



# Housing and Health: Building Partnerships to Support Public Housing Residents

February 2018



## Opening Statement

The National Center for Health and Public Housing (NCHPH) and the National Nurse-Led Care Consortium (NNCC) are pleased to support this case study publication highlighting successful Health Center Programs and public housing partnerships to improve the health of public housing residents. The publication illustrates the power of cross-sector collaboration as a vehicle for promoting the health and well-being of residents of public housing.

In the future, more Health Center Programs will be called to provide services to address the social determinants of health adversely affecting residents of public housing. For example, HUD's final rule banning smoking in public housing has the potential to improve health by reducing the exposure and harmful effects of smoking and second-hand smoke to an already vulnerable population. In order to support these and other federal efforts, Health Center Programs can build on their long history of collaboration with housing authorities to provide smoking cessation programming to public housing residents.

The examples provided in this document capture the work of five Health Center Programs and public housing authorities that are utilizing their partnership to provide progressive programming to residents of public housing. We applaud these collaborative efforts and encourage Health Center Programs and public housing authorities to utilize this publication as a framework to develop model programming to address the health of public housing residents. Sharing these model examples, resources, and infrastructure, allows Health Center Programs and housing authorities to assess individual opportunities in their communities to improve health and well-being.

We are committed to leveraging shared resources to continue advancing the work of Health Center Programs and public housing authorities to improve the health and well-being of residents of public housing.

Sincerely,

## Executive Summary

Public housing residents often have complex health conditions and are at risk for experiencing homelessness or housing instability. Partnerships between health and housing agencies can improve access to comprehensive health and social services that support public housing residents. Even with the challenges of limited funding, strategic health and housing partnerships are able to strengthen communities by providing community-based preventive primary and behavioral health care, housing, employment, child care, and education programs to populations most in need.

A notable health and housing partnership is the Public Housing Primary Care (PHPC) program at HRSA. PHPCs provide residents of public housing with primary health services, including mental health and substance abuse services, health promotion and disease prevention, oral health, and outreach services. PHPCs often work closely with their local public housing authority (PHA) to deliver the coordinated care that can improve residents' quality of life. There were approximately 2.7 million patients seen at Health Center Programs located in or accessible to a public housing site; 105 PHPC sites serving 609,751 patients and another 191 non-PHPC sites serving 2,090,249 patients (See Figure 1. PHPC program award recipient organizations).

This publication provides an overview of the PHPC program at HRSA, the public housing program at HUD, and highlights the collaborative efforts of five health and housing partnerships between PHPCs with PHAs in Chicago, IL, Philadelphia, PA, Dover, NJ, Gadsden, AL, and San Diego, CA. Interviews were conducted in 2015.

- **TCA Health, Inc. and Chicago Housing Authority** collaborated to increase the number of public housing residents enrolled in affordable health insurance programs. As a team, they were able to improve access to care for over 1,000 residents in the city of Chicago.
  - **Public Health Management Corporation and Philadelphia Housing Authority** have worked together for over 20 years to provide comprehensive care to public housing residents. They are strategic partners and pool resources to advance each other's mission.
  - **Zufall Health Center and Madison Housing Authority** collaborate on programs for seniors, including a mobile dental health van and a senior health education series. Their partnership has created a stable source of oral health care for public housing residents and those living in Section 8 housing throughout the city.
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- **Quality of Life Health Services** and **Greater Gadsden Housing Authority** transformed their city from a violent, gang-ridden community to a place where public housing residents felt safe and secure. Their shared vision and commitment to the residents, and collaboration with local police and community organizations, has led to a different culture at the housing development. It has reduced the stigma of public housing, improved community cohesion, and increased access to health and social services for this hard to reach population.
- **La Maestra Family Clinic** and **San Diego Housing Authority** collaborated on a program to educate the community on lead exposure and test blood lead levels in children. Through the partnership and extensive community engagement, the clinic was able to increase their blood lead test rate from 3% to 29%.

### Common Themes

The relationship between the Health Center Program and the housing authority in each of the case study sites has evolved and improved over time. A shared vision, commitment to the residents, open communication and transparency, and visionary leadership were key components to their success.

This publication provides a summary of the promising strategies and lessons learned within the case study communities, explores current opportunities for building health and housing partnerships, and details resources for public agencies to begin partnerships in their own communities.

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## Overview of the Health Resources and Services Administration

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The Health Resources and Services Administration (HRSA), an Agency of the U.S. Department of Health and Human Services, is the principal federal agency charged with increasing access to basic health care for those who are medically underserved. Health care in the United States is not accessible to everyone. Despite best efforts in reforming health care, millions of families still face barriers to quality health care because of their income, lack of insurance, geographic isolation, cultural and linguistic barriers or other factors. In recent years, components of the HRSA-supported safety net, including the Health Center Program, the National Health Service Corps, and a variety of health workforce programs, have expanded to address these and other access problems. However, there are still Americans without health insurance coverage who need access to affordable, quality health care. HRSA continues to make investments in public health and safety net programs to help these individuals get the health care services they need.

HRSA's mission as articulated in its Strategic Plan for 2016-2018 is: To improve health and achieve health equity through access to quality services, a skilled health workforce and innovative programs. HRSA supports programs and services that target, for example:

- Americans who have trouble accessing health care --including racial and ethnic minorities,
- Over 50 million underserved Americans who live in rural and poor urban neighborhoods where health care providers and services are scarce,
- African American infants who still are 2.4 times as likely as white infants to die before their first birthday,
- The more than 1 million people living with HIV infection.

One of HRSA's objectives is to improve population health by building healthy communities. Strategies to accomplish that goal include promoting community partnerships and collaborations with stakeholders in health and non-health sectors and strengthening the focus of health promotion and disease prevention across population, providers, and communities (Health Resources and Services Administration, 2016). One major program that addresses that goal is the Health Center Program.

### Health Center Program

For more than 50 years, Health Center Programs have delivered comprehensive, high-quality preventive and primary health care to patients regardless of their ability to pay. During that time, many Health Center Programs have become the essential patient-centered medical home (PCMH) for millions of Americans including some of the nation's most vulnerable populations. Health Center Programs emphasize coordinated primary and preventive services or a "medical home" that promotes reductions in health disparities for low-income individuals, racial and ethnic minorities, rural communities and other underserved populations. Health Center

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Programs place emphasis on the coordination and comprehensive care, the ability to manage patients with multiple health care needs, and the use of key quality improvement practices, including health information technology. A PCMH brings together a large and diverse team of individuals to meet the needs of their patients and coordinates care among the broader health care system (Agency for Healthcare Research and Quality, 2016). The Health Center Program model overcomes geographic, cultural, linguistic and other barriers through a team-based approach to care that includes physicians, nurse practitioners, physician assistants, nurses, dental providers, midwives, behavioral health care providers, social workers, health educators, and many others.

The Community Health Center Fund provides \$11 billion over a 5-year period for the operation, expansion, and construction of Health Center Programs throughout the Nation (Redhead, 2015). One out of every 15 people living in the U.S. now relies on a HRSA-funded clinic for primary care. Since the beginning of 2009, Health Center Programs have increased the total number of patients served on an annual basis by nearly 5 million people. As of 2016, 1,400 Health Center Programs operate approximately 9,000 service delivery sites that provide care to more than 26 million patients in every U.S. state, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and the Pacific Basin (Health Resources and Services Administration, 2016). In 2016, 62 percent of those served at Health Center Programs were members of ethnic and minority groups, 23.4 percent had no health insurance, and 31 percent were children (Health Resources and Services Administration, 2016).

### **Health Center Programs Are a Key Part of the Economy**

Health Center Programs are an integral source of local employment and economic growth in many underserved and low-income communities. Total Health Center Program employment is more than 156,000 individuals nationwide, and Health Center Programs added over 43,000 jobs over the last five years (Health Resources and Services Administration, 2015). Health Center Programs employ more than 11,000 physicians and more than 10,000 nurse practitioners, physician assistants, and certified nurse midwives in a multi-disciplinary clinical workforce designed to treat the whole patient through culturally-competent, accessible, and integrated care (Health Resources and Services Administration, 2016). Funding through the health care reform law passed in 2010 has also allowed Health Center Programs to train local community health worker programs, a very effective measure to reach targeted populations, provide health education, and improve access to care.

### **Health Center Programs Provide Quality Health Care**

A programmatic emphasis on quality improvement as well as community-responsive and culturally appropriate care has translated into impressive reductions in health disparities for Health Center Program patients. Calendar Year 2016 Health Center Program data demonstrate that centers continue to provide high quality care and improve patient outcomes, while

reducing disparities, despite serving a population that is often sicker and more at risk than seen nationally.

For example:

- In 2016, the percent of low birthweight babies, at 7.8 percent, was lower than national estimates (8 percent) (Health Resources and Services Administration, 2016) (Centers for Disease Control and Prevention, 2016).
- The percent of women receiving prenatal care in the first trimester increased from 73 percent in 2015 to 74.1 percent in 2016 (Health Resources and Services Administration, 2016).
- Of the Health Center Program patients with diabetes, 68 percent demonstrated control over their diabetes with a hemoglobin A1c (HbA1c) level less than or equal to nine (Health Resources and Services Administration, 2016).
- Of the Health Center Program patients with high blood pressure, 62 percent of those hypertensive patients have their blood pressure under control (Health Resources and Services Administration, 2016).

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## Overview of the U.S. Department of Housing and Urban Development

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HUD's mission is to create strong, sustainable, inclusive communities and quality affordable homes for all. Crafted with the input of more than 1,500 HUD employees and partners, HUD's Strategic Plan provides the direction and focus HUD needs to provide quality, affordable homes located in strong, sustainable, inclusive communities. It proposes to accomplish this through five core goals:

1. Strengthen the Nation's Housing Market to Bolster the Economy and Protect Consumers
2. Meet the Need for Quality Affordable Rental Homes
3. Utilize Housing as a Platform for Improving Quality of Life
4. Build Strong, Resilient, and Inclusive Communities

HUD's strategic plan includes a well-defined set of goals and strategies. Goal 3, "Utilize Housing as a Platform for Improving Quality of Life," and sub goal 3C, "Health and Housing Stability," specifically acknowledges housing as a key social determinant of health and wellbeing (U.S. Department of Housing and Urban Development, 2014). Stable housing, made possible with HUD support, provides an ideal platform for delivering a wide variety of health and social services to improve health outcomes. HUD recognizes that stable, healthy housing is tied to individual health.

One way to improve health outcomes is by increasing health literacy and access to health services. HUD aims to accomplish this by building formal and informal relationships with public and private healthcare providers to provide access to healthcare information and services for recipients of HUD assistance. HUD has also committed to improving the collection and analysis

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of health-related data across HUD-funded programs and promoting effective evidence-based models for integrating health and housing services.

### **Organization and Structure**

HUD administers numerous programs and grants to create strong, sustainable, inclusive communities and quality affordable homes for all. The largest HUD rental assistance program is the public housing program.

#### *Public Housing*

Public housing is administered through HUD's Office of Public and Indian Housing (PIH). There are approximately 1 million households and over 2 million individuals living in public housing units (U.S. Department of Housing and Urban Development, 2016). The majority of public housing residents (86%) have very low or extremely low incomes (U.S. Department of Housing and Urban Development, 2016). The average annual income of an individual living in public housing is \$14,522 (U.S. Department of Housing and Urban Development, 2016).

Public housing properties are owned and managed by some 3,400 Public Housing Authorities/Agencies (PHAs) across the country. Each PHA manages the day-to-day operations and set local policies, under the governance of a local board of commissioners, which includes public housing residents.

Public housing sites range from scattered single-family houses to high-rise apartment buildings. On the federal level, HUD establishes broad policies for public housing. PIH funds programs to address issues such as crime and security and to make supportive services available to public housing residents. The Moving to Work (MTW) status program is one example. Thirty-nine PHAs have Moving-to-Work (MTW) Status. With HUD approval, these agencies are allowed to waive certain HUD rules to best meet the goals of increasing resident self-sufficiency and employment, achieving greater cost effectiveness in administering public housing, and increasing housing choices for low-income families (U.S. Department of Housing and Urban Development, n.d.).

### **Populations Served**

HUD-assisted tenants generally fit into three subcategories of low-income households: non-elderly and non-disabled families, elderly persons, and persons with disabilities. Special needs populations, including homeless people, people with HIV/AIDS, people returning from prisons, returning veterans, the elderly, and people with disabilities all experience significant barriers to both obtaining and maintaining housing.

For some, financial assistance alone is sufficient to ensure access to housing. However, hard to house families, those with multiple, complex problems that make them ineligible for mixed-

income housing or unable to cope with the challenges of negotiating the private market with a Housing Choice Voucher, face many challenges (Cunningham, 2005). They often have weak employment histories, long stays in public housing, poor health, substance abuse, and criminal records (Cunningham, 2005). They may require housing with supportive services to assist with activities of daily living or long-term self-sufficiency.

### HUD Programs that Focus on Health

There are a few programs funded by HUD that have a health focus, including:

- Healthy Homes Initiative- In the Office of Lead Hazard Control and Healthy Homes, the Healthy Homes Initiative is a program launched in 1999 to address housing-related health and safety hazards within the home, including mold, mildew, lead, allergens, asthma, carbon monoxide, pesticides, home safety, and radon. The initiative has two major grants programs for research that identifies low-cost, effective home hazard assessment and intervention methods, and public education efforts that identify ways to mitigate housing-related hazards (U.S. Department of Housing and Urban Development, n.d.).
  - Moving to Opportunity- Moving to Opportunity for Fair Housing is a 10-year research demonstration grant given to the PHAs of Baltimore, Boston, Chicago, Los Angeles, and New York City. The grants combine rental assistance with housing counseling to help very low-income families move from poverty-stricken urban areas to low-poverty neighborhoods (U.S. Department of Housing and Urban Development, n.d.).
  - Choice Neighborhoods - The Choice Neighborhoods program provides funding to local governments to create comprehensive plans to transform and revitalize distressed neighborhoods. The grants focus on replacing poor quality public housing with mixed-income housing; youth services that lead to better educational outcomes; and neighborhood redevelopment that attracts public and private investment to improve community amenities and assets (U.S. Department of Housing and Urban Development, n.d.).
  - Sustainable Communities Initiative – The Sustainable Communities Initiative is an interagency partnership between HUD, the U.S. Environmental Protection Agency, and the U.S. Department of Transportation. The HUD program provides planning grants to local agencies to integrate housing and transportation, and to improve land use and zoning to support sustainable communities (U.S. Department of Housing and Urban Development, n.d.).
  - Housing Opportunities for Persons with AIDS (HOPWA)- The HOPWA program provides funding to local agencies, nonprofits, and States for programs that improve housing for low income people with AIDS and their families (U.S. Department of Housing and Urban Development, n.d.).
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## Health Center Programs and Public Housing Agencies

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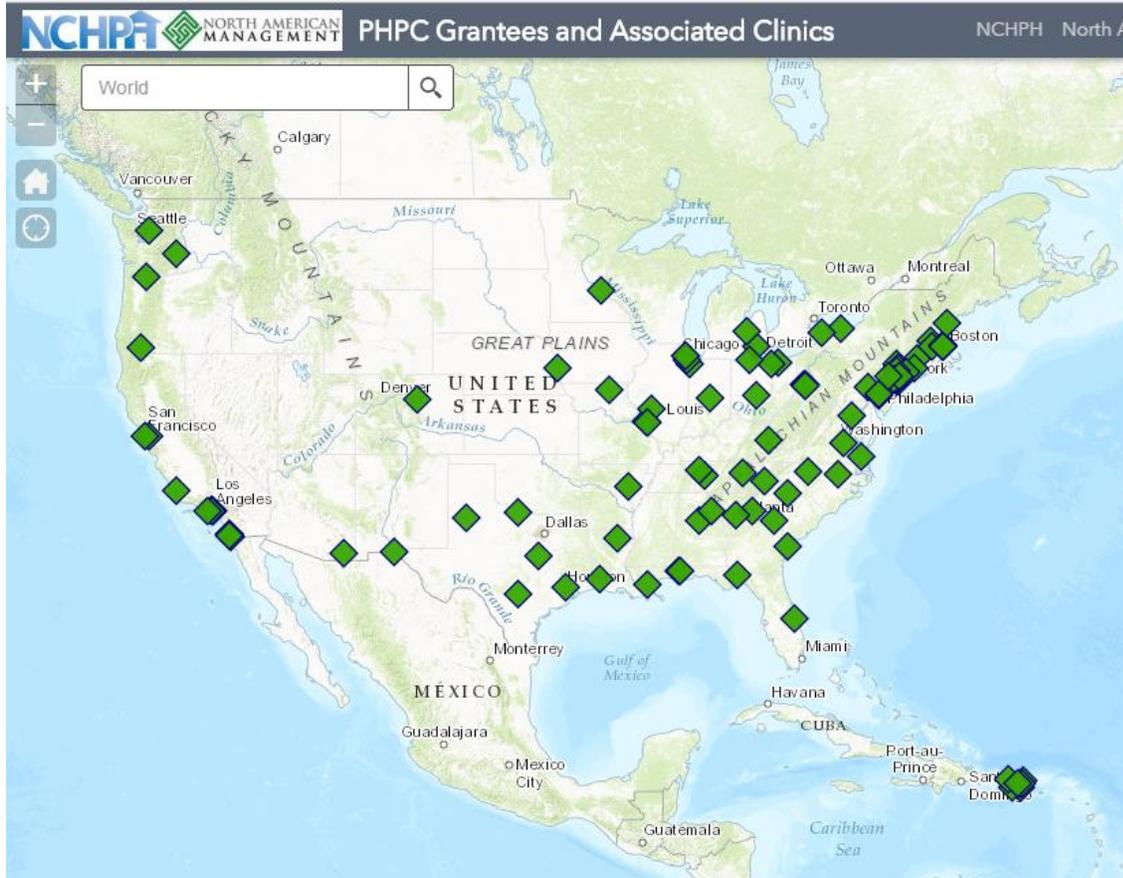
In 1965, the Office of Economic Opportunity funded the first community Health Center Program, Columbia Point Health Center. It served the low-income community living in the Columbia Point Public Housing Projects in Dorchester, Massachusetts. In 1975, Congress permanently authorized neighborhood Health Center Programs as “community and migrant health centers,” and later added primary health care programs for residents of public housing and the homeless to the portfolio of programs. Finally in 1996, the Health Centers Consolidation Act combined these authorities under Section 330 of the Public Health Service Act (PHSA) to create the consolidated Health Center Programs and what is now known as Community, Migrant (330 g), Public Housing (330 i) and Homeless Health Centers (330h).

### **Public Housing Primary Care Health Centers**

Public Housing Primary Care (PHPC) Health Centers are authorized under section 330 (i) of the Public Health Service Act (PHSA). The public housing 330(i) statute states the Health Center will provide services “on the premises of public housing projects or at other locations immediately accessible to residents of public housing.” This authorization provides residents of public housing with increased access to comprehensive primary health care services through the direct provision of health promotion, disease prevention, and primary health care services. Primary health care services include, but are not limited to, behavioral health as well as other supportive services.

Based on the 2016 UDS Report, there are 105 PHPC program award recipient organizations in 30 states, the District of Columbia and Puerto Rico (See Figure 1. PHPC program award recipient organizations). These programs provide high-quality comprehensive, case- managed, and family based preventive and primary health care services to approximately 609,751 patients.

Figure 1. PHPC program award recipient organizations



As we look more closely at the most current UDS data from 2016, it is important to be mindful of the site-based methodology used to count public housing residents (See Reporting Public Housing Residents.) Of note, the approximately 2.7 million patients served at Health Center Programs represents the number of patients served at Health Center Programs that are located in or immediately accessible to public housing. This is not an individual count of public housing residents accessing health care services at Health Center Programs.

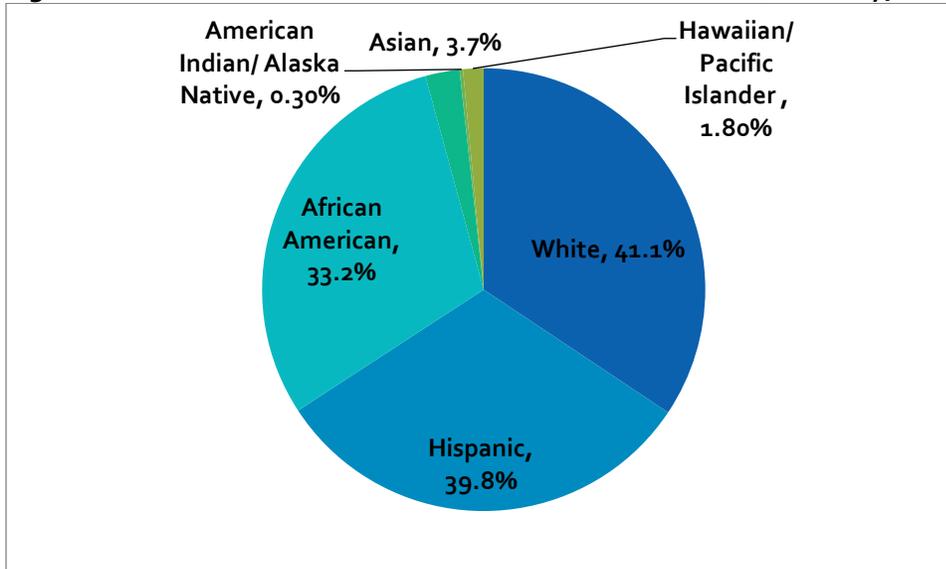
#### Reporting Public Housing Residents

As of 2014, reporting public housing residents in the Uniform Data System (UDS) has changed. Now all health centers regardless of 330(i) funding are required to use a site-based methodology to report on the number of public housing residents seeking care at health centers.

### Health Status of Public Housing Residents

PHPCs are more likely to serve racial and ethnic minorities than other Health Center Programs (Health Resources and Services Administration, 2016). Approximately 41.1% or 41% of PHPC patients are White, 39.8% are Hispanic, 33.2% are African American, and 3.7% are Asian (Health Resources and Services Administration, 2016). Almost half of PHPC patients are enrolled in a public health insurance program (8% on Medicare and 0.3% on Medicaid/ CHIP), however 22% of PHPC patients are uninsured, compared to 24% of all Health Center Program patients (Health Resources and Services Administration, 2016).

**Figure 2. Patient Characteristics at PHPC Clinical Sites: Race/Ethnicity, 2016**



The majority of PHPC patients live in poverty. For those patients whose incomes are known, 77.8% live at and below the federal poverty level, (FPL) and 4.6% live below 200% FPL (Health Resources and Services Administration, 2016). The top diagnoses include hypertension, diabetes, depression and other mood disorders (Health Resources and Services Administration, 2016). In 2008, a study in Boston showed that public housing residents have higher rates of asthma, cancer, diabetes, hypertension, obesity, and oral diseases compared to other residents in the city (Digenis-Bury EC, 2008). African American public housing residents are particularly more likely to report chronic disease risk factors (Rivo ML, 1992).

The PHPC patient population is aging; from 2015 to 2016, the number of patients aged 65 and older has increased by more than five percent (Health Resources and Services Administration, 2015) (Health Resources and Services Administration, 2016). In June 2013, NCHPH conducted a focus group study with 18 PHPCs. Those centers explained that the number of elderly residents exhibiting mental illness is also on the rise. Since 2014, there has also been a 52% increase in depression and other mood disorders, 46% increase in the number of obesity and overweight

visits, and 58% increase in the number of tobacco use disorders visits (Health Resources and Services Administration, 2015). At an annual training conference hosted by NCHPH in 2014, 42% of participants ranked oral health care as one of the greatest health care needs of public housing residents.

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## Case Studies

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As a way to learn more about how Public Housing Primary Care Health Centers (PHPC) and Public Housing Authorities (PHA) collaborate to serve public housing residents and low-income populations, Health Resources and Services Administration (HRSA) and Housing and Urban Development (HUD) approached North American Management (NAM) and the National Nurse-Led Care Consortium (NNCC), to conduct case studies of five PHPCs and PHAs with known partnerships.

The purpose was to highlight the work that PHPCs and housing authorities are doing to advance the health and well-being of public housing residents. This report presents the contexts of their partnerships, the service and assistance they provide, issues they face in forming partnerships, and their tips for other Health Center Programs and housing authorities looking to partner in order to better serve their community.

The approach to this study was a semi-structured in-person interview process. Those selected at each site for interview were the individuals identified as most knowledgeable about services and programs. In order to achieve the most robust grantee participation, an initial email from HUD and HRSA was sent to each PHPC and PHA. Then a follow up email was sent to each participant from NAM and NNCC staff describing the research, asking for their participation, and asking for a convenient interview time. Once arrangements were made, NAM and NNCC staff sent a confirmation communication and included a meeting agenda and an interview guide (see copy at the conclusion of this report). In several instances, telephone communication or additional correspondence was undertaken prior to the interview to make arrangements or further discuss the best individual(s) at the center to participate in the study.

Interviews took place in 2015. Each interview took approximately 1.5 hours, was conducted in person or by telephone, and included at least one representative from the Health Center Program and the housing authority. Every participant provided a different perspective on the value of the partnership and successes and challenges that have emerged since its inception. Interviews were recorded and extensive notes were taken during each interview. The notes were transcribed and coded to find patterns.

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Staff from HRSA, HUD, NAM, and NNCC selected the sites based on geographic dispersion and urban/rural environment. Once the list of cities and states to interview were selected, PHPCs with known relationships with their PHAs were invited to participate in the case study.

The FQHCs involved in these case studies and their headquarter locations are:

1. TCA Health and Chicago Housing Authority: Chicago, IL
2. Public Health Management Corporation and Philadelphia Housing Authority: Philadelphia, PA
3. Zufall Health Center and Madison Housing Authority: Dover (Zufall), NJ
4. Quality of Life Health Services and Greater Gadsden Housing Authority: Gadsden, AL (rural representative)
5. La Maestra Family Clinic and San Diego Housing Authority: San Diego, CA

Each case study includes a description of how and why the collaboration was initiated; the motivation behind the collaborations; the key elements that made the partnership a success; and how the collaboration has impacted the community and has benefitted the lives of public housing residents.

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**Site:** Chicago, Illinois

**Housing Authority:** Chicago

**Housing Authority**

**Health Center Program Grantee:**

**TCA Health, Inc.**

**Total Patients Receiving Services at**

**PHPC Site in 2015: 5,373**



### **The situation:**

Illinois issued special funding to community Health Center Programs to help individuals and families enroll into affordable health insurance plans. TCA Health Inc. (TCA), a Chicago Health Center Program, had previously experienced challenges reaching public housing residents in their service area. Many public housing residents under-utilized the health services available at the Health Center Program and ended up visiting the clinic only when there was a medical emergency. TCA contacted the Chicago Housing Authority (CHA) to find ways to educate public housing residents about healthcare coverage and services available, particularly those in the Riverdale, Altgeld/Murray community.

“Part of our mission at the Chicago Housing Authority (CHA) is to support stability and quality of life. So, what’s more important to that than health?”- CHA

### **The solution:**

From the TCA perspective, collaborating with CHA was an ideal choice. TCA was seeking to expand its reach to educate public housing residents about their options under the Affordable Care Act and a partnership with CHA provided an excellent opportunity to accomplish this goal. As part of the grant application for outreach and enrollment, each organization provided a letter of support defining the initiative and outlining the terms of the collaboration. With shared resources, TCA and CHA were able to hire and train two public housing residents to conduct outreach and enrollment activities. TCA worked with CHA’s property managers to enroll public housing residents into health insurance when they came in to pay their rent, at CHA laundromats, and at local advisory council meetings and other events hosted by CHA. Together, the organizations were able to maximize opportunities to reach residents and enroll them into affordable health insurance.

### Why it works: Strategies for Success

TCA and CHA were able to advance their own programmatic goals by creating a constructive relationship built on open communication and an appreciation of the unique contributions each of them had to offer residents. As a result, they were able to enroll more residents into affordable health insurance and teach them how to use their health benefits effectively. A few keys to their successful partnership include work to identify a resident champion to promote the initiative to other residents; an ongoing commitment to communicate through regularly scheduled meetings; and to ensure shared knowledge. Both organizations were responsive to residents' needs and accountable to each other and the community for meeting those needs. They established protocols, documented efforts, and delegated roles effectively. TCA and CHA set realistic, attainable and tangible goals, and then worked intentionally to orchestrate success.

### The results:

Collaborating on outreach and enrollment was beneficial for CHA and TCA, and the community at large. According to CHA, "all Housing Authorities want to help people advance economically and get more financially independent." One of the greatest impacts of the collaboration was the sustained employment of two public housing residents. Those residents now have a stable source of income and are an essential part of the communication chain between the housing authority, Health Center Program, and residents.

The collaboration was extremely effective in reaching public housing residents. Through their combined efforts, over 1,000 residents were enrolled into health insurance and 3,000 received one-on-one health education training. Another benefit of the partnership was the ability to collaborate with additional stakeholders to serve the residents. The two organizations planned and formed workgroups with 25 other organizations to identify and address various public housing resident issues. With more partners at the table, TCA and CHA were better positioned to identify key issues and barriers residents face in accessing health and social services, which then informed their programmatic goals.

### How it Works

There is no formal agreement between CHA and TCA. They work together on a project-by-project basis. Each organization writes a letter of support when they are applying for funding together. For them, it is easier to identify a project, have clearly defined roles, identify the appropriate communications, etc. and build the collaboration around that, rather than have an MOU that has a vague outline of collaboration.

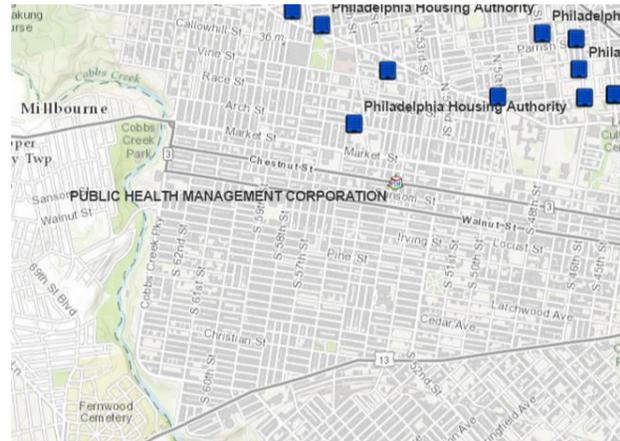
The goal of the partnership, however, was not limited to improving health care access; it was focused on improving the overall well-being of public housing residents. The original collaboration led to a gradual increase in the number of health-related initiatives in public housing, including a Youth Sports Fitness Program, Adult Fitness Program, Cooking Classes, Community Gardening Projects, Food Accessibility Initiatives, Community Health Education Workshops, and access to mobile health care services.

**Site: Philadelphia, PA**

**Housing Authority: Philadelphia Housing  
Authority**

**Health Center Program Grantee: Public Health  
Management Corporation (PHMC)**

**Total Patients Receiving Care at PHPC Site in  
2015: 10,131**



### **The situation:**

The Philadelphia Housing Authority (PHA) is the nation's fourth largest public housing authority. It administers approximately 18,600 public housing units, and an additional 16,800 families through the Housing Choice (Section 8) Voucher Program. Public Health Management Corporation (PHMC) oversees five Health Center Program Grantees and homeless shelter sites in the Philadelphia area. Three of these Health Center Programs are immediately accessible to public housing residents.

The relationship between the Health Center Programs and housing authority dates back to the 1990's when the Health Center Programs were first embedded in public housing sites in the City. However, there has recently been a significant shift in how the organizations work together. In the last three years, PHA went through a significant transition period, resulting in a new president and CEO, entirely new senior administration team, and a renewed desire to strengthen existing relationships and focus more acutely on the resident services.

### **The solution:**

PHA and PHMC collaborate on three major initiatives: Choice Neighborhoods Planning Grant, Choice Neighborhoods Implementation Grants, and working together to align services across PHA's portfolio of residents.

In one of the Choice Neighborhoods, PHA had to create a relocation plan for 600 families living in public housing, including seniors. PHMC assessed all 96 seniors living in the senior tower, which helped PHA to understand their needs during the relocation process. According to the PHA Director, "that was a tremendous help and a tremendous service to the residents."

PHMC is also one of the strategic partners in the City's other Choice Neighborhoods grant, currently in the implementation phase in North Central Philly neighborhood, near Temple University. According to the PHA Director, "One of the requirements of Choice grants is that

you have to provide comprehensive services. The goal of Choice neighborhoods is not just to improve physical development, it's also to improve the person. Our work and our support that we receive from PHMC are fundamental to that service.”

### **Why it Works: Strategies for Success**

According to PHMC, “MOUs, confidentiality agreements, and information exchange agreements have all helped facilitate the partnership. It provides the freedom and the flexibility to work together.” The PHA Director added, “We needed to put those building blocks into place as part of the administrative requirements, in order to have the interaction that we have.” Having a legal document that allows the organizations to exchange information freely was particularly important when PHMC conducted a needs assessment of the seniors living in the senior tower.

Another critical component of the partnership is the commitment of resources from both organizations. They are working on a large five-year plan, 10-phase initiative that will consolidate PHMC services at one of the PHA development sites. Part of that plan includes finding a resident services provider and connecting a host of community-based services in the community. It has required a great deal of planning and sharing of resources.

The third area of collaboration is on identifying opportunities to coordinate services across PHA’s portfolio. PHA has 59 developments across the city; together PHMC and PHA have identified ways to connect PHA services to PHMC clinics through coordination of transportation services and participation at resident council meetings.

### **How it Works**

There are no formal or standing meetings between these agencies; however, PHA has PHMC written into their business plan as a strategic partner. This relationship is integrated at all levels of both organizations, starting at the executive level, through the staff providing direct services, and then onto the residents.

Philadelphia Housing Authority (PHA) has been a Moving to Work (MTW) agency since April 2001. This program operates under a MTW Agreement with HUD. The goal of the program is to help residents find employment and become self-sufficient, and increase housing choices for low-income families. MTW allows PHA to leverage resources with PHMC and invest in staff to plan and integrate health programming into the mission and daily operations of the housing authority.

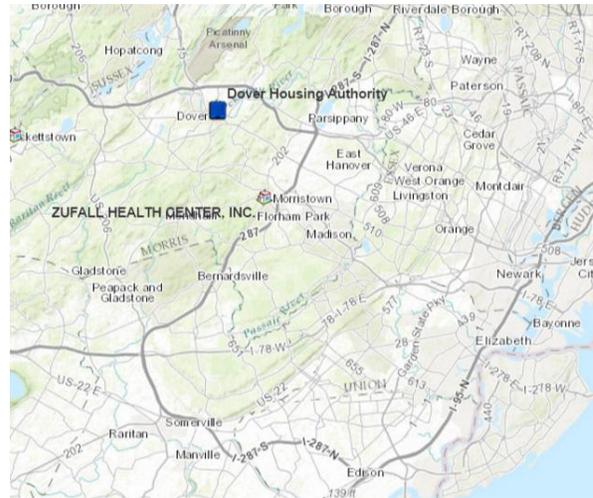
A MOU between PHMC and PHA as well as writing PHMC into PHA's strategic business plan is an essential part of how this partnership remains at the core of both programs. Philadelphia Housing Authority provides information on their website to identify health centers that are accessible to residents of public housing. A number of collaborative efforts illustrate the partnership of PHA and PHMC such as smoking cessation and outreach and enrollment efforts incorporated into public housing sponsored events. The most recent collaborative effort of these two institutions involves PHA adopting a MOU with PHMC for the administration of an early childhood education program into a community development initiative. Funding comes from PHA for the first two years with subsequent funding contingent on performance of the program. Benefits from the PHMC and PHA partnership include but are not limited to the improved accessibility to services and programs to improve the health and well-being of residents and employment opportunities in the community.

**Site: Dover, NJ**

**Housing Authority: Madison Housing Authority**

**Health Center Program Grantee: Zufall Health Center**

**Total Patients Receiving Care at PHPC Site in 2015:  
8,674**



**The situation:**

The relationship between Zufall Health Center and Madison Housing Authority (MHA) began in 2012 when MHA received a 3-year Resident Opportunities and Self-Sufficiency (ROSS) Program grant from HUD. The funding was used to assess the needs of residents of conventional public housing and coordinate available resources in the community to meet those needs. The program utilized public and private resources for supportive services and resident empowerment activities. These services enabled participating families to increase earned income, reduce or eliminate the need for welfare assistance, make progress toward achieving economic independence and housing self-sufficiency or, in the case of elderly or disabled residents, help improve living conditions and enable residents to age-in-place.

**The solution:**

The ROSS service coordinator met with representatives from Zufall Health Center in 2012 to identify potential services for MHA residents. The first program identified was called “Live Your Better Life,” a 6-week health education series for seniors. Zufall provided the health education to seniors at the housing site and returned monthly for follow-up services. Fifteen seniors

**Why it Works: Strategies for Success**

The ROSS grant was a key element in getting the partnership started. The funding supported MHA staff to reach out to Zufall and identify programs that would benefit its residents. MHA was able to leverage services provided by the health center to deliver social and community services to residents. Even after funding for the ROSS grant ended, the relationship between the organizations was in place, allowing for continued work on other projects.

graduated from that program.

Following the success of the health education series, Zufall identified other resident health needs, including the need for oral health care. Transportation was an issue for public housing residents, so Zufall delivered dental services through a mobile dental health van. First time utilizers were given free dental services, which included fluoride treatment, dental exam, X-rays of problem areas, and oral-cancer screening. In order to streamline the administration process, staff from Zufall would pre-register patients prior to the van's arrival, which reduced wait times and allowed providers to see more patients. The goal of the first visit was to encourage patients to access additional dental services at the Health Center Program; however, staff noted that many patients preferred the mobile van. As a result, a follow-up visit offering a full dental exam was made available through the dental van for a modified fee of \$20.

**The results:**

The mobile dental van was highly successful in providing needed oral health care to public housing residents at MHA. The flexibility of the van allowed travel to multiple sites, increasing access to all public housing and Housing Voucher (Section 8) residents in the county. Because the van comes every 6 months, it provides a consistent source of oral health care. A newer, more fully equipped van will be available next year to continue the services.

Since MHA was in the process (and has now completed) the conversion of the public housing to Rental Assistance Demonstration (RAD), they are no longer eligible to apply for ROSS funding. However, the collaboration between the organizations has already been established, and there is ongoing communication, therefore joint programs will continue to develop.

**How it Works**

There is no formal arrangement between MHA and Zufall. They share information but maintain strict confidentiality for the residents. MHA has a part-time social worker that is in touch with seniors and shares information on the availability of eligible programs. For families, they ask what their health care coverage needs are and make referrals and follow up at recertification.

Zufall Health Center continues to offer dental services on their mobile van and education on the Affordable Care Act and health insurance opportunities to public housing residents. Zufall Health Center also recently provided a dental health education workshop to public housing residents. Future health education workshops, including parenting and money management skills are also being explored for residents.

**Site: Gadsden, Alabama**

**Housing Authority: Greater Gadsden Housing  
Authority**

**Health Center Program Grantee: Quality of Life  
Health Centers**

**Total Patients Receiving Care at PHPC Site in  
2015: 3,239**



**The situation:**

The greater Gadsden area was not a safe place to live in the early 1990s. Gang violence, drugs, vandalism, prostitution, and gambling were pervasive problems in the community. Many public housing residents claimed they slept in tubs or never came outside. In 1993, when funding to bring a health clinic to people living in public housing was made available, the Quality of Life Health Center (QOLHC) and the Greater Gadsden Housing Authority (GGHA) saw this as an opportunity to bring change the community.

**The solution:**

The QOLHC leadership worked with the leadership of the GGHA to open a primary care program for public housing residents. GGHA leased facilities to QOLHC and helped identify new residents for outreach purposes. Primary care sites were located in two areas designed to service residents of seven housing developments and persons living within a one-mile radius of these developments. The Project called "ProCare" focused on family health care through education and counseling, preventative care, and promotion of healthy living practices.

QOLHC had access to resident contact information provided by GGHA, which helped them to reach residents at point of entry and inform them about available programs and services. Residents received one-on-one health education on site from QOLHC staff that was committed to the health and well-being of residents. The staff was aware of the many barriers patients faced and worked hard to reduce barriers to services.

### Why it Works: Strategies for Success

The QOLHS and GGHA partnership is successful because there is a shared vision, their community presence is consistent, and they are committed to the residents. They conduct a quarterly needs assessment and adapt services and service delivery to residents, changing issues. They meet quarterly to discuss the assessment data, evaluate all of the programs, and consider any suggestions from residents on new programs.

QOLHC has repositioned their staff in order to better serve the public housing residents. They have a primary care specialist at the center, as well as an onsite manager that has direct supervision of the services provided at the housing development and who communicates on a regular basis with the housing authority. They also have two outreach employees dedicated to events in the community or overseeing outreach in the community and two unpaid Resident Presidents that support all programming. These staff work to improve and expand resident engagement and increase QOLHS presence in the public housing communities. Dedicated staff allocation is a testament to the commitment they have to the residents and is a part of their shared vision.

Whenever possible, they also try to leverage existing community services for their residents rather than seek funding for new programs and services. Their strategy has been to identify organizations that specialize in a specific program, like Big Brothers and Big Sisters, and make space available to them at the housing development site, rather than develop duplicative services.

### The results:

After collaborating, QOLHS and GGHA began to see change in the community. The partnership received support from city council, schools, community colleges, National Association for the Advancement of Colored People (NAACP), and the police department. One of the most successful joint programs was the Public Housing Drug Elimination program. GGHA employed nine police officers to improve safety in the community. It was originally funded through a grant from HUD, then later through GGHA's operations budget. Because of that program, there was a real shift in the public housing image and a reduction of the stigma of living in public housing. Residents now have a sense of belonging and importance, particularly among elderly residents.

### How it Works

The lease agreement between GGHA and QOLHC outlines the purpose of the relationship, defines the roles and responsibilities of each party, identifies the selected services provided in the donated space, and clarifies the communication and reporting requirements.

QOLHC has eight annual events focused on prevention and education and GGHA holds four annual events; each organization participates and assists in the planning. They also submit articles into each other's regional monthly and quarterly newsletters.

The desire to provide residents with quality, affordable, and accessible health care was the driving force of both GGHA and QOLHS. They continued to improve the partnership and found ways to improve and enhance systems and services to accommodate the needs of both the community's and the residents' health. Both organizations recognized they could not be successful in helping public housing residents without each of their respective organization's commitment, attitude, and flexibility to work with organizations committed to improving the health and wellbeing of the residents. Together, they have coordinated efforts to provide services that were best for the residents.

The partnership expands beyond health to services addressing social determinants of health. Their annual initiatives and events include a Father's Day program, holiday parties, Encouraging Students to Exhibit Excellent Minds (ESTEEM) youth program, Reach Out mentoring program, and many more. Residents receive job training and are linked with multiple community resources.

**Site: San Diego, CA**

**Housing Authority: San Diego  
Housing Commission**

**Health Center Program Grantee: La  
Maestra Community Health Centers**

**Total Patients Receiving Care at PHPC  
Site in 2015: 38,210**



**The situation:**

In 2002, the San Diego Housing Commission (SDHC) launched a lead-based paint testing program to address residents of public housing exposure to lead-based paint. The goal of the program was two-fold, test children for lead exposure and educate the community on healthy homes and lead-related issues. However, when the program launched, SDHC had difficulty getting parents to test their children. There was mistrust among the residents of the housing community. From 2002 to 2005, the lead testing rate was 3% and SDHC was eager to find new partners and strategies to increase the testing rate.

**The solution:**

SDHC identified La Maestra as a key community stakeholder who could help engage residents of public housing to educate them around lead hazards and encourage them to test their children. La Maestra was identified as an essential partner in this initiative in large part because of its “Circle of Care” approach. The Circle of Care encourages a holistic, solution-based approach to providing programs and services and was created because La Maestra believes that complete family wellness requires more than just medical services. Every staff member at La Maestra from receptionist to physician is trained in the Circle of Care approach - to identify the patient's needs, to work as a team to assess the patient's needs and to guide the patient towards treatment, education, training and ultimately, self-sufficiency. The Circle of Care involves a network of integrated services provided at La Maestra in addition to community resources like SDHC. SDHC refers residents to La Maestra, for various services, including blood-lead testing.

### Why It Works

La Maestra utilizes patient advocates within the public housing communities to develop trusting relationships among public housing residents. La Maestra is respected among residents as a Health Center Program that is passionate about improving the quality of life of residents in their community.

### The results:

The LMCHC and SDHC partnership eventually expanded to the Metropolitan Area Advisory Committee on Anti-Poverty MAAC Project around weatherization for seniors and low-income families. LMCHC also partnered with San Diego Gas and Electric in Sempra, specifically on how low-income families living in low-income housing and public housing save or reduce their utility bills.

### How It Works

In 2008, SDHC partnered with La Maestra and several key stakeholders to conduct blood test events. Testing was offered on site of the housing complexes by La Maestra staff and at La Maestra Community Health Centers. The test rate increased from 3% (prior to La Maestra's engagement) to 29%. La Maestra led the way to host targeted testing at various community sites around San Diego, such as elementary schools, parks and community centers. Through their family self-sufficiency program, La Maestra had greater access to their target population. Collaborating allowed La Maestra to better understand and address challenges the families who lived in San Diego Housing Commission sites had; whatever they needed to become self-sufficient or improve their quality of life, including education, job search or job training, or health.

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## Promising Strategies and Lessons Learned

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The partnerships highlighted from Chicago, IL; Dover, NJ; Gadsden, AL; Philadelphia, PA and San Diego, CA showcase important themes in creating successful partnerships. True partnerships take time to foster, develop, and often evolve over time, depending on changes in leadership, restructuring of institutions, and availability of funding opportunities. A shared vision, commitment to the residents, open communication and transparency, and visionary leadership were key components to successful partnerships. Many of the successful partnerships were able to adapt during times of change, such as in Philadelphia, by reevaluating the partnership and identifying additional stakeholders and growth opportunities. The following are promising strategies and lessons learned from these public housing authorities and community Health Center Programs.

**I. Develop a Relationship**

Developing relationships and connections with key players in other agencies can help open opportunities for partnership. You are more likely to find success in establishing a partnership when you have a previous connection. For example, you may have met your counterpart at a conference or worked together for an event. To get started, utilize your professional networks and consider asking your colleagues to introduce you to their colleagues with who you are interested in working.

**II. Outline Mutual Value**

Identifying mutual value for all parties creates sustainable incentives for working together. Steps to creating mutual value can include discussing the shared value in the partnership, identifying tangible goals and outlining methods by which to effectively achieve these goals. For example, the smoking ban in public housing provides an opportunity to link residents of public housing with smoking cessation programs at Health Center Programs.

**III. Understand Your Partner**

While it is important to focus on your primary agency responsibilities, it is also important to understand how your work interfaces with other stakeholders and identifying outside strategic partners. For example, understanding each other can help each agency identify and share different areas of expertise, such as in grant applications and program design. Additionally, understanding each other's operations can also uncover ways to reduce duplication and make existing services more effective.

**IV. Consider Additional Stakeholders**

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While this toolkit is designed to highlight partnerships between PHAs and FQHCs, the case studies show that successful outcomes often come from involving additional partners. Many of the case studies demonstrate partnerships with local city government, community organizations and academic institutions. Some also leveraged funds through these organizations and were able to secure private foundation dollars.

**V. Recognize Limitations and Expertise**

Be transparent about the value your organizations can and cannot bring to the partnership. Understanding each other's limitations can help you decipher the appropriate roles and responsibilities each party should take and avoid future misunderstanding. Likewise, recognizing each other's expertise can enable you to build from each other's strengths and ensure that each party's resources are not stretched too thinly.

**VI. Write it Down**

Once you have established a partnership, each party benefits by developing a written document to operationalize the relationship through a Memoranda of Understanding (MOU), Memoranda of Agreement (MOA) or Business Associates Agreement (BAA). This provides a clear and concrete way to make sure you have established your mutual goals and the ways that you plan to achieve them. Having such a document helps ensure that there is no confusion and keeps everyone involved on track.

**VII. Communicate Regularly**

Partnerships will evolve and change over time. It is easy for a partnership to lose its momentum after its initial launch. Continuing to communicate after an MOU has been signed is one step toward keeping the partnership alive and the partnering agencies accountable. Some of the PHAs highlighted in the case studies were able to hire a liaison or coordinator whose main duty was facilitating service referrals for public housing residents. Throughout the collaboration, this staff member could become the point of contact that maintains communication and updates all partners on the status and results of achieving set goals.

**VIII. Engage Public Housing Residents and Community Members**

Involving public housing residents and other key members of the community in program planning and implementation is vital to the successful implementation of the PHPC program. Resident engagement has the potential to reduce health inequalities. When public housing residents are involved, they feel ownership of the programs and are more likely to be active, involved participants. Numerous Health Center Programs and housing authorities testify that residents are champions of change, who drive

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their effort to improve access to resources and improve health equity. Residents are best able to ensure services are timely and relevant.

## **IX. Evaluate and Revise**

After you have entered into a partnership, it is important to evaluate its effectiveness. If particular tactics are deemed less successful than you or your partners would like, you should be open to revising the terms of the partnership. The partnership MOU or other agreement should be examined periodically to ensure that the contents and roles are still applicable. You and your partners should consider whether certain parts need to be removed, altered or added to reflect the current needs of the populations your partnership serves.

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## Opportunities for Engagement

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Developing a partnership between Health Center Programs and public housing authorities can greatly improve access to care for public housing residents. The partnership can help to identify funding opportunities, develop appropriate programming, and implement services to address the ongoing needs of public housing residents. As the landscape of public housing changes from traditional public housing complexes to mixed income communities and vouchers, Health Center Programs and public housing authorities must be primed and ready to continue to promote the health of their residents. This requires a commitment of both the Health Center Program and housing authority to collectively address barriers around resident's lack of knowledge of health care services, residents' personal or family problems, residents' trust in the Health Center Program and housing authority, and any pressing issues that could supersede their immediate health needs. As displayed in the case studies, there is great potential for significant collaboration to address these barriers. Understanding the goals and programs of each system is the first step in identifying areas for partnerships and supporting the health and wellbeing of residents. Below are examples of opportunities for engagement between Health Center Programs and public housing authorities.

### **I. OUTREACH AND ENROLLMENT FOR HEALTH INSURANCE**

- A. **Opportunity:** Residents of public housing can be assessed for and enrolled in health coverage at Health Center Programs through outreach and enrollment staff funded by the Affordable Care Act, Health Insurance Marketplaces, Medicaid or the Children's Health Insurance Program. The partnership between a public housing authority and a Health Center Program can connect residents to appropriate health care homes.

- B. **Challenge:** As health care reform continues to evolve, residents may need additional support in navigating accessible, affordable health insurance options to ensure continuity of care... Hiring, or otherwise engaging, local public housing residents to act as liaisons to the Health Center Program has been an effective strategy to build trust and encourage participation in Health Center Program activities.

## II. INSTITUTING SMOKE FREE PUBLIC HOUSING

- A. **Opportunity:** On November 30, 2016, HUD released a final rule on instituting smoke-free policies for PHA-administered buildings. Effective February 3, 2017, all PHAs have 18 months to incorporate the smoke-free policy inside public housing living units and indoor common areas, public housing administrative office buildings, public housing community rooms or community facilities, public housing day care centers and laundry rooms, in outdoor areas within 25 feet of the housing and administrative office buildings, and in other areas designated by a PHA as smoke-free.
- B. **Challenge:** Because many individuals will quit smoking, they will be in need of smoking cessation support, as well as health care services to address the effects of quitting tobacco products. Collaborations with Health Center Programs, local health departments, and social service agencies will be instrumental to meeting the needs of the population.

## III. HEALTHY HOMES PROGRAM

- A. **Opportunity:** The Healthy Homes Program at HUD addresses multiple childhood diseases and injuries in the home. The initiative takes a comprehensive approach to these activities by focusing on housing-related hazards in a coordinated fashion, rather than addressing a single hazard at a time. Health Center Programs can work with Healthy Homes' grantees to identify public housing residents in need of an intervention
- B. **Challenge:** Identification of health hazards within the home requires an in-home inspection. Some residents may be hesitant to welcome that service from a housing authority or Health Center Program. Using a peer educator or other outreach worker from a health center that they already know and trust.

## IV. HEALTH CENTER PROGRAMS MOVING OFF SITE OF PUBLIC HOUSING

- A. **Opportunity:** As Health Center Programs services and patient numbers expand, additional space may be required beyond that of the original Health Center Program sites in public housing. The expansion is an opportunity to reach more individuals in need of quality health care.
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- B. **Challenge:** Public housing residents are often considered the “hardest to engage” due to circumstances such as limited education, institutional mistrust, and/or drug and criminal records. Therefore, traditional engagement strategies to access health care may not be the right fit for some residents. A Health Center Program will need to identify successful engagement strategies to keep residents connected to care.

**V. COUNTING PUBLIC HOUSING RESIDENTS ON THE UNIFORM DATA SYSTEM REPORT**

- A. **Opportunity:** Work collaboratively with local housing authority to identify public housing addresses in order to compile an accurate count of public housing residents who receive care at Health Center Programs.
- B. **Challenge:** Need to develop data sharing agreements. The largest challenge is reporting an exact count of public housing residents at Health Center Programs and linking health outcomes to these residents. However, we can use this methodology to guide us in identifying the social determinants of health underlying and adversely affecting health outcomes.

**VI. CHOICE NEIGHBORHOODS GRANTS**

- A. **Opportunity:** The Choice Neighborhoods program provides funding to local governments to create comprehensive plans to transform and revitalize distressed neighborhoods.
  - B. **Challenge:** Limited funding available. Some applicant housing authorities may be unaware of the role that Health Center Programs can play in the planning and execution of neighborhood revitalization and comprehensive service delivery.
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## Next Steps: A Guide for Partnerships

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Here are some resources that may be helpful to PHPCs or PHAs:

### **Partnering with Public Housing Authorities to Increase Resident Participation**

Involving the local housing authority and other key members of the community in program planning and implementation is vital to the successful implementation of the PHPC program. Healthy individuals and families are more likely to be self-sufficient and become contributing members of a healthy community. This practical guide provides information and resources for Health Center Program staff to partner and collaborate more effectively with their local housing authorities

### **Outreach to Residents of Public Housing**

This practical guide provides tools to develop an effective outreach program using trained community health workers to reach public housing residents. It is designed for use by CHW's and their supervisors. The guide is divided into seven modules. At the end of each module are exercises designed to help the trainee integrate the knowledge gained from each module and apply it to their own practice.

### **Connecting Public Housing and Health: A health impact assessment of HUD's designated housing rule**

HUD's designated housing rule allows housing authorities to allocate certain public housing properties for occupancy by senior families, disabled families, or a mix of both. The health impact assessment identified the possible health implications of two proposed changes to the rule, illustrating the benefit of incorporating health data into federal housing decisions.

### **Information on Advancing the Health of patients in /or Accessible to Public Housing**

This document describes HHS', HUD's and HRSA's strategic objectives regarding public policies impacting residents of public housing, gaps in housing, current health and housing programs and data analysis for quality improvement

### **Assessing the Health Care Needs of Residents of Public Housing**

This resource toolkit provides guidance to Health Center Programs on how to define their community, structure a needs assessment tool, and evaluate their assessment process. It also offers suggestions on who to involve in the assessment process and offers additional resources.

### **Counting Public Housing Residents for the 2016 UDS Report**

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All Health Center Programs and Look A likes, regardless of the population-based funding, are required by HRSA to include a count of public housing patients. This webinar explains the reporting requirement and required methodology in plain, easy to understand steps, and is intended for staff responsible for UDS reports, as well as administrators, operations managers, and outreach and program development staff of Federally Qualified Health Center grantees and Look-Alikes.

### **Additional Resources**

#### **Counting Public Housing Residents on the 2017 UDS Report Webinar:**

This webinar provides an overview of counting total patients served at a health center site located in or immediately accessible to public housing on the 2017 UDS report, and also highlights strategies to partner with the housing community to advance patient access and outcomes.

#### **Recommendations: Counting Total Patients for 2017 UDS Report**

This publication outlines how to conduct a location-based count of residents of public housing at your health center.

#### **FAQs: Counting Total Patients for 2017 UDS Report**

This publication answers frequently asked questions about completing table 4 line 26 of the 2017 UDS report.

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## APPENDIX A: Interview Guide

### METHODOLOGY:

A 60-minute interview with both a PHA and FQHC representative will be conducted at a mutually agreed upon location with either a representative from one or both of the following organizations: [National Nurse-Led Care Consortium](#) and/or [National Center for Health in Public Housing](#). The Introduction and Establishing a Partnership sections will be conducted simultaneously with both representatives. The Challenges and Strengths section will be conducted separately with both representatives afterwards participants will convene to discuss technical assistance needs and future partnership opportunities.

### QUESTIONS/THEMES:

#### A. Background of Project (5 minutes)

#### B. Establishing a Partnership (15 minutes)

1. Please describe how you collaborate with your local [PHA/FQHC]?
2. How often do you communicate and in what form (i.e. monthly in-person meetings, quarterly teleconferences, etc.)?
3. What motivated/inspired the partnership?
4. What immediate benefits have you seen as a result of your partnership?
5. Do you currently have any of the following in place?
  - a. Defined shared objectives, vision, or mission as it relates to your partnership?
  - b. Memorandum of Understanding (MOU)?
  - c. Confidentiality Agreement?
  - d. Information Exchange?

#### C. Challenges and Strengths (20 minutes: participants will be divided up during this section)

6. Identify two key elements to a successful PHA/FQHC partnership? (i.e. committed stakeholder group, establishment of trust, establishment of clear objectives, understanding each other's strengths and weaknesses, etc.)
  7. How can you ensure the continued success of your PHA/FQHC partnership?
  8. Identify two challenges encountered in your PHA/FQHC partnership.
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9. How can you overcome these challenges to the benefit of your PHA/FQHC partnership?

**D. Technical Assistance Needs (10 minutes)**

10. In order to further your partnership and collaboratively promote the health of your clients, what technical needs or assistance would be beneficial?

11. Who would be best positioned to provide this assistance? (i.e. HUD, HHS, National Cooperative Agreement)

**E. Future Partnership Opportunities (10 minutes)**

12. Identify two possible areas where your partnership can be expanded.

13. What would an ideal PHA/FQHC partnership look like?

