

Developing Cross-Sector Partnerships

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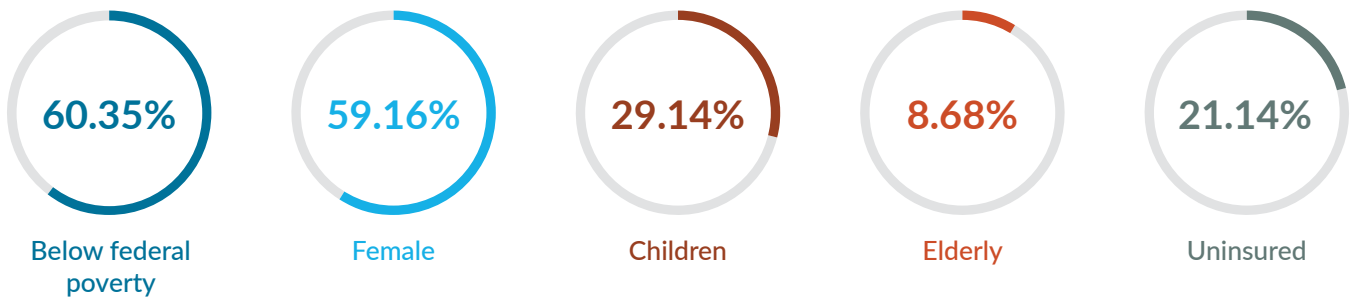
Introduction

This guide will provide health center staff with tools and strategies to initiate, develop, and sustain community partnerships to better serve older adult residents of public housing. Content was developed through a 4-session learning collaborative (LC) launched by the [SDOH Academy](#) with a small cohort of HRSA-funded health centers, Health Center Controlled Networks (HCCN), and Primary Care Associations (PCA). The focus of these LC(s) was to share learning aimed at transforming care to better meet the socioeconomic circumstances and non-clinical needs of special and vulnerable populations.

About Health Centers

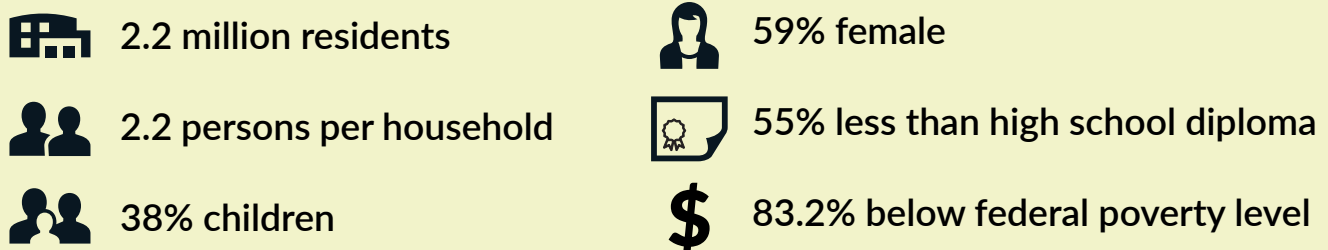
The role of health centers are to deliver affordable, accessible, quality primary health care to patients regardless of their ability to pay. There are nearly 1,400 health centers that receive federal funding through [Health Resources and Services Administration \(HRSA\)](#). Those health centers provide care to about over 28 million people. Of the nearly 1,400 health centers there are 386 health centers that are located in or immediately accessible to public housing. There are 107 health centers that receive specialized grants called Public Housing Primary Care (PHPC) grants to provide care specifically for public housing residents.

Public Housing Primary Care Health Centers



Demographics from the [HRSA National Health Center Data](#).

Public Housing Residents



Demographics from the [U.S. Department of Housing and Urban Development \(HUD\)](#).

Health of Public Housing Residents

Adults that receive housing assistance from HUD have higher rates of chronic health conditions and are greater utilizers of health care than the general population. They are more likely to have fair or poor health, be overweight or obese, or be diagnosed with diabetes, asthma, or a disability. Adults that receive housing assistance are also more likely to report these conditions compared to other low-income renters, which indicates that there are other factors, in addition to income, that are impacting their health. The environment, the conditions of the housing, safety, access to healthy food, all have a role in shaping health outcomes.¹



Table 1. Health Status of Public Housing Residents Compared to Other Adults.²

	Fair/Poor Health	Overweight or Obese	Disability	Diabetes	COPD	Asthma
HUD-Assisted	35.8%	71.0%	61.0%	17.6%	13.6%	16.3%
Low-income renters	24.0%	60.0%	42.8%	8.8%	8.4%	13.5%
All Adults	13.8%	64.0%	35.4%	9.5%	6.3%	8.7%

Table 2. Prevalence of Selected Health Conditions for Patients Visiting Public Housing Primary Care Health Centers³

	Asthma	Chronic Lower Respiratory Diseases	Diabetes	Heart Disease	Hypertension	Overweight or Obese	Tobacco Use Disorder	Depression	Anxiety and PTSD
PHPC Patients	8.7%	3.27%	14.58%	3.29%	25.56%	34.96%	6.56%	13.33%	10.77%

1 U.S. Department of Housing and Urban Development. (2017) A Health Picture of HUD-Assisted Adults, 2006-2012. Washington: U.S. Department of Housing and Urban Development. Retrieved from <https://www.huduser.gov/portal/sites/default/files/pdf/Health-Picture-of-HUD.pdf>

2 Ibid.

3 Health Resources and Services Administration, Health Center Program. 2018 National Health Center Data. Retrieved from <https://bphc.hrsa.gov/uds/datacenter.aspx?fd=ph>



Health Issues and Challenges for Older Adults

The population of older adults in the United States is growing, and those over the age of 65 will outnumber children for the first time in history by the year 2035.⁴ The majority of older adults live with two or more chronic conditions, which can include heart disease, cancer, stroke, diabetes, and Alzheimer's disease. These chronic conditions represent a significant cost for the health care system, and can affect the quality of life and ability to age in place for older adults.⁵

Environmental hazards also may limit the ability to safely stay at home, particularly as endurance diminishes over time. Poor or low vision can lead to an increased risk for falls, along with other challenges like muscle fatigue or difficulty with balance. Engaging with the community is also an essential part of staying active and completing instrumental activities of daily living (IADLs). This ability can be challenged by lack of transportation options and limited services geared towards this population. Many older adults living in the community may experience food insecurity due to limited finances or social support, putting them at risk for malnutrition.

While there is a documented connection between oral health and chronic conditions, at least one third of older adults have not had a dental visit in the last year.⁶ Limited access to dental insurance or services increase oral health disparities for this vulnerable population. Another often overlooked area of older adult well-being is depression, as providers do not always recognize the signs and may assume that symptoms are a result of a physical illness or the aging process itself.⁷ There are numerous negative effects of any mental health or substance use concerns going unaddressed, both for older adults themselves and for their caregivers. A care approach that addresses the whole person is needed in order to avoid poor health outcomes in this population.

4 "The Graying of America: More Older Adults ... - Census Bureau." 13 Mar. 2018, <https://www.census.gov/library/stories/2018/03/graying-america.html>. Accessed 27 Nov. 2019.

5 "Facts About Healthy Aging | NCOA." <https://www.ncoa.org/news/resources-for-reporters/get-the-facts/healthy-aging-facts/>. Accessed 27 Nov. 2019.

6 "Healthy Aging in Action - CDC." <https://www.cdc.gov/aging/pdf/healthy-aging-in-action508.pdf>. Accessed 27 Nov. 2019.

7 Ibid.

Older Adult-Focused Health Programs for Public Housing Residents

There is a considerable amount of research and evidence demonstrating that housing, health, and senior service agencies should work together to align their agendas and goals to provide an integrated approach to delivering services in order to reduce and eliminate barriers to care. Using a qualitative case study approach, the National Center for Health in Public Housing (NCHPH) interviewed Health Center staff to identify the key components of successful older adult programs and lessons learned for addressing the barriers to accessing care in this patient population. The report provides health centers that are interested in developing new older adult programs, or enhancing existing ones, with concrete examples on how to improve their older adult patient interactions, increase access to care, and improve health outcomes for this population. [To view the report click here.](#)

Health centers should consider:

COMPREHENSIVE PROGRAMS THAT LINK SENIORS TO SOCIAL SERVICES: A recurring theme in discussions with Health Center leadership was the importance of providing comprehensive care that integrated a range of social services for seniors and supportive housing options and services to prevent homelessness.

SUPPORTIVE HOUSING PROGRAMS THAT ADDRESS HOMELESSNESS: Many of the health centers also noted the vulnerability of the senior public housing population and importance of both preventing homelessness as well as supporting the existing homeless population.

ADDRESSING THE CHALLENGE OF TRANSPORTATION: All health centers noted that the major challenge for seniors living in public housing is access to transportation. Specialized transportation is particularly important for improving access to care for high-risk, low-income populations who do not drive and have difficulty taking public transportation because of disability, age-related conditions, or income constraints.⁸

SHIFTING THE CULTURE: Another trend in the discussion with Health Center staff focused on the challenges of attracting new senior patients. When creating new senior health programs or senior health centers, staff found it difficult to engage with the senior population and encourage them to visit the clinics for health care services.

MULTIDISCIPLINARY TEAM: The programs and services offered to senior patients at many of the health centers participating in the study include: geriatric health care, adult day health services, counseling and mental health services, case management, optometry, podiatry, dementia care, end-of-life care, and geriatric dentistry, and wellness programs. As a result, the health centers have developed a robust and diverse staff.

COLLABORATIONS ARE CRITICAL: Seniors require multiple types of health and social services; therefore, it is critical that health centers engage in partnerships with other organizations in the community.

8 Fox-Grage, W., & Lynott, J., (2015, January). Expanding specialized transportation: new opportunities under the Affordable Care Act [PDF document]. AARP Public Policy Institute. Retrieved from <https://www.aarp.org/content/dam/aarp/ppi/2015/AARP-New-ACA-Transportation-Opportunities.pdf>

Mapping Potential Partners in Your Community

Building Your Neighborhood

“A clinical-community partnership that includes the medical and social supports necessary to enhance health, with the Patient-Centered Medical Home (PCMH) serving as the patient’s primary ‘hub’ and coordinator of health care delivery. The goals of a high-functioning PCMH include collaborating with these various ‘medical neighbors’ to encourage the flow of information across and between clinicians and patients, to include specialists, hospitals, home health, long term care, and other clinical providers.”

The Patient-Centered Primary Care Collaborative

Medical neighborhood “maps” can take a variety of forms, but should be memorialized in written format so that all members of the health center care team can identify “neighbor” organizations and link patients to community resources. Medical neighborhood maps could be:

1. Circle diagrams with the patient/population in the center and partners listed on spokes
2. Excel lists of partners with relevant contact information
3. Noted on patient care plans in the EHR
4. A bulletin board in the health center

By identifying and partnering with community organizations, health centers can support patients in accessing resources that advance health outcomes outside of the health center walls. Health center staff can begin the process of identifying medical neighbors by:

1. Creating care maps for patients/populations

- A care map is a comprehensive snapshot of the medical and social supports in place to promote patient and family wellness.
- Care maps should be created in consultation with patients and families, with the patient/population at the center.
- The map should change based on evolving patient needs, and should incorporate all of the social determinants of health at play in a patient’s life.

2. Identifying the community organizations that play a role in patient/population care maps

- Identify a point of contact at the organization
- Create a contingency plan for turnover

3. Operationalize partnership by creating a shared protocol/memorandum of understanding (see page 9 for more information)

Building Your Neighborhood (Continued)

The Agency for Healthcare Research and Quality (AHRQ) has outlined several outcomes of a well-functioning medical neighborhood:⁹

Assumptions

- Patient Centered Medical Home (PCMH) function as the core of the medical neighborhood
- Health is a community issue, and medical neighborhoods can impact community health
- Financial incentives may improve care coordination
- Effective use of health IT may improve flow of information across the neighborhood

Resources/Inputs

- Patients and their Families
- Providers and health care systems
- Community and social service organizations
- State and local public health agencies
- Financial incentives by purchasers/payers
- Health IT
- Dedicated staff for care coordination
- Patient decisions aids
- Community and social services
- Multi-payer databases



Activities

- Clarify respective roles and responsibilities of clinicians in the system
- Facilitate and enhance information flow within the neighborhood
- Develop protocols for communication and coordination of patient care across providers
- Engage in referral behaviors that promote good neighbor behavior
- Train providers in coordination, communication, and team-based care
- Systematize care coordination activities within the PCMH
- Educate patients on PCMH and the medical neighborhood, and their rights and responsibilities
- Promote the medical neighborhood concept through educational activities

⁹ Taylor EF, Lake T, Nysenbaum J, Peterson G, Meyers D. Coordinating care in the medical neighborhood: critical components and available mechanisms. White Paper (Prepared by Mathematica Policy Research under Contract No. HHS2902009000191 TO2). AHRQ Publication No. 11-0064. Rockville, MD: Agency for Healthcare Research and Quality. June 2011.

Building Your Neighborhood (Continued)

Outputs

- Increased information flow among clinicians
- Improved communication between clinicians (regular, timely)
- Improved communication between clinicians and community/social services
- More appropriate referrals
- Increased accountability in terms of who is responsible for what
- Increased patient and family engagement; shared decision-making
- Increased clinician understanding of patient needs and preferences
- Increased use of public data to focus on population health

Outcomes (Short-term)

- Improved care coordination
- Improved patient safety
- Improved patient experience

Outcomes (Long-term)

- Improved clinical outcomes
- Reduced costs through reduced duplication and waste
- Improved population health management

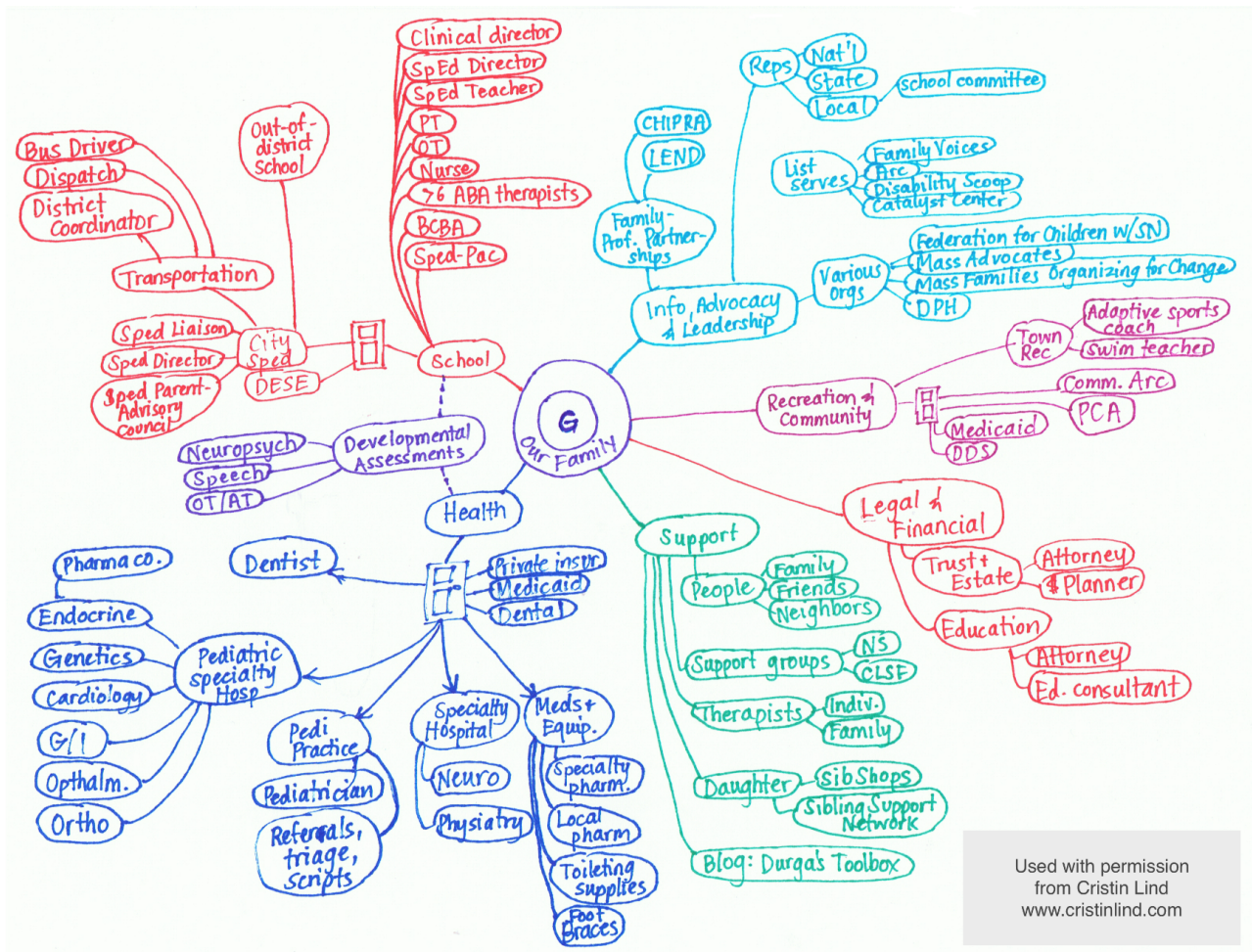
Building Your Neighborhood (Continued)

Figure 1. Patient medical neighborhood example.

To better understand the breadth of services accessed by children with special healthcare needs, pediatrician Dr. Richard Antonelli asked a patient’s mother draw a visual representation of the resources she coordinated for her son, Gabe. This figure represents Gabe’s medical neighborhood, depicting the supports he needs across sectors to live a full, healthy life. Dr. Antonelli and Gabe’s mother Cristin presented this care map at the IHI European Forum in 2014.



Medical neighborhood maps can be designed using a variety of formats, including circular diagrams, bulleted lists, or visual diagrams. Providers should work closely with patients and health center staff to determine the format that best reflects the members of a medical neighborhood.



Used with permission from Cristin Lind www.cristinlind.com

Building and Sustaining Community Partnerships

Levels of Partnerships

Organizations that are committed to improving the health of their community can support collective action through the formation of a partnership. Not all partnerships look the same, and often can develop over time with increased capacity and levels of support. There are benefits to organizations involved at any of the following stages:

- **Networking:** Information sharing between groups
 - **Coordinating:** *(in addition)* Aligning activities to meet a common goal
 - **Cooperating:** *(in addition)* Sharing resources or space through a written contract
 - **Collaborating:** *(in addition)* Enhancing capacities through seeking mutual feedback

Barriers to Partnerships

Encountering barriers on your way to having productive and meaningful partnerships is common. Roadblocks to effective partnerships may be a result of limited resources or lack of understanding/openness in new relationships. These barriers can be overcome in part by identifying a shared vision and incorporating the missions of all who are represented.

Nurturing Partnerships

During the initial stages of a collaborative relationship, it is important for organizations involved to clearly define each of their roles. Distributing responsibilities in a way that is realistic and achievable for everyone will ensure potential barriers of time and imbalanced effort can be avoided. Open communication can help to build trust in a new partnership, particularly to establish a clear plan around how goals will be set and decisions will be made.

A collaboration that has a wide variety of perspectives and life experiences is going to be able to effectively speak to the needs of the community as a whole. Valuing diversity in a partnership with individuals who have different backgrounds than our own can allow for personal growth and an expanded worldview. The common goals that often spark a partnership can help to shape the way a group talks about its mission and approach amongst each other or to the larger community. A commitment to staying engaged in the collective work will ensure a partnership can be maintained for the long-term.

Nurturing Partnerships (Continued)

Launching a pilot project can be financially challenging, particularly for non-profit organizations that have funding already assigned to specific projects. Working with an additional partner, such as a foundation in the community, can help to fund a project. The Foundation Directory can assist in searching for grant funding by location or population.

A memorandum of understanding (MOU) is a formal written agreement that outlines the level of participation and involvement in a partnership. The format of this contract may depend on organizational preference, but can be generally used to establish ground rules for collaboration.

Health centers can use a MOU to:

1. Identify purpose:
 - *Example: To facilitate individuals' consistent participation in health-enhancing activities*
2. Identify principle:
 - *Example: Focus on patient and family needs*
3. Defining common terms
 - *Example: elderly vs older adult*
4. Define funding and duration – even though a specific funding source may start a partnership, how might the partnership be continued if the funds are depleted?

Maintaining Partnerships

Once organizations are on board for a partnership, there should be clear ground rules about standards of conduct, meeting frequency, and task management. While all members can play an important role, it will be helpful to identify and maintain a core leader or leadership team to keep track of goals. Those in a leadership role should be committed to navigating the group through changes, including identifying future projects and potential collaborators. Aiming for multiple sources of financial support can allow partnerships to secure sufficient funding that is sustainable over time.

Health center patients should be informed that partnership services are available. It may be feasible to provide information directly through the Electronic Health Record (EHR) or patient engagement channels if the programming addresses chronic conditions. Discharge staff members should also be informed of the services available to patients, and signage can be placed at the reception desk or waiting areas so they are easily seen. Clear communication about the availability of resources and a common understanding amongst health center staff about the benefits for patients will assist in encouraging participation and satisfaction over time.

Maintaining Partnerships (Continued)

Maintaining healthy partnerships requires conflict to be addressed in a prompt and direct manner. Leaders may need to embrace the initial discomfort of talking through a disagreement in order to avoid long-term consequences. Depending on the size of the group, opportunities for feedback may be approached with more casual asks or scheduled times for reflection. A willingness to revisit an approach and make necessary changes will allow the group to continue to effectively work towards agreed upon goals. Employee turnover or other staffing changes at an organization may lead to delays with projects or meetings, but clear documentation of roles and responsibilities for all involved parties will allow for new employees to be accurately informed around details of the partnership and any relevant timelines.

Evaluating Partnerships

There are several approaches to evaluating the goals and efforts of a partnership, depending on the level of resources and stakeholder expectations. Some important questions to ask:

1. Who is the evaluation for?
2. What are their priorities?
3. What do they want to know?
4. What targets does the partnership want to reach?
5. When do you want to reach those targets?

Formal evaluators will be able to look at a partnership's progress over time if clear objectives have been developed and if those involved in the work are on the same page about how to best achieve them. Core leadership should oversee the organizational process, and communicate to the group how much time and analysis the evaluation will require. However, including all involved parties in the evaluation process can continue to strengthen group rapport.

The evaluation of a partnership focused on better health outcomes for a specific community will not provide sole credit for a long-term positive change that occurs in the target population, particularly if there are other organizations working towards a similar goal. However, this does not detract from a collaboration's positive contribution, and an evaluation can help identify the most effective short-term efforts that were made. The results of this evaluation should be shared with all groups represented in an interested and invested audience, including stakeholders, potential future collaborators, and any others who might be affected by the results.

Case Study: Casa Maravilla

Casa Maravilla, a collaboration between Alivio Medical Center, The Resurrection Project, and City of Chicago, Dept of Family Support Services, Senior Area Agency on Aging

The following case example describes a \$20 million, public and private partnership between Alivio Medical Center, an FQHC in Chicago; The Resurrection Project, a non-profit community development corporation; and the City of Chicago.

The three organizations worked together to create Casa Maravilla, a 7,000 sq. ft. senior housing building in Chicago's Pilsen neighborhood that has 73 independent apartments for adults age 55 and older.



Partnership Stage: Nurturing

The genesis of the relationship between the organizations began when community activists realized that the population in the community was aging and there were no affordable housing options for seniors. The Resurrection Project, a non-profit community development corporation, was interested in building a development that anchored the community, to fend off gentrification as much as possible. They approached the CEO of Alivio Medical Center to purchase some of its land north of the medical center. Alivio agreed with one condition; that some of the land was reserved for a senior building and a senior center. The Resurrection Project contacted the City of Chicago's Department of Family Support Services, Senior Area Agency on Aging to discuss creating a satellite senior center. Since Alivio was experienced in providing care to seniors, The Resurrection Project asked them to manage the site.

Partnership Stage: Maintaining

The Resurrection Project owns the building and they lease part of the first floor to the City of Chicago for the senior center at no cost. Alivio Medical Center manages the senior center at no cost. The unique public and private partnership has extended care to over 6,000 seniors in the area.

The senior center has monthly wellness programs. A nurse, registered dietician, and a pharmacist provide health education presentations for the seniors. Senior and outreach and enrollment staff are housed at the site. The senior center also operates as a Benefits enrollment center to help people with SNAP, Medicare, Medicaid, Medicare Savings Program, Low Income Subsidy, and some local programs. They also work with local school programs to allow students to work or volunteer at the senior center, which is beneficial for both age groups.

Partnership Stage: Evaluating

The partners routinely evaluate the quality of care delivered to the seniors in the community and strive to improve it where possible. One of the unique characteristics of the community is its diversity. The area is multilingual and multicultural, and the staff of the Senior Center has evolved to reflect those changes. Agencies that serve limited-English speakers must have appropriate staff to provide culturally competent care, beyond just language translation. The staff of Casa Maravilla is not only bilingual, but bicultural.

One of the challenges for seniors served at Casa Maravilla has been misinformation; seniors are often unaware of the programs and services for which they are eligible. Therefore, through funding through the National Council on Aging, Casa Maravilla can now screen and identify programs and services needed for over 2,000 seniors.

Benefits of the partnerships have extended beyond those served directly at Casa Maravilla. It has also enriched the community by connecting the aging population with youth. Students from the neighboring schools spend time at the facility as interns, externs, and volunteers. According to the director, “It’s been a remarkable experience, one of the things that it enables us to do is to talk to people in the community and young people about how meaningful and fulfilling it is to work with older adults. And we think some of that is sticking.”

The partnership continues to grow. On land purchased from Alivio, The Resurrection Project completed construction of a \$15 million Casa Morelos, an environmentally green building with 45 units of affordable rental housing. The complex contains energy efficient appliances, geo-thermal heating systems, semi permeable pavement on the parking areas and a green rooftop.

Conclusion

In order to meet the needs of vulnerable populations like older adults and residents of public housing, health centers must develop and sustain cross-sector partnerships that leverage community resources for optimal, patient-centered services. By mapping community partners, overcoming barriers to collaboration through shared goal setting, and creating sustainable partnership strategies, health centers can improve their patients’ quality of life, both in and outside of the clinic walls. Robust, cross-sector partnerships can be pathways to health center expansion and growth, and can facilitate the fulfillment of the health center program’s mission to provide comprehensive wellness services for patients in their communities.

Notes

This resource was a collaboration between the National Nurse-Led Care Consortium, National Center for Equitable Care for Elders, and National Center for Health in Public Housing.



nurseledcare.org

The National Nurse-Led Care Consortium is a national leader supporting and advocating on behalf of nurse leaders. We are a nonprofit member-supported organization, and provide a wide range of services to educate and support nurses on the frontlines of health care.



ece.hsdm.harvard.edu

The National Center for Equitable Care for Elders (NCECE) is a program of the Harvard School of Dental Medicine. NCECE provides innovative and culturally competent models of care, inter-professional training and educational resources, and technical assistance to health care professionals.



nchph.org

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