center in deciding what behavioral health related services to offer and who to partner with. The local public health department, if they have made behavioral health a priority may have a “landscape assessment” to determine what local communities are underserved, what agencies offer services and what additional services or programs are needed. If no such community wide assessment exists, then The health center may want to create one for the geography that The health center serves. Whether using a local public health department’s work or creating a new landscape assessment, this assessment will help a health center to determine what services they may want to expand to offer. Once those choices have been made, the health center can work towards expansion of services if needed, or develop referral networks for community services.



SAMHSA's FindTreatment.gov⁵ website is a secure and anonymous resource for persons seeking treatment for mental and substance use disorders in the United States and its territories.

Developing a Referral Network

Once a health center has decided what specialty behavioral health services will be referred out, then the landscape assessment can also help to determine what agencies in the community offer services that the health center is unable or does not offer.

SOME QUESTIONS TO ADDRESS ARE:

- Does the health center have a standard outside referral process in place?
- What agencies are part of a current referral network and what agencies need to be added?
- Is there a staff role dedicated to managing the referral network and relationships and ensuring quality?

Answering these questions, health center wide and setting up workflows that support those answers, can ease the transition to another provider for health center patients.

In particular, knowing local referral networks for Substance Use Disorder (SUD) patients can be critical. Historically, SUD treatment programs have taken an abstinence-only approach, meaning they will only treat persons whose treatment goals are complete abstinence from all substances. Over time, SUD treatment providers are beginning to evolve to consider a more harm reduction approach. A harm reduction approach will support any treatment goal that reduces harm to the patient.⁹ **Interviews with local specialized SUD providers are likely required to determine their agency's perspective and approach.** Patients whose treatment goals are abstinence-only can be referred to abstinence-only providers successfully. However, evidence has shown that some patients who may have goals more focused on managing substance use or ending the use of one substance but not all substances (also known as “harm reduction”) would be better served by providers who will support these goals with a harm reduction approach. Referrals of a person whose treatment goal is not total abstinence to an abstinence-only program might not be as effective as a harm reduction approach, which can help build confidence.¹⁰

Health centers also need to know eligibility criteria of their local community-based provider agencies. For example, how does the local agency respond to persons who are uninsured? Only CCBHC agencies are commonly required to treat persons regardless of ability to pay. What type(s) of insurance does your local specialty behavioral health providers accept? Does the local CMHC start with a full psychiatric assessment? Can access to care be improved and barriers lifted by sharing the assessment data between agencies? What specific services is the health center commonly referring for, and what health center assessments can facilitate access to that care? Knowing these key details in the referral network process will ensure that health center patients are connected to the specialty care they need as quickly as possible.

As a health center takes a more Whole Person Care (WPC) approach¹¹, you may also be referring out for a variety of social service needs. This will also require a specialized network and information regarding local social services agencies. What services are offered? For what populations? At what times? What costs will those you refer to incur if they receive these services? Often such services are delivered by way of large agencies that require navigation, particularly with housing.

For patients experiencing homelessness, each community or geographic area has a homeless response system called the “Continuum of Care,” (CoC). Each CoC manages a system to prioritize people experiencing homelessness for housing resources and be placed on the referral list. To learn more about Coordinated Entry and how health centers can connect patients to these resources, see the CSH publication ***Health Center Role in Housing Innovations: Coordinated Entry***.¹² HUD maintains an ***online directory of CoC contact and award information***¹³ searchable by state to assist in connections to services.

Health Centers serving the unique needs of aging patients may also work with their Area Agencies on Aging (AAAs), Aging and Disability Resource Center (ADRCs) or Centers for Independent Living (CILs) for patients who meet these systems criteria for assistance. To assist those who are Aging, the Administration for Community Living’s ***Eldercare Locator (acl.gov)***¹⁴ can be useful. The federal Administration for Community Living also supports the Disability and Access Line (***DIAL***¹⁵) for disability related services in local communities.

States, managed care entities and even some health centers are creating or participating in “closed loop referral networks” that offer information about what agencies in a community address health-related social need. States such as North Carolina (***NC Cares 360***¹⁶) and Arizona (***Community Cares***¹⁷) are building statewide SDOH data platforms that health centers can access for resources. The Social Interventions Research and Evaluation Network or (***SIREN***¹⁸) has a helpful summary of the role of these data platforms ***here***.¹⁹ These platforms are also growing to address care coordination needed across providers and potentially billing software for agencies that have no infrastructure to support Medicaid billing.

To ensure patients receive a quality service and are treated with respect and dignity, health centers will need to regularly assess their community partners and their referral networks. Health centers should be aware of how referral partners respond to persons without the ability to pay and only refer patients such as these to referral sources that will serve these persons. Considerations for developing an effective referral network for SUD services was noted above. Internal data on these referral partners should include opening hours, eligibility criteria and any other factors likely to affect patient experience.

System Level Partnerships

Health centers should be aware of the increasing of system level partnerships between their work and those they serve, behavioral health and other systems. For health centers that serve persons with multiple complex needs, these system level partnerships can more efficiently and effectively serve their complex care population. Washington State is creating a state level partnership between their Medicaid benefit for supportive housing services and new state funded affordable housing resources. Called ***Apple Health and Home***²⁰, the program is designed to create a cross sector referral system so that multiple funding stream coordination becomes the work of government, rather than the responsibility of health and service providers or their patients. Currently those persons who meet the HUD ***definition of homelessness***²¹ can be referred to the local Coordinated Entry system, but there is no ‘front door’ for those who lack housing stability but do not meet the HUD definition of homelessness. Apple Health and Home is creating that front door. The goal is a referral system that health centers and other community partners can easily utilize, where the responsibility for coordination lives within the system, rather than the individual needing assistance. For persons with significant behavioral health challenges, the ease of access to resources can literally save lives.



Another example of a system level partnership is between the City of Philadelphia's Office of Homeless Services coordinated entry system and the City's ***Department of Behavioral Health and Intellectual disAbility Services (DBHIDS)***²² including a City-run managed care organization (MCO) Community Behavioral Health (***CBH***²³). Unsheltered street outreach services funded by SAMHSA's Program for Assistance in Transition from Homelessness, or ***PATH***²⁴ grants and SAMHSA's Substance Abuse and Mental Health Block Grant funds engages those on the streets with behavioral health challenges. Persons are referred

to specialized small shelters, with behavioral health services and trained staff, also funded by PATH and mental health block grant funds. Persons are connected to benefits and referred first to the CBH for behavioral health services including targeted case management (TCM), psychiatric rehabilitative services (PRS) and peer supports. Services are assigned based on the MCOs medically necessary criteria and each person receives an individualized services package. Not all people receive all services. The TCM then supports the person through engagement in the HUD-funded coordinated entry system where most are prioritized for permanent supportive housing. Rental assistance is commonly supported by HUD Continuum of Care (CoC) programs or Housing Choice Vouchers (HCV) from the Philadelphia Housing Authority. **The person is receiving seamless assistance from multiple systems over time, unaware of this complexity, only that their needs are being met.**

A different type of systems-level example in Philadelphia comes from the Public Health Management Corporation (PHMC), which operates several FQHCs in the area. In this example, one health agency has structured its own system to ensure maximum access for behavioral health needs for patients experiencing homelessness, in addition to implementing partnerships with other providers and the city. PHMC's health centers all utilize an integrated model of care—weaving together primary care with behavioral health supports. As a result, all have Behavioral Health consultants embedded in the clinic/team. To specifically meet the needs of unhoused individuals, the PHMC health network partners with the City of Philadelphia and provides nurses who provide care onsite to city homeless shelters. Adding to this, PHMC has a psychiatric nurse practitioner at one of its sites, the Mary Howard Health Center, that holds open office hours for walk-ins one day a week. Patients can be taken by City case managers or other social services, or walk in on their own, to get medication prescriptions, assistance with benefits, and documentation of disability—all of which facilitate their access to housing through the coordinated entry system. **The ability to access these services without the need for an appointment was cited as key to helping meet the behavioral health service needs by former City of Philadelphia case management staff.**



Funding, Contracting and Memorandums of Understanding (MOUs)

After assessing the landscape of providers and determining the fit of services, health centers looking to partner with CMHCs or CCBHCs can consider a range of partnership arrangements. Formalizing a partnership via either a jointly received grant (such as from a local foundation, or through the community benefit dollars of a local hospital) and/or a contract for services can help to solidify an arrangement.

One such example comes from Kansas City, MO. University Health Behavioral Health (UHBH) is a CCBHC that is attached to a large hospital, University Health. UHBH is not only a behavioral health provider but also plays a critical role in the homeless services continuum in Kansas City by using the financing flexibility available to CCBHCs to provide the services in supportive housing for people experiencing homelessness referred by the homeless Continuum of Care. UHBH partners with Samuel Rodgers Health Center and KC Care to provide behavioral health services for more acute patients, despite ability to pay. Senior staff from UHBH strongly advise going beyond simple referrals and engaging in formal reciprocal agreements or even a small contract to allow for staff time and to help supplement the costs of services. This will help a potential behavioral health partnering organization move to “yes” to the partnership.



Whether contracting or simply partnering, a memorandum of understanding, or MOU, between agencies is critical to establish roles and responsibilities and outline joint workflows for collaboration. The Health Center Resource Clearinghouse has an ***MOU template***²⁵ approved for use by HRSA. An MOU should set forth the responsibility(s) of each agency party with respect to the patients and services they are offering. It should layout the workflows for how referrals will flow from one agency to another (e.g. using a referral network data system, a “warm handoff” from staff, or other way).

Data Sharing to Improve Referrals and Care Coordination

It is difficult to overstate how critical data sharing is to ensuring continuity of care and service integration between physical and behavioral health providers. Some types of community level data sharing—referral networks and community information exchanges—were discussed above. Other types that might exist agency-to-agency range from paper referrals to electronic health record exports. While data sharing is critical, it is important to keep in mind the privacy of patients being served, and share only the minimum necessary data, especially on behavioral health. The parties to the agreement should consult with their health information technology vendors to see what is technologically possible.

THERE ARE A RANGE OF RESOURCES AVAILABLE TO HELP REFINE AND IMPROVE UPON DATA SHARING FOR THESE PURPOSES, SEE THE TEXT BOX FOR MORE INFORMATION.

- ☑ ***[Lessons-Learned-Data-Sharing-Care-Coordination_Final.pdf \(nhchc.org\)](#)***²⁶
- ☑ ***[Minimum Necessary Requirement | HHS.gov](#)***²⁷
- ☑ ***[Data Integration Best Practices for Health Centers and Homeless Services](#)***²⁸

Endnotes

- 1 <https://bphc.hrsa.gov/about-health-centers/health-center-program-impact-growth>
- 2 <https://www.samhsa.gov/national-coe-integrated-health-solutions>
- 3 <https://www.samhsa.gov/certified-community-behavioral-health-clinics>
- 4 <https://prapare.org/>
- 5 <https://uscode.house.gov/view.xhtml?hl=false&edition=prelim&req=granuleid%3AUSC-prelim-title42-chapter6A-subchapter2-part-D&num=0&saved=%7CZ3JhbnVsZWlkOIVTQy-1wcmVsYW0tdGl0bGU0Mi1zZWNOaW9uMjU0Y-Q%3D%3D%7C%7C%7C0%7Cfalse%7Cprelim>
- 6 <https://www.samhsa.gov/certified-community-behavioral-health-clinics>
- 7 <https://findtreatment.gov/>
- 8 <https://www.cdc.gov/publichealthgateway/cha/index.html#:~:text=A%20community%20health%20assessment%2C%20also,comprehensive%20data%20collection%20and%20analysis>
- 9 Harm Reduction Principles | National Harm Reduction Coalition — <https://harmreduction.org/about-us/principles-of-harm-reduction/>
- 10 Collins, Susan E. et al. “Randomized controlled trial of harm reduction treatment for alcohol (HaRT-A) for people experiencing homelessness and alcohol use disorder”. *International Journal of Drug Policy*, Vol. 67, May 2019. <https://doi.org/10.1016/j.drugpo.2019.01.002>
- 11 Whole Person Health: What You Need To Know | NCCIH (nih.gov) — <https://www.nccih.nih.gov/health/whole-person-health-what-you-need-to-know>
- 12 <https://www.csh.org/resources/health-center-role-in-housing-innovations-coordinated-entry/>
- 13 <https://www.hudexchange.info/housing-and-homeless-assistance/>
- 14 <https://eldercare.acl.gov/Public/Index.aspx>
- 15 <https://acl.gov/DIAL>
- 16 <https://nccare360.org/>
- 17 <https://www.azahcccs.gov/AHCCCS/Initiatives/AHCCCSWPCI/closedloopreferralsystem.html>
- 18 <https://sirenetwork.ucsf.edu/>
- 19 <https://sirenetwork.ucsf.edu/sites/default/files/wysiwyg/Community-Resource-Referral-Platforms-Guide.pdf>
- 20 <https://housedemocrats.wa.gov/chopp/2022/03/30/apple-health-and-homes-act-signed-by-governor/>
- 21 <https://www.hudexchange.info/news/huds-definition-of-homelessness-resources-and-guidance/>
- 22 <https://dbhids.org/>
- 23 <https://cbhphilly.org/>
- 24 <https://www.samhsa.gov/homelessness-programs-resources/grant-programs-services/path>
- 25 <https://www.migrantclinician.org/resource/memorandum-agreement-mou-template.html>
- 26 https://nhchc.org/wp-content/uploads/2021/06/Lessons-Learned-Data-Sharing-Care-Coordination_Final.pdf
- 27 <https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/minimum-necessary-requirement/index.html>
- 28 https://www.csh.org/wp-content/uploads/2020/12/CSHData-Integration-Report_Final11.12.20.pdf



CSH, the Corporation for Supportive Housing, is the national leader in supportive housing, focusing it on person-centered growth, recovery, and success that contributes to the health and wellbeing of the entire community. Our greatest asset is our team. From our Board of Directors to staff, we work every day to build healthier people and communities. Through our consulting, training, policy, and lending, we advance innovation and help create quality supportive housing. Our hub offices drive initiatives in 48 states and more than 300 communities, where CSH investments create thousands of homes and generate billions of dollars in economic activity.

For more information, visit [csh.org](https://www.csh.org).