HEALTHY TOGETHER

A Toolkit for Health Center Collaborations with HUD-Assisted Housing and Community-Based Organizations

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TABLE OF CONTENTS

INTRODUCTION 1

MODULE I: HEALTH AND HOUSING ASSISTANCE – PROGRAMS AND PEOPLE 3

1. Health Service Providers 3
   a. HRSA/BPHC/Federally Qualified Health Centers(FQHC) Section 330 3
   b. Public Housing Primary Care Program - Section 330(i) 5

2. Federal Housing Assistance Programs 6
   a. Public Housing Programs 6
      i. Housing Choice Voucher Program (HCV) 7
      ii. Family Unification Program (FUP) 7
      iii. Project-Based Rental Assistance (PBRA) 7
      iv. Foster Youth to Independence Initiative (FYI) 8
      v. HUD-VA Supportive Housing Program 8
   b. Resident Service Programs 8
      i. Family Self Sufficiency (FSS) 8
      ii. Resident Opportunity and Self Sufficiency (ROSS) Service Coordinators Program 9
      iii. Jobs Plus Initiative 9
      iv. Strong Families Initiative 9
      v. ConnectHome 9
      vi. CHOICE Neighborhoods 9
      vii. Moving To Work Demonstration (MTW) 10
   c. Special Populations 11
      i. Housing and Services Resource Center (HSRC) 11
      ii. Supportive Housing for the Elderly (Section 202) 11
      iii. Supportive Housing for Persons with Disabilities (Section 811) 11
      iv. Housing Opportunities for Persons with AIDS 11
      v. Youth Homelessness Demonstration Program 12

vi. Resident Opportunity for Self Sufficiency (ROSS) for Education Program 12
vii. House America 12
viii. Continuum of Care Program (CoC) 12

d. Public and Indian Housing Programs 13
i. The Tribal HUD-Veterans Affairs Supportive Housing Program 13

e. The Coronavirus AID, Relief and Economic Security Act (CARES ACT) 13
i. Emergency Housing Vouchers (EHV) 13

f. Other Programs for States and Localities 13
i. U.S. Department of Agriculture (USDA) Rural Rental Housing Program 13
ii. Other 14

3. Other Low-Income Housing Programs 14
a. Homeless Shelters 14
b. Transitional Housing 15
c. Halfway Houses 15
d. Rooming Houses/Boarding Houses 15
e. Housing First 16

4. Public Housing Residents and Patient Demographics 16
a. Socio-Demographic Characteristics 17
b. Social/Environmental Concerns 17
c. Health Status of Public Housing Residents 18
d. PHPC Grantee Data 18

MODULE II: COLLABORATIVE STRATEGIES 20
1. Understanding Collaboration 20

2. Collaborative Relationships 20
a. Networking 20
b. Cooperation 20

c. Coordination ... 21

d. Collaboration ... 21

e. Communication ... 21

3. Collaboration Skills ... 21

a. Communication Skills ... 21

b. Emotional Intelligence ... 22

c. Understanding Diversity/DEI ... 23

4. Building Blocks To Successful Collaboration ... 24

a. Defining Purpose ... 25

b. Assessing Need ... 25

c. Building Strategic Partnerships ... 25

d. Potential Collaborators and Partners ... 26

e. Achieving Buy-In ... 29

f. Conducting Effective Collaboration Sessions/Meetings ... 29

g. Planning, Prioritizing and Performing ... 30

h. Implementing Change ... 31

i. Evaluation ... 32

j. Celebrate Success ... 32

5. Barriers to Effective Collaboration ... 32

6. Resident Perspective – Recruiting and Involving Residents ... 34

a. Tips for Recruiting and Retention ... 34

b. Resident Involvement in Governance ... 35

c. Communicating with Public Housing ... 36

d. Memorandum of Understanding with Public Housing ... 37

7. Social Mobilization ... 38

8. Collaboration Tools ... 39

MODULE III: MODELS THAT WORK – PROMISING PRACTICES AND CROSS-SECTOR COLLABORATIONS 41
1. Collaborative Initiatives between Health Centers and PHAs 42
2. Collaborations with Foundations, Hospitals and Universities 44
3. Collaborative Data Collection and Research Initiatives 46
4. Collaborations to Address the COVID 19 Pandemic 48
5. Flu Linkages To End Disparities (Flu LEAD) 49
6. Other Cross-Sector Partnerships 49
7. Lessons Learned 51
APPENDICES 52
1. Glossary of Terms 52
2. References 54
3. Tools 58

INTRODUCTION

The World Health Organization, (WHO), defines health as ".... a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity." Poverty, unfortunately, has a disproportionate impact on an individuals' health status, and conditions associated with an impoverished social environment result in negative health outcomes.

Housing and health are human rights, inter-dependent, and any infringement of these rights severely impacts the most vulnerable in our society, including the elderly, communities of color, youth, families with children, those who are transgender and gender non-conforming, veterans, and persons with disabilities. A national crisis, such as the COVID-19 pandemic, compounds the socio-economic issues faced by this population, resulting in a disproportionate impact on their health, often resulting in unemployment and a corresponding increase in housing instability and homelessness.

This tool kit addresses the significant impact that social environment has on the health of residents of public housing, and other low-income housing, and the tools to effectively address this impact. Social determinants of health (SDOH) generally include economic stability, education and life opportunities, childcare, quality and safety of housing, community and social support, access to food and transportation. Health centers (HCs) serving residents need to forge partnerships and collaborations at all levels of government, the private sector, philanthropic organizations as well as community and faith-based organizations to best meet their patient's health needs as well as address the underlying SDOH issues.

This tool kit was designed for health centers administering **The Health Services for Public Housing Residents program, Section 330(i)** as well as other HCs serving residents of public housing. It provides information, resources, and references to enable community health center staff, Public Housing Agency (PHA) staff, and residents to:

- Understand The Health Services for Public Housing Residents program grantee requirements, services to be offered and population to be served.
- Increase understanding of U.S. Department of Housing and Urban Development (HUD) subsidized housing programs and improve collaboration with a focus on Public Housing Authority and HUD assisted programs.
- Increase collaboration with other service providers and supplement supportive services in order to mitigate the impact of SDOH through the provision of comprehensive, holistic health care to all residents.

- Review examples of best practices and effective models of care.

The National Center for Health in Public Housing (NCHPH) and the **National Nurse-Led Care Consortium (NNCC)** have been tasked by the US Department of Health and Human Services, Health Resources and Services Administration (HRSA), to strengthen the capacity of federally funded community health centers to increase access to health care, eliminate health disparities, and enhance health care delivery for residents of public housing through the provision of training and technical assistance services and other resources.

This practical guide provides information and resources for health center staff to partner and collaborate more effectively with their local housing authorities and with other providers serving residents of public housing and other low-income housing.

About the Author: Villie M. Appoo has over 30 years' experience as a senior executive with community-based organizations, including 23 years at the Grace Hill Neighborhood Health Centers in St. Louis, Missouri. In her capacity as Executive Vice President and COO, she was responsible for the operation of five community health centers, fostering collaborations at the federal, state and local levels and for the development and funding of numerous innovative, community-based programs and support services.

Villie provided the leadership for Grace Hill to become one of the first recipients of the Stewart B. McKinney Health Care for the Homeless grant in 1987, as well as one of the first Public Housing Primary Care grant recipients in 1992. Under her leadership, Grace Hill has also received numerous awards and recognition for its' innovative, community-based programs and services for special populations. In addition to her extensive career in community health, Villie served as the Chief Executive Officer of the Girl Scouts of Southern Illinois.

Villie is a consultant with the National Center for Health in Public Housing and is the author of "Outreach to Residents of Public Housing: A Resource Tool Kit for Health Centers," published early in 2009, under the auspices of the NCHPH.

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MODULE I: HEALTH AND HOUSING ASSISTANCE – PROGRAMS AND PEOPLE

1. HEALTH SERVICE PROVIDERS:

Health and housing are interdependent and strategic collaboration between health centers, Public Housing Agencies and residents is key to achieving the goal of improved health outcomes for residents of public housing. Module I will cover basic information on community health centers and the federally funded health programs that they administer, as well as the numerous housing assistance programs and services available through federal, state and local resources.

Health center staff are the primary advocates for their patients, ensuring that they successfully navigate the healthcare system to access needed health resources and achieve optimal health outcomes. When the patients they are working with are also unhoused, face housing instability, or reside in subsidized housing, health center staff need to address the issues arising from the impact of these living conditions on their patients' health.

Module I provides basic information on the healthcare system within which health centers operate, and the federal and non-federal housing resources and programs that can be accessed or coordinated with to mitigate or alleviate unfavorable health outcomes. This module also provides socio-demographic patient data and community characteristics to better address the needs of patients and residents.

a. HRSA/BPHC/Federally Qualified Health Centers (FQHC) Section 330

The Health Resources and Services Administration (HRSA), is an agency of the U.S. Department of Health and Human Services (HHS). HRSA provides health care to people who are geographically isolated and/or economically or medically vulnerable. This includes people living with HIV/AIDS, pregnant women, mothers and their families, and those unable to access high quality health care. HRSA also supports access to health care in rural areas, the training of health professionals, the distribution of providers to areas where they are needed most, and improvements in health care delivery.

The Bureau of Primary Health Care (BPHC) is one of six bureaus under HRSA. BPHC funds health centers in underserved communities, providing access to high quality, family-oriented, comprehensive primary and preventive health care for people who are low-income, uninsured, or face other obstacles to getting health care.

DID YOU KNOW?

HRSA has awarded more than **$7.3 billion** to health care providers in response to the COVID-19 pandemic to diagnose and treat COVID-19 and increase access to telehealth services and training for providers; managed the distribution of **$178 billion** Provider Relief Fund; and provided an additional **$7.6 billion** for COVID-19 relief to Community Health Centers nationwide. HHS.gov | NACHC.org.

Health Centers - For over 50 years, HRSA/BPHC-funded health centers, also known as Federally Qualified Health Centers (FQHCs) or Community Health Centers (CHCs) have provided high quality preventive and primary health care to patients regardless of their ability to pay. According to HRSA, one in 11 people in the U.S. relies on a health center for medical care.

As of 2020, there are nearly 1,400 health centers operating more than 13,500 service delivery sites in every U.S. state and territory, with more than 255,000 staff who provide primary medical, dental, and/or behavioral health care for almost 29 million people.

For millions of Americans, including some of the most vulnerable individuals and families, health centers are the essential medical home where they find services that promote health, diagnose and treat disease and disability, and help them cope with environmental challenges that put them at risk.

All health centers are required to:

- Deliver high quality, culturally competent, comprehensive primary care, as well as supportive services such as health education, translation, and transportation that promote access to health care.
- Provide services regardless of patients' ability to pay and charge for services on a sliding fee scale.
- Operate under the direction of patient-majority governing boards of autonomous community-based organizations. These include public and private non-profit organizations and tribal and faith-based organizations.
- Develop systems of patient-centered and integrated care that respond to the unique needs of diverse, medically underserved areas and populations.
- Meet requirements regarding administrative, clinical, and financial operations.

Learn more about the Health Center Program.

Several HRSA-funded health centers also receive grants to serve special populations including those experiencing homelessness, residents of public housing, and migratory and seasonal agricultural workers. Funding to serve residents of public housing is provided through the Public Health Service (PHS) Act 330(i).

DID YOU KNOW?

The first two "Neighborhood Health Centers" were established by the federal Office of Economic Opportunity (OEO) – one in Boston, Massachusetts in 1965 and the other in Mound Bayou, Mississippi in 1967. The Community Health Center program model was pioneered by Dr. H. Jack Geiger based on similar health models he observed in South Africa. This health center model targeted the roots of poverty by combining the resources of local communities with federal funds to establish neighborhood clinics in both rural and urban areas throughout the country. Dr. Geiger believed that sickness was not just a biological phenomenon, but a social, racial, economic, and political phenomenon. Dr. Geiger died in New York, at the age of 95, on December 28, 2020. | medicine.tufts.edu.

DID YOU KNOW?

Health Centers are the primary medical home for over 29 million people in more than 12,000 rural and urban communities in America. | HRSA.gov.

b. Public Housing Primary Care Program – Section 330(i)

There are 108 health centers receiving a Health Center Program award or designation under section 330(i) of the Public Health Service Act. The population served by these health centers includes residents of public housing and individuals living in areas immediately accessible to public housing. Public housing includes Public Housing Agency (PHA) - developed, owned, or assisted low-income housing, including mixed finance projects, but excludes housing units with no PHA support other than Section 8 housing vouchers. (Section 330(i) of the PHS Act).

The Public Housing Primary Care (PHPC) program was established "to provide residents of public housing comprehensive primary health services, including mental health and substance abuse services, health promotion and disease prevention, oral health and outreach services."

Grantees funded under the Section 330(i) Public Housing Primary Care program are encouraged to focus on "whole person care" and to:

- Help residents access health and support services.
- Encourage the appropriate use of these health services.
- Reduce the inappropriate use of emergency room services.
- Help reduce barriers to accessing comprehensive health and social services.
- Help improve compliance with a prescribed plan of care.
- Help understand the diverse needs of the community served and to provide services that are responsive to these needs.
- Provide information to residents about available services and resources.
- Increase community support and reduce perceived isolation.
- Provide education to residents regarding health issues.
- Do all of the above in a culturally sensitive, linguistically appropriate manner.

For additional information regarding the 330(i) legislation ❙ nachc.org/wp-content/uploads/2018/05/Section-330-statute-as-of-March-2018-Clean.pdf.

2. Federal Housing Assistance Programs:

The U.S. Department of Housing and Urban Development (HUD) administers programs that provide housing and community development assistance. HUD also works to ensure fair and equal housing opportunities for all. HUD was created in 1965 as part of President Johnson's War on Poverty. However, low-income housing programs were originally created because of the National Housing Act of 1934 and 1937 which established the nation's public housing system. HUD administers the Public Housing Program through the Office of Public and Indian Housing (PIH).

The mission of the Office of Public and Indian Housing (PIH) is to ensure safe, decent, and affordable housing; create opportunities for resident self-sufficiency and economic independence; and assure fiscal integrity by all program participants. Today, PIH provides affordable housing to approximately 3.2 million households nationwide through a combination of traditional public housing (Section 9), Housing Choice Vouchers (Section 8), and other housing assistance funded through Public Housing Agencies (PHAs). These housing units are managed by over 3,800 local PHAs. HUD administers federal aid to local PHAs, and furnishes technical and professional assistance in planning, developing, and managing these developments.

Eligibility for public housing is limited to low-income families and individuals. The resident's rent is based on a formula, which is either 30% of the resident's monthly adjusted income or 10% of the monthly income, whichever is higher. Applications for housing assistance can be obtained through the local PHA or the local HUD Field Office. ❙ hud.gov/program_offices/field_policy_mgt/localoffices.

Public and Indian Housing (PIH) Programs and Services: There is a wide range of programs administered and managed by PIH. A working knowledge of these programs will help PHPC grantees understand the resources currently available to their clients through HUD and their local PHAs. This information will also provide grantees information needed to initiate collaborations with their local PHAs. More details about HUD programs can be accessed through HUD's website, Programs of HUD and the Congressional Research Service (CRS) website. ❙ CRS Reports ❙ hud.gov/sites/dfiles/Main/documents/HUDPrograms2020.pdf.

Public Housing Agency/Housing Agency (PHA): A public housing agency (PHA), is any state, county, municipality or governmental entity that is authorized to engage or assist in the development or operation of low-income housing under the U.S. Housing Act of 1937. PHAs generally own or manage public housing properties, own other types of affordable housing and administer housing programs that help their residents, such as the Section 8 Housing Choice Voucher programs or the Family Self-Sufficiency (FSS) program. There are approximately 3300 PHAs in the US administering units that range from 50 to over 1000 units.

Following is a brief overview of these programs:

a. Public Housing Programs

Public Housing is rental housing for low-income residents where tenants generally pay 30% of their adjusted gross household income. These units are publicly owned and managed by local PHAs. Some units are reserved exclusively for seniors or people with disabilities. These units are also project-based and the subsidy stays with the unit. Waiting lists for these units are usually exceedingly long.

The following are HUD-funded and supported programs:

i. Housing Choice Vouchers (HCVs)

Formerly known as Section 8, these vouchers allow very low-income families, the elderly, and disabled to afford decent, safe, and sanitary housing in the private market. Housing voucher recipients are responsible for finding suitable single-family homes, townhouses, or apartments of their choice. The owner of the unit must agree to participate in the program.

A housing subsidy is paid to the landlord directly by the PHA on behalf of the participating family. The participant only pays the difference between the actual rent charged by the landlord and the amount subsidized by the program.

Eligibility is based on a family's total annual gross income and size and is limited to U.S. citizens and those with eligible immigrant statuses. In general, the family's income may not exceed 50% of the median income of the area within which the family chooses to live. By law, the PHA must provide 75% of its vouchers to families whose income does not exceed 30% of the area median income. Participants generally pay approximately 30% of their monthly adjusted gross income for rent and utilities. This program is administered by local PHAs who receive federal funds through HUD.

ii. Family Unification Program (FUP)

The Family Unification Program (FUP) is a program under which HCVs are provided to families whose housing situation is about to result in the out-of home care of their children, such as foster care/custodial care, or to families with children currently in out-of-home care but who cannot be discharged and reunited with them due to their current housing condition not being conducive to having children at home.

FUP vouchers are also provided for a period up to 36 months to eligible youth between 18 years and 24 years of age who have left the foster care system and are homeless or at risk of becoming homeless. In addition to rental assistance, supportive services are also provided by the Public Child Welfare Agencies (PCWA) to FUP youths for the entire period of participation.

PHAs administer the FUP in partnership with PCWAs.

FUP Fact Sheet: provides general program information.

FUP Awards All Years: provides a list of PHAs that have been awarded FUP vouchers.

iii. Project-Based Rental Assistance (PBRA)

Project-Based Section 8 housing (PBRA) is a government-funded program that provides rental housing to low-income households in privately owned and managed rental units. The subsidy stays with the unit; when the tenant moves out, they no longer have the rental assistance. Generally, the rental cost for these units is also 30% of the tenants' adjusted gross income. A variety of housing types is available through this program, including single-family homes, townhomes, and apartments. Other project-based programs that are similar include: Section 202 – housing for seniors, Section 236 – mortgage interest reduction program, Section 515 housing assistance for rural areas, and Section 811- supportive housing for persons with disabilities | hud.gov/program_offices/public_indian_housing/programs/hcv/project.

iv. Foster Youth to Independence Initiative (FYI)

FYI makes Housing Choice Voucher (HCV) assistance available to Public Housing Agencies (PHAs) in partnership with Public Child Welfare Agencies (PCWAs). Under FYI, PHAs provide housing assistance on behalf of youth at least 18 years and not more than 24 years of age (have not reached their 25th birthday) who left foster care, or will leave foster care within 90 days, in accordance with a transition plan described in Section 475(5)(H) of the Social Security Act, and are homeless or are at risk of becoming homeless at age 16 or older.

As required by statute, an FYI voucher issued to such a youth may only be used to provide housing assistance for the youth for a maximum of 36 months.

In addition to providing up to 36 months of rental assistance, youth must be provided supportive services to assist the young person on their path to self-sufficiency.

v. HUD-VA Supportive Housing Program

HUD-VASH is a collaborative program between HUD and VA, combining HUD housing vouchers with VA supportive services to help Veterans who are unhoused and their families find and sustain permanent housing.

Through public housing authorities, HUD provides rental assistance vouchers for privately owned housing to veterans who are experiencing homelessness. VA case managers may connect these veterans with support services such as health care, mental health treatment and substance use counseling to help them in their recovery process and with their ability to maintain housing in the community. Among VA homeless continuum of care programs, HUD-VASH enrolls the largest number and largest percentage of Veterans who have experienced long-term or repeated homelessness. At the end of FY2021, over 105,000 subsidized housing vouchers were allocated to HUD-VASH, with more than 80,000 formerly homeless veterans living in their own permanent housing as a result of this partnership between HUD and VA. | hud.gov/program_offices/public_indian_housing/programs/hcv/about.

b. Resident Service Programs

i. Family Self-Sufficiency Program (FSS)

Family Self-Sufficiency is a HUD program designed to help public housing residents, Housing Choice Voucher participants, and residents of multifamily assisted housing to increase their earnings and build assets and financial capability.

PHAs work in collaboration with a Program Coordinating Committee (PCC) to secure commitments of public and private resources for the operation of the FSS program, to develop the PHA's FSS Action Plan (the FSS policy framework), and to implement the program.

Once an eligible family is selected to participate in the program, the PHA and the head of each participating family execute a FSS Contract of Participation that specifies the rights and responsibilities of both parties. The term of the FSS contract is generally 5 years, but it may be extended for another 2 years by the PHA for good cause.

The FSS contract also incorporates the family's individual training and services plan (ITSP). The ITSP is the document that records the plan for the family. FSS Coordinators in each local program build partnerships with employers and service providers in the community to help participants obtain jobs and services. These services may include childcare, transportation, basic adult education, job

training, employment counseling, substance/alcohol abuse treatment, financial empowerment coaching, asset-building strategies, household skill training and homeownership counseling. ❙ hud.gov/program_offices/public_indian_housing/programs/hcv/fss.

ii. Resident Opportunity and Self-Sufficiency (ROSS) Service Coordinators Program

The ROSS-SC program links residents of public housing and tribal housing to supportive services and activities, enabling them to make progress towards economic independence and housing self-sufficiency. Grantees can identify additional goals based on the needs of the public and Indian housing communities they serve.

Many public housing residents - particularly those experiencing unemployment - rely on service coordinators to help with emergency and long-term needs. Residents are most commonly connected to health and adult education services, as well as access to food and transportation. Other services include youth programming and emergency-related services.

Common barriers to accessing services include lack of local transportation and child care, limited English proficiency and a dearth of service providers in lower-resourced, more geographically isolated communities with smaller populations. ❙ hud.gov/program_offices/public_indian_housing/programs/ph/ross/about.

iii. Jobs Plus Initiative

The purpose of the Jobs Plus Initiative program is to develop locally based, job-driven approaches to increase earnings and advance employment outcomes through work readiness, employer linkages, job placement, educational advancement, technology skills, and financial literacy for residents of public housing. Jobs Plus enables a PHA to choose a single public housing development and offer assistance to all the residents in that development. Case managers work with unemployed residents to identify short and long-term employment goals and create plans to accomplish them. ❙ hud.gov/program_offices/public_indian_housing/jpi.

iv. Strong Families Initiative

HUD Strong Families Initiative provides fathers, mothers and children access to local resources for health, education and economic empowerment. It builds on longstanding Father's Day efforts to involve fathers in the lives of their children. ❙ hud.gov.

v. ConnectHome

ConnectHome is a movement to bridge the digital divide for HUD-assisted housing residents in the United States. By helping residents in participating communities to get connected at home and providing access to digital literacy and educational content, HUD aims to make public housing a platform for change. ConnectHome creates a platform for community leaders, local governments, non-profit organizations and private industry to unite to produce locally-tailored solutions for narrowing the digital divide. Through these stakeholders' specific commitment to provide free or low-cost broadband access, devices and digital literacy training, ConnectHome extends affordable access to low-income families, ensuring that high-speed internet follows their children from their classrooms back to their homes. ❙ ConnectHomeUSA.

vi. CHOICE Neighborhoods

The Choice Neighborhoods Initiative supports the transformation of housing and neighborhoods in targeted areas. HUD created Choice in 2010 as a successor to the HOPE VI program. Choice grants fund the replacement of severely distressed public housing and privately owned HUD-assisted

properties with new, energy efficient and safe mixed-income properties that strive to contain the appropriate number of units for families of various sizes and ages. Research has shown that housing affects health. Poor quality housing can impede child development, and place stress on the entire family.

The grantee must develop a comprehensive neighborhood revitalization plan, called a Transformation Plan, which describes how the grantee will address community problems, increase opportunity, and improve social outcomes and interactions for residents of the redeveloped housing and surrounding neighborhood in a variety of areas, including education, employment, and health. Program funds may also be used to provide supportive services and make improvements to the surrounding community.

Choice Neighborhoods also includes a requirement for ongoing resident involvement from the planning stages through implementation.

Download | Health Conditions in Five Choice Neighborhoods, Reed Johnson (January 28, 2016).

DID YOU KNOW?
Michael Schubert, Principal of Community Development Strategies, wrote a comprehensive guide: Designing & Directing Neighborhood Change Efforts: How to be More Intentional and Effective - Choice Neighborhoods Resource Guide.

This guide is designed to help Choice Neighborhoods grantees, as well as others engaged in neighborhood change efforts, be more effective in their revitalization work. At the core of this guide is a simple yet profound idea: the importance of influencing individual investment decisions made by neighbors and by other stakeholders in ways that benefit the neighborhood. Neighborhood conditions are driven largely by the range of investment decisions neighbors and other stakeholders make about the neighborhood and how others interpret those decisions. Organizations that intervene – whether public, private, or non-profit – often mistakenly believe that their decisions will drive the future of the neighborhood. In reality, however, the decisions of neighbors matter most Using this lens, the focus of the guide is on four areas: (**1**) building a positive neighborhood image; (**2**) stabilizing the housing market; (**3**) improving physical conditions; and (**4**) strengthening the social fabric in the neighborhood.

Download | Designing & Directing Neighborhood Change Efforts: How to be More Intentional and Effective – Choice Neighborhoods Resource Guide by Michael Schubert – August 2015.

vii. Moving To Work Demonstration (MTW)

Moving to Work (MTW) is a demonstration program for PHAs to design and test innovative, locally designed strategies that use federal dollars to help residents find employment and become self-sufficient, and increase housing choices for low-income families. MTW grants PHAs exemptions from many existing public housing and voucher rules, and provides funding flexibility with how PHAs use their federal funds. PHAs in the MTW demonstration have pioneered several innovative policy interventions that have been successful at the local level, and subsequently rolled out to the rest of the country's PHAs. Currently, there are 80 MTW PHAs nationwide, and HUD plans to expand the program to an additional 59 PHAs by 2022. | hud.gov/program_offices/public_indian_housing/programs/ph/mtw.

DID YOU KNOW?

On May 7, 2021, HUD announced that the first forty-one agencies, representing communities across the nation, have been selected for the expansion of the MTW Demonstration Program. Additionally, HUD published notices inviting interested PHAs to apply to the fourth cohort of the MTW Expansion. PHAs interested in joining the MTW Demonstration Program and other interested individuals can find information on the MTW Expansion by going to the MTW Expansion webpage.

c. Special Populations

i. Housing and Services Resource Center (HSRC)

Partnerships between the aging and disability networks and the housing sector are a powerful way to enhance housing options for older adults and people with disabilities. The Administration for Community Living (ACL) partners with other federal agencies to make community living a reality for older adults and persons with disabilities and helped initiate the HSRC in partnership with the U.S. Department of Health and Human Services and the U.S. Department of Housing and Urban Development.

The Housing and Services Resource Center was created to foster partnerships between organizations and systems that provide housing resources and homelessness services, behavioral and mental health services, independent living services and other supportive services. The goal is to improve access to affordable, accessible housing and the critical services that make community living possible. | acl.gov/HousingAndServices.

ii. Supportive Housing for the Elderly (Section 202)

The Section 202 program provides very low-income older adults with housing and voluntary support services that allows them to live independently with support services such as cleaning, cooking, transportation. | hud.gov/program_offices/housing/mfh/progdesc/eld202 | hud.gov/program_offices/housing/mfh/grants/section202ptl.

iii. Supportive Housing for Persons with Disabilities (Section 811)

The Section 811 program provides assistance for housing and voluntary supportive services for very low-income adults with disabilities. Similar to Section 202, it provides supportive services to enable persons with disabilities to live as independently as possible within the community. | hud.gov/program_offices/housing/mfh/progdesc/disab811.

iv. Housing Opportunities for Persons With AIDS

The Housing Opportunities for Persons With Aids (HOPWA) program is the only federal program dedicated to meeting the housing needs of low income persons living with HIV/AIDS. Under the HOPWA program, HUD makes grants to local communities, states and non-profit organizations for projects that benefit low-income individuals living with HIV/AIDS and their families.

By providing housing assistance and related services, the HOPWA program contributes to housing stability, reduces risks of homelessness, improves health outcomes through increased access to care, and prevents transmission of HIV. Persons living with HIV/AIDS and their families that are low-income (at or below 80 percent of area median income) are eligible for assistance under this program. Grants may be used to assist various forms of housing. Website | hudexchange.info/programs/hopwa.

v. Youth Homelessness Demonstration Program

The Youth Homelessness Demonstration Program (YHDP) aims to demonstrate how a comprehensive approach and new strategies can help to prevent or reduce homelessness in youth aged 24 and under. HUD will select up to 25 communities within which grants will be awarded. For technical assistance | hudexchange.info/programs/yhdp.

vi. Resident Opportunity and Self-Sufficiency (ROSS) for Education Program

The ROSS for Education Program, also known as Project SOAR (Students + Opportunities + Achievements = Results) is a demonstration program reflecting HUD's commitment to expand educational services to youth living in HUD-assisted housing. Project SOAR provides grant funding to PHA's to deploy education navigators to provide individualized assistance to public housing youth between the ages of 15-20 and their families in FAFSA completion, financial literacy and college readiness, postsecondary program applications and post-acceptance assistance. HUD awarded approximately $2 million to nine PHAs in 2016 to hire education navigators. | hud.gov/program_offices/public_indian_housing/projectsoar.

vii. House America

House America is a federal initiative in which the U.S. Department of Housing and Urban Development (HUD) and the U.S. Interagency Council on Homelessness (USICH) are inviting mayors, city and county leaders, tribal nation leaders, and governors into a national partnership. House America will utilize the historic investments provided through the American Rescue Plan to address the crisis of homelessness through a Housing First approach.

Through the American Rescue Plan, communities now have historic housing resources - 70,000 emergency housing vouchers, $5 billion in HOME grants, and significant investments to preserve and protect housing on tribal lands - to help more Americans obtain the safety of a stable home. The American Rescue Plan also provides $350 billion in State and Local Fiscal Recovery Funds through the Through the American Rescue Plan, communities now have historic housing resources - 70,000 emergency housing vouchers, $5 billion in HOME grants, and significant investments to preserve and protect housing on tribal lands - to help more Americans obtain the safety of a stable home. The American Rescue Plan also provides $350 billion in State and Local Fiscal Recovery Funds through the Department of the Treasury to support the many needs communities face, including homelessness and housing instability, as they respond to the pandemic and its negative economic impacts. Communities also have resources through the CARES Act, the Consolidated Appropriations Act of 2021, and other state, tribal, and local resources to re-house people experiencing homelessness and create additional dedicated housing units to address homelessness.

House America provides communities with the focus, resolve, and technical know-how needed to deploy these resources to maximize impact.

viii. Continuum of Care (CoC) Program

The Continuum of Care (CoC) program is designed to promote community-wide commitment to the goal of ending homelessness; provide funding for efforts by non-profit providers, and State and local governments to quickly re-house homeless individuals and families while minimizing the trauma and dislocation caused to homeless individuals, families and communities by homelessness; promote access to and effect utilization of mainstream programs by homeless individuals and families; and optimize self-sufficiency among individuals and families experiencing homelessness.
| hudexchange.info/programs/coc | hudexchange.info/homelessness-assistance.

d. Public and Indian Housing Programs

HUD also has numerous Indian Housing Programs listed under PIH for American Indians or Alaska Natives; Indian tribes; Indian housing authorities and Native Hawaiians. ❙ hud.gov/program_offices/public_indian_housing/ih/homeownership/184.

i. Tribal HUD-Veterans Affairs Supportive Housing (VASH) Program

The Tribal HUD-Veterans Affairs Supportive Housing program (Tribal HUD-VASH) provides rental assistance and supportive services to Native American veterans who are homeless or at risk of homelessness living on or near a reservation or other Indian areas. Eligible homeless veterans receive case management services through the Department of Veterans Affairs (VA). Native American veterans participating in this program will be housed based on a Housing First approach, where homeless veterans are provided housing assistance and then offered the supportive services that may be needed to foster long-term stability and prevent a return to homelessness.
❙ hud.gov/program_offices/public_indian_housing/ih/tribalhudvash.

e. The Coronavirus AID, Relief and Economic Security Act (CARES ACT)

i. Emergency Housing Vouchers (EHV)

The EHV program is available through the American Rescue Plan Act (ARPA). Through EHV, HUD is providing 70,000 housing choice vouchers to local Public Housing Authorities (PHAs) to assist individuals and families who are homeless, at-risk of homelessness, fleeing, or attempting to flee, domestic violence, dating violence, sexual assault, stalking, or human trafficking, or were recently homeless or have a high risk of housing instability.

DID YOU KNOW? PHA AND TRANSIT AGENCY PARTNERSHIP RESOURCES

On November 12, 2020, PIH and the Federal Transportation Administration (FTA) partnered to educate stakeholders on how PHAs can coordinate with transit agencies, local municipalities, and school districts to provide essential services in their communities, including access to transportation, education support services (such as Wi-Fi), food, medical appointments, and other essential services.

DID YOU KNOW?

The average wait-list length for Section 8 vouchers ranges from 1.5 years to over 7 years, although wait times for older adults and persons with disabilities may be shorter. Almost half of all housing authorities have closed their lists to new applicants, while many of the larger cities have instituted a lottery system just for a chance to get on the waiting list. However, PHA's are permitted to give local preference to those experiencing homelessness in their Admissions and Continued Occupancy Policy(ACOP), and many do.

f. Other Programs for States and Localities

i. U.S. Department of Agriculture (USDA) Rural Rental Housing Programs

The USDA's Rural Housing Service (Sections 515, 521, 538) offers single-family and multifamily housing programs to support a variety of activities in rural areas. Single-family programs help low and moderate-income residents of rural cities, towns, and counties purchase homes and make home repairs, while multifamily programs provide support for acquisition-rehab and new construction, provision of related facilities and infrastructure, and project-based rental assistance.

ii. Other

- Low Income Housing Tax Credit
- Community Development Block Grants
- HOME Block Grants
- The Native American Housing Assistance and Self-Determination Act (NAHASDA)

hud.gov/program_indian_housing/ih/codetalk/aboutonap.

DID YOU KNOW?

Federal nondiscrimination laws provide housing protections for individuals with disabilities. These protections apply in most private housing, state and local government housing, public housing, and any other federally assisted housing programs and activities. The Fair Housing Act prohibits discrimination in housing and housing-related transactions because of disability. Section 504 of the Rehabilitation Act prohibits discrimination based on disability in any program or activity receiving federal financial assistance. Titles II and III of the Americans with Disabilities Act prohibit discrimination based on disability in all programs, services, and activities of public entities and by private entities that own, operate, or lease places of public accommodation.

3. Other Low-Income Housing Programs:

The availability of federally subsidized, low-income housing programs, coupled with support services, enables a community to house its most vulnerable population, as discussed above. Unfortunately, in most communities, these resources are insufficient or inadequate to meet the need or demand for low-income or supportive housing, resulting in a large population that is unhoused. It is estimated that there are over half a million unhoused people in the US.

There are many different contributing factors that result in homelessness, and different types of shelters and services have been developed to address these issues. While homeless shelters meet the immediate need for housing, resources and services also need to be developed to enable the unhoused to access more permanent housing to end homelessness in this country.

HUD has several re-entry housing initiatives which are described in “It Starts With Housing” (June 2016).

Following is a brief description of resources for the unhoused:

a. Homeless Shelters

i. Homeless Shelters

Provide short-term housing. Usually, there is a maximum stay of three months or less. Clients are usually asked to leave after breakfast and spend the day seeking employment or participating in training and other programs. Meals and other supportive services are often offered. Some shelters accommodate the entire family, while others are for adults only, or youth, or for women and children only.

ii. Day Shelters

Are emergency shelters that permit clients to stay during the day. Resources offered often include meals and basic hygiene including laundry and bathing facilities. Some also offer case management and social services.

iii. Faith-Based Shelters

Provide emergency beds to nearly 30% of the homeless families and single adults nationally.

iv. Other Shelters include

- Wet shelters (where being intoxicated is acceptable)
- Dry shelters/treatment/detox programs
- Extreme weather temporary shelter programs
- Domestic Violence/Women's Shelters

DID YOU KNOW?

According to a 2017 report by the National Alliance to End Homelessness, faith-based organizations are critical but usually underutilized partners in ending homelessness. Because of their strong connections within the community, they have a robust volunteer and advocacy base and flexible donor funds that could be harnessed more strategically.

b. Transitional Housing

Provides a temporary home to people getting back on their feet. Generally, numerous support services are provided to residents to become self-sufficient and live independently.Residents can stay for 6 months up to 2 years and are usually required to participate in employment training, GED classes, and other training programs. A wide range of services are provided, from employment training, substance abuse treatment, mental health services, domestic violence assistance, and other needed resources. The housing provided is typically affordable and low-cost. Residents may be asked to pay at least 30% of their income towards program fees. Sometimes, these fees are banked and returned to them upon successful completion of the program.

c. Halfway Houses

Are a form of transitional housing and are mostly used by recently released prisoners to help them transition back into society.

d. Rooming Houses/Boarding Houses

These are examples of Shared Housing. This is a building in which renters occupy single rooms and share kitchens, bathrooms, and common areas. The location may be a converted single-family home, a converted hotel, or any other structure designed for communal living. These houses may have as few as three rooms for rent, or more than a hundred. Rent is usually subsidized.

All of these shelter programs are designed to provide short-term housing and to meet the critical and immediate needs of the unhoused, but studies have shown that these shelter models do not address the problem of chronic homelessness.

e. Housing First

Housing First is a model developed by Dr. Sam Tsemberis at Pathways to Housing in New York in the early 1990s. Its goal was to provide safe, affordable, permanent housing quickly to people who are experiencing homelessness, including those with mental health or substance abuse issues. Unlike the shelter system, Housing First programs do not mandate that residents participate in mental health or substance abuse treatment or require participation in other programs offered – participation is voluntary. It is meant to move individuals quickly into independent/permanent housing first, then provide appropriate support services once they are housed.

The following are two best practices based on the Housing First model:

- **Rapid Re-Housing (RRH)** is a Housing First model for non-chronic homelessness where individuals and families are helped to rent an apartment as quickly as possible, preferably within the first 30 days of being unhoused. They are provided temporary community support services, which can include case management and time-limited financial assistance, with the goal to bring them quickly out of homelessness.
- **Permanent Supportive Housing (PSH)** is another Housing First model designed to provide housing and supportive services on a long-term basis to chronically unhoused people who have been continuously homeless for one or more years and have been diagnosed with a physical or mental disability. For a significant number of unhoused Americans with physical or mental disabilities, long-term homelessness can only be addressed by providing permanent housing combined with intensive supportive services. PSH provides safe and stable housing environments with flexible and voluntary services.

DID YOU KNOW?
A Housing First program funded by the U.S. Department of Housing and Urban Development in 2007 and 2008 showed favorable results for people who had been homeless for five years or longer and were struggling with mental health and substance use challenges (Tsemberis, Kent, & Respress, 2012).

There have been numerous studies that have demonstrated the success of the Housing First model - the value of providing affordable, permanent housing to the unhoused to reduce the incidence of homelessness. Federal housing programs like public housing play a critical role in the effort to end homelessness. Coordination and partnerships at all levels, between PHA's, Public Housing service agencies, homeless service providers and others is needed.

4. Public Housing Resident and Patient Demographics:

In order to develop an effective working relationship with a community and to address its needs successfully, it is important to have an in-depth knowledge of the socio-demographic characteristics of that community. Numerous research studies indicate that health center patients, especially residents of public housing, represent diverse cultural and ethnic backgrounds, and are impacted by disproportionately higher rates of many chronic conditions than the general population.

a. Socio-Demographic Characteristics | Resident Characteristics Report

Following are some socio-demographic characteristics of individuals receiving housing assistance through HUD:

- 6.1 million household members living in 2.8 million housing units.
- Approximately 2.4 million (39%) household members are children under the age of 17 years.
- Nearly 944,192 (16%) are seniors over 62 years.
- 44 percent of households include a member who is disabled.
- 36 percent are female headed households with children.
- The average annual household income was $15,253.
- The federal poverty level was $17,240 for a household of two and $26,200 for a household of four in 2019. 2020 Poverty Guidelines.
- Only 29 percent of households listed wages as a source of income.
- Most individuals fall into HUD's "Extremely Low Income" category with an income of less than 30 percent of the national median.

b. Social/Environmental Concerns

Although each public housing complex is different with its own unique needs and characteristics, some common issues affecting most residents include:

- Poor access to health care services. Barriers include lack of adequate transportation, health facility operating hours, inability to pay for prescriptions, lack of adequate community health and other support services, lack of trust in the system by undocumented and other foreign born residents, and language barriers.
- Poor access to healthy nutrition. Lack of grocery stores with limited access to fresh fruit and vegetables resulting in food deserts.
- High homicide rates. Criminal, drug and gang activity resulting in anxiety, stress, and fear for personal safety.
- Neighborhood environment that is not conducive to walking or outside exercise.
- Neighborhood blight resulting in social isolation and depression.
- Hazardous buildings, with corresponding problems of lead poisoning, mold, fire, and other safety hazards.
- Disability and a higher incidence of morbidity and mortality.
- Overcrowding because of extended families living in the same house.
- High rates of unemployment and poverty.
- Cultural barriers also play a significant role in limiting access including:

- Language - a critical barrier that often results in misunderstanding a health practitioner's patient care directives, tends to violate patient confidentiality if interpreters need to be present and reduces overall level of trust.
- Belief Systems - knowledge and respect for belief systems and patient care behaviors based on a patient's ethnicity is essential. Frequently those beliefs and behaviors do not interfere with traditional care and can even be complementary.
- Health literacy - a lack of knowledge of western concepts of health and hygiene.
- Ethnocentrism - evaluating and judging other cultures based on one's own.

c. Health Status of Public Housing Residents

In 2017, the U.S. Department of Housing and Urban Development (HUD) and the Centers for Disease Control and Prevention (CDC) released a report showing that adults that receive public housing assistance were more likely to be in poor health and have higher rates of chronic conditions than the general adult population.

- 35.8% of HUD-assisted adults were in fair or poor health compared to 13.8% adults nationally.
- 71% were overweight or obese compared to 64% of adults nationally.
- 17.6% were diabetic versus 9.5% of all adults nationally.
- 16.3% had asthma versus 8.7% of all adults nationally.
- 61% had a disability compared to 35.4% of all adults nationally.

d. PHPC Grantee Data

2020 Health Resources and Services Administration. 2020 National Health Center Data: National Public Housing Primary Care Program Awardee Data. Retrieved from Special Populations | hrsa.gov.

In 2020, there were 107 Public Housing Primary Care (PHPC) Health Centers that received population based grants to provide care to patients living in or immediately accessible to public housing.

- PHPC health centers served 866,859 individuals.
- Approximately 78% were living at or below the poverty line.
- 58% were female.
- 25% were children.
- 10% were elderly.
- 22% were uninsured.

Chronic diseases accounted for a growing number of encounters in 2020, including:

- 84,410 diabetes patients.
- 49,180 asthma patients.
- 146,686 hypertension patients.

These figures underscore the critical need for providing comprehensive health and social services to residents of public housing.

DID YOU KNOW?

The U.S. Department of Housing and Urban Development (HUD) and the National Center for Health Statistics agreed in 2011 to link administrative records for individuals receiving housing assistance from HUD with records from the National Health Interview Survey. This report uses the linked data from 2006 through 2012 to present a broad statistical summary of demographic characteristics, health diagnoses and conditions, and health care access and utilization for HUD-assisted adults. The data showed that relative to unassisted low-income renters, HUD-assisted adults are shown to be an older population with more disabilities and more prevalent health problems by numerous measures. A Health Picture of HUD-Assisted Adults, 2006-2012.

MODULE II: COLLABORATIVE STRATEGIES

1. UNDERSTANDING COLLABORATION:

Collaboration is the key to achieving desired outcomes.

The goals of improved health, enhanced living conditions, and increased access to affordable community resources for residents of public housing can best be achieved through strategic collaboration between residents, health and social service providers, PHAs, and other local, regional, and federal entities that affect resident wellbeing. Collaboration partners must therefore share a common vision and mission and be willing to jointly plan, implement, and develop systems to sustain ongoing collaborative efforts. History has shown that organizations and communities are far more successful in effecting change when they work together to solve existing and emerging problems to reach their common goals.

2. COLLABORATIVE RELATIONSHIPS:

To understand collaboration, it is important to examine the different ways people interact. Each of the following processes have inherent value and can be effective in achieving certain goals.

a. Networking

This is one of the most basic forms of interacting with others and is frequently the mode by which people develop professional or social contacts.

b. Cooperation

The process of individuals or organizations working together to achieve common goals. While working collaboratively to achieve common goals, each individual or organization may have their own independent goals, which may or may not align with, and may conflict with, those of their partners. Although these goals may or may not overlap or may sometimes be conflicting, there is usually a formal or informal agreement to avoid duplication and interference. Cooperative efforts are successful when there is frequent and open communication, and the cooperating parties have the flexibility to work independently.

c. Coordination

The process by which all participants share a common goal and are working in the same direction. Participants usually have assigned roles with reduced individual flexibility, and someone is assigned as the "coordinator" to help facilitate the accomplishment of individual tasks and achieve the common goal(s).

d. Collaboration

This requires participants to have a shared vision, mission, and work together creatively to achieve common goals. Collaboration is the most effective process for groups to not only achieve their goals, but to ensure that their collaborative efforts result in long-term, sustained change.

e. Communication

The central element of all of the above relationships and is a critical component of any group effort. It is the process by which information and ideas are exchanged. Open, clear, and timely communication is critical to success, while the absence of good communication can derail any group effort.

| RATE YOURSELF |

What kind of interactions do I have with.... the local PHA?... other health centers?.... Colleagues?

3. COLLABORATION SKILLS:

| hudexchange.info/trainings/fss-program-online-training/6.1-partnerships.html.

Alison Doyle from the University of Strathclyde in Glasgow discusses skills needed for effective collaboration under three broad categories: effective communication, emotional intelligence, and a knowledge and respect for the diversity of the individuals with whom one is working.

a. Communication Skills

All of the collaborative relationships described above have one thing in common to be successful – good communication skills. Working in a group with diverse viewpoints can be challenging, especially when the goal is for the group to reach consensus and move forward together. It takes practice and skill to express differing perspectives and to be open to others as well. Good communication skills are vital to any collaborative effort. Following are some widely accepted communication skills as outlined by Doyle and others.

- **Active listening:** Active listening means listening with an open mind, not just 'hearing' the words but 'listening' and understanding the meaning behind them. Very often, we are thinking of what we plan to say next or are so anxious to make our point that we miss what the other person is saying and fail to comprehend their point of view. Keeping an open mind, listening empathetically, asking questions, and repeating back what was just said are helpful tools.
- **Written communication:** Communicating through emails and texts is the norm in the modern healthcare landscape. It is therefore important to pay attention to the 'tone' of what is being conveyed in writing. When communicating face-to-face, we rely on non-verbal cues to understand the full meaning of what is being said. Since there are no non-verbal cues when writing, it is especially important to ensure that other collaborators do not misunderstand what is being conveyed.

- **Verbal communication:** 'How' you convey your ideas and suggestions is just as important as 'what' you say. This is particularly important when you are trying to convey a different perspective or proposing ideas that are not popular. Discussions can get quite heated in a group setting, and many collaborations fail due to perceived misunderstandings caused by faulty communication. Developing the ability to convey your ideas succinctly and disagree respectfully are important aspects of verbal communication.

- **Nonverbal communication:** Equally important is nonverbal communication, like body language and tone, which affect what you are trying to convey. Facial mannerisms, posture, and hand gestures can significantly alter the meaning behind your words.

  As a result of our increasing reliance on video calls and texting, many verbal and non-verbal cues are easily missed. Therefore, attention to what we communicate and how we do it can make a significant difference.

The key elements to improving your communication style are:

- Understand yourself – your strengths and weaknesses, your communication style.
- Read, take online or actual courses, listen to Ted Talks (Technology, Entertainment and Design), a nonprofit devoted to spreading ideas, usually in the form of short, powerful talks.
- Practice, practice, practice – in front of a mirror, in front of friends, record yourself.
- Ask for feedback – from friends and colleagues.

| RATE YOURSELF |

On a scale of 1 to 5, with 1 being the lowest and 5 the highest – what score would you give yourself on each of these communication skills? Ask a friend or colleague to rate you. Compare scores.

TOOLS

MindTools.com has an excellent short quiz you can take to test your own listening skills | mindtools.com/pages/article/listening-quiz.htm.

DID YOU KNOW?

The Greater Good Science Center of the University of California, Berkeley has an interesting quiz on how to "read" other people | greatergood.berkeley.edu/quizzes/ei_quiz.

b. Emotional Intelligence

Emotional intelligence (EI) is one of the most sought-after skills in the workplace, and is a key component of both personal and professional success. EI is the ability to identify and regulate your emotions, recognize emotions in others, react appropriately, and apply your emotions to tasks to enable you to work more effectively with others.

People with high EI can handle difficult situations and people more effectively, and are more likely to overcome adversity and remain calm during the most stressful situations. In today's uncertain and volatile work environment with shifting norms and an increased need for flexibility, people with high EI are more likely to adapt and be successful.

Below is a list of some **key elements of EI:**

- Self-Awareness – understanding how your emotions affect your behavior.
- Self-Regulation – ability to manage your emotions in a healthy manner, including being resilient, not being offended easily, and not taking criticism personally.
- Relationship Management – involves developing and maintaining healthy relationships, demonstrating empathy, curiosity, and compassion, and fostering the ability to resolve conflicts.

| RATE YOURSELF |

On a scale of 1 to 5, with 1 being the lowest and 5 the highest, what is your EI score on the 3 key elements?

TOOLS

MindTools.com has a fun quiz to test your emotional intelligence | mindtools.com/pages/article/ei-quiz.htm.

c. Understanding Diversity/DEI

Health inequities arise directly from a lack of culturally and linguistically appropriate services which result in disparities that directly affect the quality of life for all individuals and communities. In order for organizations to collaborate successfully, they need to improve their ability to address health care disparities in their community.

The HHS Office of Minority Health has developed the National Standards for Culturally and Linguistically Appropriate Services (CLAS) to address health equity, improve quality of services and eliminate disparities. The National CLAS Standards align with the HHS Action Plan to Reduce Racial and Ethnic Health Disparities and the National Stakeholder Strategy for Achieving Health Equity, which aim to promote health equity through providing clear plans and strategies to guide collaborative efforts that address racial and ethnic health disparities across the country.

The Standards gives health organizations 15 action steps for providing CLAS. The Principal Standard (No. 1) calls on organizations to "provide effective, equitable, understandable and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs." There are 14 additional standards in this Blueprint which can be accessed | thinkculturalhealth.hhs.gov/clas.

At the individual level, it is also important to understand and address unconscious bias in order to provide quality healthcare with positive outcomes for all patients. Unconscious or implicit bias refers to judgements or associations made regarding individuals or groups regarding race, gender, disability, sexual orientation or other social categories, without awareness. These social stereotypes are counterproductive and impede successful collaborations. Working in the public housing and health center settings may necessitate collaborating with individuals from all sectors of the community, both public and private, who represent diverse cultures. Training alone cannot change behaviors and attitudes, but

it can increase awareness and help develop the knowledge and skills needed to collaborate successfully within diverse groups. To be successful, it is essential to be aware of any implicit biases you may hold so you can work respectfully with your colleagues.

Respect for diversity in a collaborative environment includes:

- Maintaining open communication.
- Demonstrating knowledge, understanding, and acceptance of racial, ethnic, religious, gender, and all diverse backgrounds.
- Building and managing diverse expectations.
- Facilitating group discussion, eliciting viewpoints from all team members, and being inclusive.
- Agreeing on roles that capitalize on individual strengths.
- Building consensus.

TOOLS

Diversity, Equity and Inclusion: Diversity Awareness Quizzes | An EdChange project by Paul C. Gorski.

TOOLS

National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care. | thinkculturalhealth.hhs.gov/clas.

"OF ALL THE FORMS OF INEQUALITY, INJUSTICE IN HEALTHCARE IS THE MOST SHOCKING AND INHUMANE."

-Dr. Martin Luther King, Jr.

In conclusion, collaboration skills include communication, emotional intelligence, understanding of cultural and linguistic inequities in your community and respect for the diversity of your colleagues. These skills are essential when working in a community setting where there are multiple agencies working towards a common goal of effecting lasting change.

4. BUILDING BLOCKS TO SUCCESSFUL COLLABORATION:

HUDs' mission is "To create strong, sustainable, inclusive communities and quality affordable homes for all." It also states that it utilizes "...housing as a platform for improving quality of life; building inclusive and sustainable communities free from discrimination..." To that end, HUD established public housing to provide decent and safe rental housing for eligible low-income families, the elderly, and persons with disabilities. By working together, health centers and PHAs can build partnerships to successfully navigate the numerous barriers to achieving this mission. Like any structure, the foundation on which this partnership is built needs to be strong.

Following are some basic steps that are fundamental to building this partnership.

a. Defining Purpose

Foremost is a commitment to a shared purpose. Health centers, PHAs, and other involved organizations need to take time to explore why they chose to collaborate and agree on the goals. Spending a little time upfront to discuss and clarify their common purpose will provide clarity of focus, ensure that the collaboration is moving in the right direction, and ultimately achieve the goal. In some settings, a discussion on mission and vision may also be appropriate at this stage.

b. Assessing Need

A formal community needs assessment with relevant data should be used as the basis for establishing the goals, including the community issues and needs to be addressed. Equally valuable is an assessment based on resident input, formal or informal. This can be conducted through a resident survey, review of complaints/work orders, or comments made to staff at community meetings, on the website, or through social media.

At the same time, a successful collaboration should also be aware of and address the overt or covert needs of the collaborating entities. Collaborations require commitment of staff time and are doomed to fail if additional demands are placed on a PHA or health center that is already short staffed. On the other hand, the collaboration is more likely to succeed if the goals of the collaboration can incorporate some or all the goals and tasks that are already part of each individual organization's established work plan. Getting organizational and staff "buy-in" will be discussed later in this guide.

TOOLS

You can access tips on defining purpose, addressing needs, and setting goals at the following sites:

- atlassian.com/blog/productivity/how-to-write-smart-goals.
- articles.bplans.com/7-ways-to-set-team-goals-that-actually-work.
- wrike.com/blog/science-backed-goal-setting-techniques-need-know-4-avoid-like-plague.

c. Building Strategic Partnerships

Identifying the best people to achieve goals and having decision makers at the table is important. Organizations need to reflect on the skills and expertise needed for this collaboration, the diverse perspectives that could be helpful, and the resources that need to be leveraged. High profile or trusted partners can lend additional credibility to the effort. Based on this, include all stakeholders – key staff, residents, policymakers and funders. Be sure to include those who are closest to the problem – residents. Use the collaborative skills discussed above when forming this partnership. If a key stakeholder cannot actively participate in the collaboration and attend meetings, keep them in the loop in whatever way possible. Ensure they receive meeting minutes, call them and give them updates, ask for their advice, ask to meet them periodically, and keep them involved in other ways.

To ensure continuity and representation, PHAs and Health Centers may also want to encourage reciprocal board or advisory group membership.

DID YOU KNOW?

HUD's ConnectHome Playbook contains some useful tips on building successful partnerships

- hudexchange.info.

d. Potential Collaborators and Partners for Health Centers and PHAs

Following are some suggestions for potential partnerships and collaborations for staff of health centers, PHAs, and other organizations serving residents of public housing. These are organized in a framework used by Healthy People 2030, outlining the five key areas of the Social Determinants of Health:

i. Healthcare Access and Quality

Healthcare Access and Quality including access to primary care, health insurance coverage, and health literacy.

- Primary care providers accepting Medicaid, including health centers and health center "Look-Alikes"
- Behavioral Health/Mental Health providers
- Local health departments, including sexually transmitted diseases (STD) clinics, infectious disease offices, opioid treatment offices, mold remediation offices, immunization offices
- Hospitals – Emergency Room (ER) department, discharge staff, social workers
- Dental providers; State Dental Associations, volunteer dentists
- Vision - Ophthalmology/optometry training programs, volunteer screening and other services
- Affordable Care Act Enrollment centers/staff
- Lead Poisoning remediation officials
- State Primary Care Associations
- Veteran Hospitals, other Veterans Affairs (VA) providers
- Health Literacy organizations
- Telehealth/Access to technology
- Other teaching institutions - medical schools, schools for pharmacy, podiatry, chiropractic, and others who can provide volunteer screenings and services

ii. Education Access and Quality

Including early childhood education and development, language and literacy, and educational attainment in general.

- School-based clinics
- School social workers, Parent/Teacher Associations
- Trade/Vocational schools
- Charter Schools
- Community Colleges
- Head Start Centers
- Day Care – private centers, family/neighborhood childcare

- Parents as Teachers
- Reach Out and Read programs
- Other mentoring programs
- Universities – Public Health/Social Work Departments, Service Clubs
- After-School Programs

iii. Social and Community Context

Contexts within which people live, learn, work and play, including civic participation, discrimination, conditions in the workplace, and incarceration.

- Youth Organizations – Girl Scouts and Boy Scouts, Boys and Girls Clubs. These organizations may be the only ones providing opportunities for young people to socialize and participate in safe, organized, after-school activities in many inner-city neighborhoods and isolated communities
- Urban Leagues
- Civil Rights/Fair Housing Organizations
- Legal and Immigration services, including Legal Aid
- Junior Achievement
- Area Agencies on Aging
- Neighborhood Churches – including storefront churches and other faith based organizations - mosques, temples, as well as religious leaders in the community. Services provided range from soup kitchens and food pantries to daycare and educational classes
- Board of Alderman – local politicians can be very influential in helping residents with environmental issues – from getting stop signs installed and making neighborhood streets safer, to getting unsafe, abandoned buildings boarded up in order to reduce drug trafficking and loitering
- Social Action and Community Organization Agencies
- Foundations
- Public Safety/Law Enforcement including local “community liaison” programs

iv. Economic Stability

Including key issues such as poverty, employment, food security, and housing stability.

- PHAs
- Homeless Organizations – faith-based, city/state/federally-funded emergency shelters
- “Housing First” programs
- Immigrant/refugee/international aid organizations

- AmeriCorps/HealthCorps/Senior AmeriCorps/JobCorps/VISTA/Jobs Plus
- Area Agencies on Training and Employment/Goodwill/EnVision Centers
- Civil Rights/Fair Housing Organizations
- Small Business Enterprises
- Incarcerated/Work Release programs
- Habitat for Humanity
- Trade Unions
- Women Infant and Children programs
- Department of Labor programs
- FEMA
- Chambers of Commerce
- The U.S. Dept. of Labor, Employment and Training Administration has information on adult training programs and other resources on its website
- Other Adult Training programs include YouthBuild, Goodwill, Workforce Partnership programs
- Food banks and pantries including Feed the Children, FarmShare, Midwest Food Bank and numerous others nationally and in every community

v. Neighborhood and Built Environment

Including quality of housing, access to transportation, availability of healthy foods, air and water quality, and neighborhood crime and violence.

- Transportation – city/state/older adult
- Transportation – private – Uber/Lyft
- Mobility impairment or the absence of personal transportation results in social isolation
- Victims of Crime organizations
- Community Development Corporations
- Urban Strategies
- Environmental Organizations

In addition to the above, the following organizations have a track record of service to the community and would be a good resource for exploring potential collaborations:

- March of Dimes – maternal and child health, premature birth
- Easter Seals – individuals with disabilities
- Alzheimer's Association – care, support, and research

- Lions Club – Vision screening/eyeglasses
- Rotary Clubs – immunizations/community service
- Red Cross – emergency assistance, disaster relief, and disaster preparedness education
- Sororities/Fraternities – social organizations that also engage in philanthropic activities
- Shriners – aid to children facing orthopedic and other surgeries
- Corporations – most large corporations and many small ones as well have Employee Service clubs/charities that provide volunteers and raise funds

e. Achieving Buy-In

As discussed above, some individuals may consider participation in a collaboration as additional work in an already busy schedule. Use effective communication skills to understand and acknowledge what partners' needs are and to try to address them. Then, discuss how their participation could be beneficial to them personally, in addition to meeting their organizational goals. Could their participation increase their professional network? Increase their own skills and knowledge? Increase their own or their organization's profile with funders? Help them with their career goals? Increase resources and services for their clients? Barriers to participation are discussed below.

f. Conducting Effective Collaboration Sessions/Meetings

Once there is buy-in, it is equally important to ensure that collaborators do not drop out. Holding meetings, in person or virtually, is the most common method for working together. However, it is important to note that meetings and collaboration sessions are not the same thing. The purpose of a business meeting is to exchange information, discuss issues, or make decisions. In contrast, the purpose of a collaboration session is to accomplish actual work, working closely with others. Exchange of information is important, but should be minimized during the sessions by planning and distributing all reading material prior to the meeting.

It is important to ensure that these sessions are run efficiently and are not viewed as a waste of time. Following are a few tips on conducting effective sessions:

- Each session should have a clear purpose, with an agenda developed collaboratively and distributed along with meeting logistics at least two weeks prior to the session.
- Reading materials should be distributed prior to the meeting.
- Sessions should always start and end on time, ideally no longer than 90 minutes - 2 hours.
- Barriers to attendance need to be understood and addressed upfront. These include lack of childcare, eldercare, transportation, flexible hours at work, language barriers and access.
- At the end of each session, there should be a clear action plan that is clearly summarized with responsibilities assigned for carrying it out.
- A system for reporting on progress in between sessions should be established.
- Assign roles. Research shows that groups work best when members have clearly defined roles and responsibilities. Early on, assign or elect a "lead" or "chair/co-chair" to keep the collaboration on track. Other possible roles could include someone to take notes and a 'gate keeper' to keep

discussions on topic and on time. For larger, more formal collaborations, a parliamentarian can be helpful, especially when decisions are to be made using a formal voting process. **Ideally, in a collaboration, decisions should be made by consensus.**

- Provide opportunities for feedback from participants.
- A collaboration is a partnership of equals, so schedule time during or outside of the sessions for socializing, building trust, and fostering productive relationships that are key to the success of all collaborations.

| RATE YOURSELF |

Think of the last meeting you attended and apply the 9 criteria listed above to it. Were these met "Not at All", "Somewhat" or "Completely"?

If you rated yourself in the first two categories, then choose one or two criteria to work on at your next session and continue building on that, one meeting at a time.

DID YOU KNOW?

Conducting efficient meetings takes practice and ensures that collaborators stay engaged and goals are achieved. The following links provide tips on conducting successful meetings.

- managementhelp.org/misc/meeting-management.htm.
- nytimes.com/guides/business/how-to-run-an-effective-meeting.
- hbr.org/1976/03/how-to-run-a-meeting.

g. Planning, Prioritizing, and Performing

These are the 3Ps of Time Management that can help guide effective collaboration.

Planning involves creating a road map to achieve the desired goal.

Some essential elements of a good plan include:

- Involving all stakeholders, especially residents, in developing quantifiable goals. This ensures their buy-in.
- Separating the goals into smaller tasks with short-term deadlines.
- Making goals public – this helps with accountability.
- Incorporating feedback and adjusting goals to keep them relevant.
- Tracking and reporting progress.
- Always focusing on the big picture.

> **"BY FAILING TO PLAN, YOU ARE PLANNING TO FAIL."**
>
> *- Benjamin Franklin*

Prioritizing involves making decisions to do the right tasks at the right time. A useful tool is to ask the following 4 questions:

- Is this task important and urgent?
- Is this task important but not urgent?
- Is this task urgent but not important?
- Is this task neither important nor urgent?

There is a tendency to react and respond to "urgent" tasks, resulting in neglecting the important work that would have the biggest impact. If urgent tasks are constantly disrupting the normal flow of work, then lack of planning may be an underlying issue.

> **"MOST OF US SPEND TOO MUCH TIME ON WHAT IS URGENT AND NOT ENOUGH TIME ON WHAT IS IMPORTANT."**
>
> *– Steven Covey*

Performing involves initiating work on the tasks promptly and not procrastinating. Many collaborations are sidetracked because they spend a disproportionate amount of time planning and discussing and fail to implement plans promptly.

There is considerable literature on how to set SMART goals: Specific, Measurable, Attainable, Realistic and Time based. However, some consider that setting "attainable" and "realistic" goals is limiting and contrary to the need for collaborative goals to be "stretch" and "transformative" goals. You may therefore want to consider setting BHAG goals instead – Big, Hairy, Audacious Goals!

h. Implementing Change

Executing the plans developed by the collaborative is the next step in this process. Successful implementation involves all stakeholders and partners and requires that all members of the collaborative continue to maintain their commitment and the ownership that was established at the beginning of the collaboration. Maintaining this commitment needs ongoing nurturing, keeping the focus on the big picture, having open communication, and providing prompt feedback. Ongoing monitoring is valuable during this phase to ensure that problems are identified early, and barriers removed before the plan is seriously sidetracked.

The Deming Cycle of **PLAN-DO-STUDY-ACT** (PDSA) is an excellent method for continual improvement of a process or service without spending months planning and discussing | deming.org/explore/pdsa.

i. Evaluation

Although evaluation is the final component in this process, it should be incorporated into the planning right from the beginning and included in every phase. Most leaders assess the impact of their work on an ongoing, informal basis by inviting feedback, asking questions, and using this information to improve programs and processes. A collaboration, however, should incorporate a more formal evaluation process to assess whether the strategies are working, and the outcomes are as planned in order to document progress for funders and policymakers. Based on the evaluation, recommendations can be formulated for continued action, or change in strategies or revisions to the current plan.

The Centers for Disease Control and Prevention (CDC) suggests that evaluation questions fall into the following groups:

- Implementation - Were your program's activities put into place as originally intended?
- Effectiveness - Is your program achieving the goals and objectives it was intended to accomplish?
- Efficiency - Are your program's activities being produced with appropriate use of resources such as budget and staff time?
- Cost-Effectiveness - Does the value or benefit of achieving your program's goals and objectives exceed the cost of producing them?
- Attribution - Can progress on goals and objectives be shown to be related to your program, as opposed to other things that are going on at the same time?

j. Celebrate Success

It is important to celebrate all successes - to keep the group motivated and energized.

DID YOU KNOW?
There are tools and tips on Evaluation on CDC's website
| cdc.gov/eval/guide/introduction/index.htm.

5. BARRIERS TO EFFECTIVE COLLABORATION:

Barriers to collaboration can be organizational, cultural, or interpersonal. Leaders of a newly forming collaboration should determine whether any barriers exist and address these at the beginning. Some of the most common barriers in general are:

- A lack of alignment around goals (or fuzzy goals).
- Turf issues and competitiveness.
- A lack of respect or trust in the other organizations.
- Staffing shortages or lack of staff time to participate in the collaboration.
- Lack of open communication, withholding or not sharing information.
- Limited resources or unwillingness to share existing resources.
- Lack of consensus regarding priorities or conflicting priorities.

- External factors such as pressure from individuals or groups outside the collaboration.
- Significant differences in levels of technical and staffing capabilities between collaborators.
- Temporary withdrawal of support during a crisis.

In addition to the above, other barriers are specific to representatives of public housing:

- PHA Executive Director (ED - turnover) - Some PHAs have been known to have a frequent change in top management, including the position of ED, resulting in having to establish relationships with the new ED all over again. The negative impact of this frequent turnover can be mitigated by a well-drafted Memorandum of Understanding, which specifically outlines the working relationship between the two entities and can continue to be implemented without disruption regardless of the turnover. Reciprocal board or advisory group membership is another way for PHAs and health centers to ensure continuity and representation.
- PHA Staff turnover - Frequent contacts between health center and PHA staff will alert the health center when key PHA staff have been replaced. A brief orientation of the new staff should be undertaken as soon as new staff are on board to ensure continuity of the relationship. Health center staff should prepare "orientation" packets to be given to the new PHA staff. These can include information on health center services, clinic and staff schedules, and contact information.
- Space issues - Some public housing complexes do not have adequate meeting room facilities for health center staff to hold health education or other activity sessions. Health center staff may need to arrange for space as well as transportation.
- HUD/PHA regulations/policies regarding confidentiality - Because PHAs cannot provide names of their tenants for any health information that health centers may wish to distribute to tenants, health center staff should negotiate other arrangements including providing the PHA with stamped mailers that the PHA can then address and mail or e-mail ready materials or information that can be pasted/posted on the PHA's website.
- Trust issues - In some public housing complexes, there may be conflict between the resident managers and the residents. It is critical for all staff to maintain neutrality and not be seen as taking sides.

  There are many techniques for addressing these barriers, which need to be resolved from the onset. Increased interpersonal communication, trust-building games and exercises, and icebreakers designed to enhance teamwork are some useful tools.

TOOLS

Trust Building Activities For Co-Workers/Collaborators.

DID YOU KNOW?

The following article contains excellent tips on overcoming barriers to collaboration

uxmatters.com/mt/archives/2017/10/overcoming-common-barriers-to-collaboration-part-1.php.

This link directly addresses how to build trust in a remote team beyond games and activities

knowyourteam.com.

6. RESIDENT PERSPECTIVE – RECRUITING AND INVOLVING RESIDENTS OF PUBLIC HOUSING:

The success of any collaborative effort is dependent on the individuals and entities involved. It is incumbent that residents of public housing be involved from the start in the planning, implementation, and evaluation process, since they are closest to the issues in their community and are in the best position to provide suggestions and recommendations that are most meaningful and will have the greatest support. Involving residents as key stakeholders from the beginning also ensures that errors are avoided due to ignorance of issues and history. This is true whether the involvement is in a collaborative, or in an individual health center or PHA's programs and services.

Residents who feel ownership of their programs are also more likely to be active, involved participants. Through their involvement, they will ensure that services are timely and relevant, and will actively promote the participation of other residents. Similarly, housing authority staff who are involved in program planning at the start are more likely to have ownership, and can provide useful information, ensure that programs can be implemented on site without violating PHA regulations, assist in removing barriers, and provide increased access to residents, services, and to health center staff.

Positive community change is also more likely to occur and successfully sustained if it has leadership from within, therefore leaders from within the community should be nurtured – they have credibility and have already gained the community's trust.

a. Tips for Recruiting and Retention

Effective strategies for reaching out to residents of public housing vary and are based on various factors present in the community. Gaining the support of community leaders – both natural leaders and those elected/appointed - is a standard rule of thumb followed by many successful community organizers. Following are some suggestions:

i. Identify Community Leaders

Include church/faith leaders, area school principals, resident management council presidents/chairs, resident managers, and others with current or potential impact on the community. Approach informal leaders - the residents to whom other residents usually turn to for help.

ii. Communicate Program Mission and Vision

Clearly communicate the reason for collaboration, share information on current programs and issues/needs, and invite residents to be part of the decision-making process.

Communication can be individual, one-on-one, or in group settings at resident council meetings, other events or through focus groups.

iii. Ensure Buy-In

Seek resident input into the planning and delivery of services. Program limitations need to be presented clearly and up front to ensure that residents are aware of the parameters and do not feel discouraged or angry if their ideas are not accepted or implemented.

iv. Partner with the Housing Authority – Health Center

Staff need to work closely with their local housing authority staff. They can request permission to attend PHA staff meetings, at which they can share information on their programs, suggest ways they can be of help, and enlist the support and cooperation of the housing authority staff. Have designated "points of contact".

v. **Repeated Contacts**

After the initial meeting, follow up with subsequent meetings or contacts. Provide residents with regular program updates to ensure their continued support and keep channels of communication open in order to head off any impending or brewing problems.

vi. **Address Opposition Promptly**

Understand why a plan or program is being opposed, who is opposing the plan, and promptly initiate discussion and resolution directly with the key players. Do not ignore problems or delay discussion and resolution, as an unaddressed issue may grow bigger and be harder to resolve.

vii. **Recruit Constantly**

Use every community contact as an opportunity to recruit staff and volunteers from the resident community.

viii. **Floor Captains**

In high rise buildings, health center staff may want to set up a system for designating one or more responsible residents on each floor as 'floor captains'. Floor captains can be asked to volunteer to distribute health information and updates - either by email or door-to-door, refer residents to resources, and serve as the onsite contact.

Health center staff should communicate regularly and frequently with floor captains, provide ongoing support and assistance, and provide recognition for their efforts. Support can be offered in the form of regular meetings at which refreshments are served and awards given in recognition of the floor captains' efforts. The floor captains serve as an extension of the health center staff and are particularly helpful if the housing authority policies restrict the health center staff and other non-residents from going door-to-door.

ix. **Groups**

Working with groups is an effective way to reach a larger audience using fewer resources. Health center staff can provide information and education and conduct recruitment efforts at resident management meetings, neighborhood school PTAs, in health center waiting rooms or any other site where residents congregate and where they can find a captive audience.

x. **Community Events**

Health Center staff should maintain an updated calendar of community events such as health fairs, back-to-school fairs, veterans stand-down events, and other events. Appropriate staff should both attend and volunteer.

b. Resident Involvement in Governance

Health centers are required to have a representative governing board with a majority of the members being patients served by the center and who, as a group, represent the individuals being served. If patients from public housing represent only a small minority of the total patients served by a health center, it is possible that the board would have just one or two public housing consumers represented. To ensure that residents have a voice and participate in program planning and oversight, it is recommended that the health center also establish a PHPC Advisory Committee.

The PHPC Advisory Committee should include representatives from resident councils, PHAs, local schools, community organizations, and other groups affecting the lives of residents. This committee can serve as an excellent resource from which to select potential consumer board members for the health center Board of Directors, members for future collaborations, and other committees.

Some of the issues to be addressed and steps involved in setting up an Advisory Committee include:

- Recruiting committee members – Health center clinicians and other staff are usually a good resource for referring patients who are outspoken, involved, and care about their community and access to services. Self-referrals should also be welcome.
- Comprehensive orientation – informed board members are usually effective board members. All board and committee members should receive a comprehensive orientation within a month of being elected.
- Members should be offered the opportunity to tour the health center service sites. Tours can be organized just before or after a committee or board meeting or at a time convenient for the residents.
- Efforts should be made to remove any barriers to participation at meetings, including provision of transportation, childcare services, translators, and any other resource to enhance consumer participation, attendance, and retention.
- Board and committee members should receive regular program updates, preferably from their respective program staff.

c. Communicating With The Housing Agency

The most successful partnerships have a few things in common – open and frequent communication, appropriate involvement, timely feedback, positive reinforcement, and acknowledgment of effort. Following are some methods that have been successful in developing a highly collaborative relationship between community health centers, housing authority staff, and resident councils:

i. Solicit buy-in and support from the CEO of the Housing Agency

Arrange a face-to-face meeting with the Housing Agency CEO. Explain the PHPC program (including its benefits) and 'sell' the advantages of partnering. Use this opportunity to initiate discussion towards formalizing a Memorandum of Understanding or another form of a written agreement for working together.

ii. Attend PHA staff meetings regularly

Provide program updates and offer to assist with outreach and recruitment.

iii. Attend resident council meetings

Ask to be on the agenda each month if possible. Provide health education tips and sessions for staff. Recruit residents for future activities.

iv. Provide tangible services

Tuberculosis screening, flu shots, blood pressure, diabetes, and other screenings on site. These are always welcome and will help staff gain a foothold in the PHA community.

v. Say 'thank you' often

Invite key PHA staff to a lunch meeting, invite them to health center activities and functions.

vi. Provide positive press

Feature PHA staff and activities in health center newsletters, annual reports – send the CEO of the PHA copies of these.

DID YOU KNOW?
The Public Housing Resident Organizing and Participation Toolkit is another resource for residents, housing authorities and community organizations interested in creating or supporting a resident council, or increasing their engagement with public housing residents. | hudexchange.info/programs/public-housing/resident-toolkit/overview-and-common-terms.

d. Memorandum of Understanding with Public Housing

A Memorandum of Understanding (MOU) between the PHA and the health center helps to ensure continuity of the relationship between the two entities. Without a formalized relationship, frequent or sudden turnover at any level in PHA staff is likely to result in a set back and disruption of services. The MOU ensures that regardless of turnover, the working relationship endures unless there is a conscious decision at the executive level to terminate the agreement.

MOU's are also sometimes referred to as Memorandum of Agreement (MOA) or Letter of Intent (LOI).

A meeting between the CEO of the health center and the CEO of the PHA is usually the first step for both agencies to come together and explore a mutually beneficial relationship. The health center should come prepared to discuss the healthcare needs of residents and the programs and services it can offer to both residents and PHA staff.

The health center should bring handouts, including statistics on resident use of health center services; non-identifiable, aggregate resident health data; any unmet needs; as well as brochures describing health center services.

The health center should also come prepared to suggest areas for collaboration – have specific "asks" outlined. Some typical areas for collaboration include:

- Provision of rent-free clinic space in a centrally located housing complex, usually two or more modified apartments at ground level.
- Attendance at PHA staff meetings to discuss the PHPC program with PHA staff.
- Attendance at resident council meetings held at their various housing complexes.
- Meeting with resident council managers on a regular basis.
- Holding meetings with residents in on-site community spaces.
- Posting/distribution of fliers and brochures regarding health center events and activities on PHA property or PHA websites.
- Non-identifiable, aggregate patient and resident data collection and sharing to the extent available and allowed by regulations.
- Providing resident managers with pre-packaged "welcome" packets to be distributed virtually or as hard copies to all new tenants. Packets should be assembled by health center staff and may include information on the health center services and programs, useful health information, coupons, and 'freebies' such as magnets with health center contact information.

If the PHA is unwilling/unable to execute a formal MOU, the health center should be prepared to suggest establishing a less formal collaboration. Either the health center or the PHA can create a document on

official letterhead that outlines the discussion that took place and the specifics of the collaboration agreed to by both parties.

TOOLS

Following are some resources that can help with developing a MOU/MOA/LOI specific to the project at hand:

Samples for partners | Memorandum of Understanding.

| Guidelines for a Memorandum of Understanding.

| Sample Memorandum of Understanding Template - CDC.

7. SOCIAL MOBILIZATION:

Collaborating to achieve common goals and realize systemic changes is an effective process, but also takes time. Due to increasing needs and competing demands for shrinking or limited resources, residents and service providers may also need to resort to other strategies such as social mobilization or social action to achieve their desired outcomes.

According to the World Health Organization (WHO), social movements often emerge from a sense of shared grievance and injustice. These movements use social media and new information technology to gain momentum and advocate for social change on issues ranging from health equity, climate change, women's empowerment, wage equity, social and racial justice, and many other issues.

WHO defines social mobilization as the process of bringing together all societal and personal influences to raise awareness of and demand for healthcare, assist in the delivery of resources and services, and cultivate sustainable individual and community involvement. Social mobilization aims to facilitate change through an interdisciplinary approach.

Health centers and PHAs that want to mobilize residents may want to include their local social action or Community Action Agencies (CAA) in any collaboration and work closely with them on specific issue oriented tasks.

CAAs were founded by the 1964 Economic Opportunity Act to fight poverty by empowering the poor as part of the War on Poverty. Programs frequently administered by Community Action Agencies include Head Start programs, Low-Income Home Energy Assistance (LIHEAP) utility grants and Weatherization Assistance Program (WAP) funded through the U.S. Department of Energy (DOE).

There are currently over 1,000 CAAs across the country engaged in a broad range of activities. Additional information on CAA's can be found at | capslo.org.

It is important to note that while agencies receiving federal funding can advocate for their clients, they are not allowed to use federal funding to lobby federal, state, or local officials or staff to influence legislation.

Tips for mobilizing residents can be found at | Social Mobilization.

For more information on | Community Action Agencies.

8. COLLABORATION TOOLS:

Collaboration tools have evolved over the decades with advances in technology. Traditional tools like face-to-face meetings, emails, and conference calls have been replaced by a slew of online tools designed to facilitate working from home and collaborating with team members stationed at multiple remote locations online and in real time.

However, working remotely raises several challenges when those remote workers have to collaborate with other team members. To be productive, team members need to be able to collaborate in real time, work together, and share documents online. They need online collaboration tools and project management tools that offer features such as instant messaging, video calls, screen sharing, and time tracking to help them work together.

Following is a list of some of the collaboration tools currently available. This list is just an introduction and will continue to grow exponentially with technological advances and become outdated even as you read this. When your team is ready to invest in collaboration software, an internet search should give you the most updated information.

- Google Workspace – Google provides a lot more than a web search engine and browser. Google Workspace includes remote collaboration tools including Google Docs, Sheets, Slides, and communication tools including Hangouts Meet and Chat.
- SLACK – Slack can integrate with a wide array of services, from Dropbox and Google Drive to Salesforce and Zoom. It is used across the world by a wide range of companies, including big names like Lyft and NASA's Jet Propulsion Laboratory. There is a free plan available for small teams.
- Dropbox – In addition to file storage, Dropbox Business is a smart workspace where teams, tools, and content come together. It enables users to create, store, and share cloud content from Google Docs, Sheets, and Slides, and easily access your team's work from your computer, mobile device, or any web browser. There is also deep integration with tools such as Slack and Zoom.
- ASANA – Asana is designed for groups that need to focus on getting projects done. It allows users to map their project out as a Gantt chart, then create portfolios of steps, and monitor the workload of each member. Asana also has a wide range of integration tools, connecting to a broad range of online services, such as Adobe Creative Cloud, Slack, Microsoft Office 365, Gmail, and more. There is a free plan available.
- Microsoft – Microsoft Teams and SharePoint – are two totally different platforms that offer different features. Despite their differences, you can integrate the two platforms.
- SharePoint – is a collaboration platform that integrates well with other Office 365 apps.
  - Microsoft Teams – on the other hand, is a hub that allows remote workers to chat, meet, call, and collaborate all in one place.
  - SKYPE for Business – Skype for Business is an enterprise software application for instant messaging and video chat developed by Microsoft as part of the Microsoft Office suite. It is designed for use with the on-premises Skype for Business Server software, and a software as a service version offered as part of Office 365.

- **Basecamp** – Basecamp is a complete project package that includes all the tools teams need to work together, such as message boards, to-dos, schedules, docs, file storage, real-time group chat, and automatic check-in questions. You can rename them, turn off the ones you do not need, or integrate with third-party tools like time trackers to tailor things to the project at hand. It is highly flexible. Basecamp offers a free trial.
- **Trello** – Trello uses boards, lists, and cards to allow you to organize and prioritize your projects in a flexible and easy-to-use way. A limited free plan is available.
- **Flock** – Flock has everything you need to collaborate – instant messaging, video conferencing – in a single package, and combines that with powerful search features. There is also support for a broad range of third-party services, including Asana, IFTTT, Google Analytics, Twitter, Google Drive, and Todoist. A free starter plan is available.
- **PODIO** – Podio is a flexible and customizable online platform for work and communication among teams. It provides a way to organize large stacks of work and to delegate tasks between employees. It has the tools to share files, view the status of ongoing projects and get feedback on the things you are currently working on.

  Podio is also equipped with mobile apps for the times you need to use your smartphone or tablet, and integrates with third-party services and apps including Dropbox, Google Drive, Evernote and Zendesk.
- **Flowdock** – Flowdock is a group and private chat platform. Its most interesting feature is its team inbox which aggregates notifications from other channels, like Twitter, Asana and customer support tools.
- **WebEx** – Cisco's WebEx provides personalized video meeting rooms where users can host and join meetings. Users can use WebEx for team collaboration, webinars, training and customer support.
- **GoToWebinar** – GoToWebinar enables webinar hosting for up to 3,000 people for events such as marketing, training, and corporate communications. Features include flexible scheduling, automatic reminder emails, and instant-join links.
- **GoToMeeting** – GoToMeeting is a web conferencing tool that allows users to host an online meeting with high-definition video conferencing from their Mac, PC, iPad, iPhone or Android device, with up to 250 participants.
- **ZOOM** – Zoom has become one of the leading video conferencing software apps. It enables users to virtually interact with co-workers when in-person meetings are not possible. Frequently used socially as well, it is a useful tool for small, medium and large-sized teams wanting to collaborate.
- **Other** – an internet search will show numerous other collaboration tools available to users, either free or at a fee.

> **"IF YOU WANT SOMETHING NEW, YOU HAVE TO STOP DOING SOMETHING OLD."**
>
> *– Peter F. Drucker*

MODULE III: MODELS THAT WORK – PROMISING PRACTICES AND CROSS – SECTOR COLLABORATIONS

In Module II, the advantages and barriers to collaboration were covered as well as the tools and techniques needed to be effective. Module III will highlight some of the promising practices involving cross-sector collaborations around the country, ranging from traditional collaborations between health centers and PHAs, to those fostered by emergencies such as the COVID-19 pandemic, to other models of successful collaboration between multiple entities.

As highlighted in Module I, residents of low-income housing face increasingly complex social and environmental issues that cannot be solved by any one organization or through a siloed approach. There is an urgent need for private, public, non-profit, and government organizations to pool their resources and work together to achieve mutually beneficial outcomes. This cross-sector approach is supported at all levels of government as well.

In December 2009, the Office of Management and Budget released the Open Government Directive, (OGD). The Open Government Directive describes collaboration as improving "the effectiveness of Government by encouraging partnerships and cooperation within the Federal Government, across levels of government, and between the government and private institutions."

In order to achieve this goal, HUD adopted a plan to institutionalize and expand on its existing partnerships with organizations throughout government and the private sector. HUD proactively adopted and disseminated best practices that improved efficiency and greater cooperation with the public, and especially with community-based nonprofits.

For news and updates on HUD programs and services.

DID YOU KNOW?

A promising practice is a model, program, or activity with at least preliminary evidence of effectiveness in small-scale interventions or the potential to generate data that could be useful for making decisions about taking the practice to scale and generalizing the result to diverse populations and settings. Learn more about Promising Practices on HRSA's website. For a more focused list, see the Health Center Resource Clearinghouse page on promising practices. | bphc.hrsa.gov/qualityimprovement.

Following are some examples of Promising Practices and Cross-Sector collaborations:

1. COLLABORATIVE INITIATIVES BETWEEN HEALTH CENTERS AND PHAS:

- **Inter-Departmental Health Equity Collaborative (IHEC)** – IHEC is a collaborative led by OMH and co-chaired by HUD. Its goal is to identify and promote effective practices, interventions, and policies addressing Social Determinants of Health (SDOH) across federal agencies. The IHEC Team works with federal partners from varied sectors, including education, environment, housing, and labor, and has prioritized CHWs as an overarching strategy for reducing disparities and improving health in historically under-resourced communities. | minorityhealth.hhs.gov.
- **Embedding Community Health Workers (CHW) in Public Housing - A Place-based Approach To Health (CHW PATH)** – The CHW Place-based Approach To Health (CHW PATH) is a pilot program launched on October 1, 2019. The goal of CHW PATH is to create CHW job opportunities for residents of public housing and to assess the benefits of embedding CHWs within their own public housing communities to provide peer-to-peer support for health and social needs. CHW PATH aims to develop novel CHW positions that are informed by existing CHW models/roles (e.g., care coordinator/navigator, health educator, cultural mediator, community organizer, promotores de salud) while tailored for the unique needs and contexts of public housing settings.

  CHW PATH is a pilot within the Jobs Plus program and is a collaboration between the U.S. Department of Health and Human Services (HHS), Office of Minority Health (OMH), and the U.S. Department of Housing and Urban Development (HUD).

  CHW PATH is piloted at seven public housing communities in two cohorts (2019 and 2020): Nickerson Gardens in Watts, Los Angeles, CA; and Gilmor Homes in Sandtown-Winchester, Baltimore, MD., as well as University of Southern California (USC) in Los Angeles, CA; Total Health Care (THC) in Baltimore, MD; Mile Square Health Center (MSHC) and Sinai Chicago in Chicago, Il; DePaul Community Health Center and Ashe Cultural Arts Center in New Orleans, LA; and Akron Children's Hospital in Akron, OH. In all of these communities, CHWs were hired using a cost-sharing model with local health partners.

The health centers involved in implementation are:

- **AxessPointe Community Health Center (Akron, Ohio)** – coordinates with the Akron Metropolitan Public Housing Authority to bring services to residents of public housing, including older adults and people with disabilities, with funding from CHW-PATH. Mobile units support the provision of enabling services, with outreach done by CHWs who know the residents, health care providers, and public housing managers. The CHWs are shared by the health center and the local PHA.
- **WATTS Healthcare Corporation (Los Angeles, CA)** – was invited by HUD and the Office of Minority Health (OMH) to develop and implement a Jobs Plus Community Health Worker program in coordination with the Nickerson Gardens housing complex. Also involved in this collaborative was the PHA of the City of Los Angeles (HACLA) and the Interdepartmental Health Equity Collaboration (IHEC).

Other key partners include:

- Office of Minority Health (OMH), Department of Health and Human Services.
- Office of Public and Indian Housing, HUD.
- Baltimore Field Office.
- Office of Field Policy and Management, HUD.
- Environmental Protection Agency/Office of Environmental Justice.
- Housing Authority of Baltimore City (HABC).
- Housing Authority of the City of Los Angeles (HACLA)
- Health and other community partners in Baltimore,Chicago, New Orleans, Akron and Los Angeles.

  OMH is supporting CHW PATH with FY19-21 funds and plans to provide additional funding upon receipt of FY20 Congressional appropriations. HUD is leveraging resources and in-kind support from Jobs Plus investments (total of $13.6M allocated for all sites over 4 years) to support CHW PATH. | minorityhealth.hhs.gov.

DID YOU KNOW?

The recently enacted American Rescue Plan Act of 2021 allocates funding for the recruitment, hiring, and training of CHWs by public health departments in recognition of their role in the community during the COVID-19 pandemic. American Rescue Plan Act of 2021-Summary-Holland & Knight. It provides $7.6 billion to HHS to be awarded for grants and cooperative agreements to community health centers and qualified Hawaiian entities for COVID-19 vaccine distribution, testing, contract tracing, equipment, staff, infrastructure, and community education and outreach. | hklaw.com/-/media/files/insights/publications/2021/03/americanrescueplankeyprovisions.

DID YOU KNOW?

Although the effectiveness of CHWs in tackling social determinants of health is well established, there are very few sustainable financing mechanisms for their work. According to the National Academy of State Health Policy, there are currently 15 states that reimburse CHW's through their State Medicaid program. Several states are currently exploring the option. | nashp.org/state-community-health-worker-models.

- **Bronx Health and Housing Consortium (NY)** – The Bronx Health & Housing Consortium is a collaborative network of health care, housing, homeless and social services organizations, and government partners with the shared goal of improving health equity and housing stability by fostering cross-sector relationships, informing policy, and building the capacity of frontline workers to support people with unmet health and housing needs.

  It was started in the Bronx in 2011 as a response to the reform and redesign of New York State's Medicaid program. The Consortium was formed to help break down the barriers that existed between the healthcare, housing, and homeless services sectors.The Consortium is comprised of hospitals, managed

care organizations, housing and homeless services providers, and other community-based organizations and advocates, together with City and State government agencies. In 2018, they replicated their model in Brooklyn through a partnership with NYU Langone Health's Department of Population Health. ❙ healthandhousingconsortium.org.

- "Developing Cross Sector Partnerships" – is a publication authored by the National Nurse-Led Care Consortium (NNLCC), The National Center for Equitable Care for Elders (NCECE) and The National Center for Health in Public Housing (NCHPH). It cites the case study of Casa Maravilla, 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 ages 55 and older. ❙ ece.hsdm.harvard.edu/files/ece/files/developing_cross-sector_partnerships_publication.pdf.

- The Orlando Housing First initiative - "Housing the First 100" – is a collaborative effort among various homeless service, providers, hospitals, and city and county agencies in the City of Orlando and tri-county area, that is led by the Health Care Center for the Homeless - Orange Blossom Family Health.

  The project connects frequent users of homeless services to housing and support services. Other partners include Florida Hospital (the largest hospital system in the area), Homeless Service Network (the local Continuum of Care – a HUD funded program responsible for coordinating homeless services), local law enforcement, and the local government, while outreach to other providers and agencies continues.

- "Housing the First 100" is funded through various sources including the local hospital, local government, and a HUD Continuum of Care Homeless grant. The Central Florida Foundation, a public grant-making foundation that houses over 400 charitable funds, manages funding for the initiative. ❙ astho.org/ASTHOReports/Cross-Sector-Partnerships-to-Improve-Health-and-Housing-Outcomes_Resource-Guide/10-24-18.

- "It Starts with Housing" – This resource was published by HUD in June 2016 and describes three distinct reentry housing models – King County Housing Authority, Burlington Housing Authority and New York City Housing Authority. These three models demonstrate successful partnerships in the government, non-profit and private sectors, and show why collaboration between Housing Authorities and community stakeholders is so essential. ❙ hud.gov/sites/documents/HUD_IT_STARTS_WITH_HOUSING.PDF.

2. COLLABORATIONS WITH FOUNDATIONS, HOSPITALS AND UNIVERSITIES:

- Annie E. Casey Foundation – The Annie E. Casey Foundation is a charitable foundation focused on building better futures for disadvantaged children and their families in the United States. The Foundation is committed to community change and improving outcomes for children and families in high-poverty neighborhoods. AEC's focus is to identify effective tools and strategies for working with low-income families and communities nationwide. They address these challenges through public, private and nonprofit partnerships.

  The Annie E. Casey Foundation has expanded its housing-focused investments and plans to partner with other stakeholders, including those in the public, private and nonprofit sectors, along with communities, to improve housing stability for those most vulnerable to homelessness and other issues.

Some of their numerous partnerships and initiatives include:

- Study Circles Resource Center/Family Circles in Indianapolis.
- Resident Leadership and Facilitation Program in Indianapolis, San Antonio, Providence, RI.
- Trusted Advocates, Seattle.
- Construction Ready Program, Atlanta.
- Plain Talk – a resident led initiative aimed at protecting sexually active youth from pregnancy and sexually transmitted diseases in five cities.

  AEC also partnered with eight other national foundations for the "Funders for Housing and Opportunity" – an initiative to ensure that families can afford safe, stable rentals in healthy communities. They include: The Bill and Melinda Gates Foundation, Conrad N Hilton, Ford, John D and Catherine T MacArthur, JPB, Kresge and the Oak Foundations and the Melville Charitable Trust.

  "Anchored in Place" is another AEC initiative where anchor institutions like hospitals and universities drive economic development locally. Case studies have been conducted in Albuquerque, Baltimore, Chicago, Denver and Twin Cities.

  More information on these and other initiatives can be found on their website | aecf.org.

- The James Irvine Foundation – is a philanthropic nonprofit organization established to benefit the people of California.

  Irvine New Leadership Network members come together to form collaborative design teams, each focused on co-creating solutions to local challenges. The New Leadership Network is based in California's Central Valley, in both Fresno and Stanislaus County. As of 2019, both networks have transitioned to a local leadership structure. NLN: Stanislaus is operating under the guidance of the Stanislaus Community Foundation. | newleadershipnetwork.org/network.

- The Hospital Community Collaborative (HCC) – Launched in 2019, HCC provides proven ideas, insights and resources for creating effective, sustainable collaborations between American Hospital Association (AHA) member hospitals and community organizations across sectors.

  HCC facilitates the development of grassroots interventions, leadership by local residents, working together to transform their living conditions and promote health equity.

  HCC is supported by the charitable Novartis US Foundation, established by Novartis to support philanthropic efforts in the United States. The mission of the Novartis US Foundation is to improve health in underserved communities in the United States by creating innovative and sustainable solutions to expand access to healthcare and build trust within the healthcare system.
  | aha.org/center/hcc.

- King County Hospitals for a Healthier Community – This is a collaborative of 10 hospitals and health systems and Public Health – Seattle & King County, who have formed a collaboration to identify the greatest needs and assets of the communities they serve and develop plans to address them. Working together they have leveraged their expertise and resources to address the most critical health needs in the county, avoiding duplication while focusing shared resources on the most important health needs.
  | kingcounty.gov/depts/health/data/community-health-indicators/king-county-hospitals healthier-community.aspx.

- St. Joseph Health, Humboldt County, in California – has a medical respite program for chronically homeless individuals who have been recently discharged from the hospital.

  This respite program manages 17 respite beds in three locations with teams comprised of a registered nurse, social worker and a health coach providing assessment, care coordination, case management and navigation assistance to homeless patients after discharge. | nhchc.org/business-directory/226587/st-joseph-health-humboldt-medical-respite-program.

- Children's Mercy Kansas City's Healthy Homes – program offers environmental health assessments and repairs and renovations to improve housing stability in the community.
  - The Environmental Health Program at Children's Mercy is a nationally recognized program that provides environmental health consulting, patient case management, research, education, training and analytical services. Their aim is to help improve and advocate for the health of individuals with environmentally triggered illnesses.
  - The programs and activities that Children's Mercy supports across the community are known as Community Benefit. In Fiscal Year 2019, Children's Mercy recorded over $163 million in programs and activities that support the health and well-being of children across the community. The Children's Mercy triennial Community Health Needs Assessment identifies current conditions affecting children's health in the Kansas City region.
- Housing is Health – St. Luke's Health System and Saint Alphonsus Health System have forged a public private partnership to leverage resources to develop a single-site Housing First program in Boise, Idaho, part of a collaboration with the city and other local organizations. | cityofboise.org.
- Better Health Through Housing – University of Illinois Hospital & Health Sciences System is partnering with the Center for Housing and Health in Chicago to provide stable housing and supportive services to homeless individuals. This partnership aims to reduce health care costs and provide stability for the chronically homeless by moving individuals directly from hospital emergency rooms into stable, supportive housing, with intensive case management. | hospital.uillinois.edu.

3. COLLABORATIVE DATA COLLECTION AND RESEARCH INITIATIVES:

- Data Across Sectors for Health and Housing Partnership (DASHH Partnership) – In 2016, the King County Housing Authority (KCHA), Seattle Housing Authority (SHA), and Public Health – Seattle and King County (PHSKC) joined to form the DASHH partnership, focused on creating a unique and sustainable dataset containing linked health and housing administrative data. The goals for DASHH were to use linked data to inform and measure future interventions, including policy, outreach and programming to improve the health of King County residents, as well as to share this actionable data with key health and housing stakeholders. | kingcounty.gov/depts/health/data/~/media/ depts/health/data/documents/housing-health-data-summary.ashx.
- Integrating Housing and Health - Prepared For Home Forward by: The Center for Outcomes Research & Education (CORE), Portland, OR – This is an evaluation study of Oregon's Coordinated Care Organizations' (CCOs) strategy to generate positive health outcomes in the Bud Clark Commons (BCC) apartments. BCC has provided stable housing to some of Portland's most vulnerable residents since 2011, with over 80% remaining in permanent housing. BCC is one of many housing-first/ harm reduction-based permanent supportive housing programs across the country. The approach is

recognized by HRSA as an evidence-based practice and supported by HUD as a best practice for chronically homeless adults. ▎ homeforward.org/sites/default/files/2014-4-14-BCC-report-with-appendix.pdf.

- Housing is Healthcare: Why Public Housing is a Leader in Healthcare Savings – This brief examines key issues for health and housing collaborations and highlights lessons from three such programs: the New York Medicaid Redesign Team Supportive Housing Initiative, the Houston Integrated Care for the Chronically Homeless, and Portland's Housing with Services initiative. ▎ housing-futures.org/2018/07/03/housing-is-healthcare-why-public-housing-is-a-leader-in-healthcare-savings.
- MDRC projects – Following are some innovative programs that MDRC, formerly the Manpower Demonstration Research Corporation, has assisted in developing, implementing, and evaluating. MDRC designs new interventions, evaluates existing programs, provides technical assistance, and works as an intermediary to convene public and private funders to test new policy-relevant ideas and communicate what is learned to policymakers and practitioners — all with the goal of improving the lives of low-income individuals, families, and children. ▎ mdrc.org/population/focus/public-housing-residents.
- Building Self-Sufficiency for Housing Voucher Recipients - Interim Findings from the Work Rewards Demonstration in New York City: By Stephen Nunez, Nandita Verma, and Edith Yang - 06/2015 – Opportunity NYC–Work Rewards was launched in 2007 by New York City's Center for Economic Opportunity to test three ways of increasing employment and earnings for families who receive rental assistance under the federal Housing Choice Vouchers Program. Two of the interventions include the Family Self-Sufficiency (FSS) program, the main federal effort for increasing employment and earnings and reducing reliance on government subsidies. FSS, which is administered by local PHAs, offers participants case management to connect them to employment and social services, as well as a vehicle for building their assets through an escrow savings account. ▎ mdrc.org.
- Creating Moves To Opportunity Demonstration (CMTO) – Encouraging findings from recent studies conducted by Harvard University researchers suggest that young children who move to certain types of neighborhoods, called high-opportunity neighborhoods, are likely to earn more money as adults and are more likely to attend college, compared with their peers who live outside of high-opportunity neighborhoods.

  As part of Creating Moves to Opportunity (CMTO), researchers at Harvard's Opportunity Insights—in partnership with MDRC and other researchers—are testing whether delivering services to families in the Housing Choice Voucher program in Seattle and King County, Washington, can help foster moves to high-opportunity areas. Early positive results from CMTO have sparked interest in testing new mobility initiatives that lead to larger and more sustained moves to high-opportunity areas around the country, particularly those with historically high patterns of racial segregation in housing markets.

  MDRC, as part of the Supporting Moves to Opportunity (SMTO) demonstration, is spearheading a next generation of mobility initiatives. In partnership with public housing agencies and service providers in Chicago-Cook County, IL; Milwaukee, WI; and St, Louis, MO, SMTO will build on earlier efforts and test the effects of initiatives that offer services and supports either before or after families move—developing evidence that will inform federal efforts to expand housing choice policy.

  The St. Louis and Milwaukee programs began enrolling families in 2020 and Chicago-Cook County will be next. ▎ mdrc.org.

- MyGoals for Employment Success – MyGoals for Employment Success is a new workforce program intended to help recipients of federal housing subsidies who are not employed find work, build careers, and advance toward greater self sufficiency. The program incorporates executive skills coaching to help participants with emotional control, stress tolerance, time management, organization, flexibility, and persistence, which are vital to success in the workplace. This pilot program is based on research that shows that poverty causes stress and impedes these skills.

  With an initial grant from the Laura and John Arnold Foundation and additional support from other private foundations, and in partnership with the Housing Authority of Baltimore City and the Houston Housing Authority, the MyGoals demonstration project is rigorously testing this coaching and incentives program that has the potential to improve substantially upon the impact of other employment-related initiatives, not only for subsidized tenants, but also for other groups of highly disadvantaged adults. | mdrc.org/project/mygoals-employment-success#overview.

- Medicaid Supported Housing Collaboration – Housing Futures is a blog on housing strategies for cities around the globe and lists several innovative, Medicaid-supported housing collaborations including examples from Louisiana, New York, Arizona, and Washington State. These Medicaid programs have realized that partnering with affordable housing programs can help their members live healthier, more fruitful lives while simultaneously reducing medical costs. | housing-futures.org/2018/12/06/4-innovative-medicaid-supported-housing-programs-in-the-usa-you-should-know.

- "Housing and the Role of Hospitals" – is the second guide released by the American Hospital Association (AHA) as part of a series on how hospitals can address the social determinants of health. This guide discusses how hospitals and health systems can implement strategies and programs to improve housing stability such as neighborhood revitalization, home assessment and repair programs, and care transition programs. It also recommends a step-by-step pathway for hospitals to consider when developing housing programs. The guide also features five case studies on hospitals and health systems with innovative interventions to reduce housing barriers in their communities. | aha.org/ahahret-guides/2017-08-22-social-determinants-health-series-housing-and-role-hospitals.

4. COLLABORATIONS TO ADDRESS THE COVID-19 PANDEMIC:

- North Carolina Farmworker Health Program (North Carolina) – works with employers to coordinate vaccinations of farmworkers as they arrive and to make sure they get their second doses, using mobile teams of interpreters, volunteers, and outreach workers to find farmworker populations and deliver services and health education in Spanish. | ncfhp.ncdhhs.gov.

- North Texas Area Community Health Center (NTACHC) (Fort Worth, TX) – collaborated with a large local employer (General Motors) to vaccinate employees.

- Many health centers including NTACHC (Fort Worth, TX), AxessPointe Community Health Centers (Akron, Ohio), Community Medical Centers (Stockton, CA), have collaborated with educational institutions, including universities, colleges and community colleges, to recruit student nurses, doctors, pharmacists, and physician's assistants to administer vaccines. | ntachc.org | axesspointe.org | communitymedicalcenters.org.

- San Benito Health Foundation (Hollister, CA) collaborated with San Juan Bautista Rotary Club, the local chapter of the Rotary organization, which includes fighting disease as part of its mission and history, on several initiatives to fight COVID-19. | sanbenitohealth.org.

- In May 2021, HHS Secretary Xavier Becerra and HUD Secretary Marcia L. Fudge announced a joint agency effort to increase access to COVID-19 prevention and treatment services among HUD-assisted households and people experiencing homelessness. The program will leverage the Health Center COVID-19 Vaccine Program. HHS and HUD expect the effort will reach over 6,000 multifamily housing properties, 6,700 homeless shelters, and approximately 7,500 public housing properties across the country to respond to and stop the spread of COVID-19. Health centers that do not currently partner with HUD and their local PHAs can and should join this partnership initiative.

DID YOU KNOW?

Additional examples of PHA/FQHC partnerships can be found in HUD's COVID-19 Recovery Webinars | hudexchange.info/trainings/place-based-initiatives-covid-19-recovery-webinars.

5. FLU LINKAGES TO END ACCESS DISPARITIES (FLU LEAD):

The Flu LEAD pilot project is a partnership between HUD, the Health Resources and Services Administration's (HRSA) Bureau of Primary Health Care, and the Ambulatory Team of the COVID-19 Healthcare Resilience Working Group (HRWG). The project's goal is to increase influenza vaccination coverage among residents of HUD-assisted communities and improve community health and resilience by fostering partnerships between HUD-assisted communities and local HRSA-funded health centers. | hudexchange.info/trainings/courses/hud-hrsa-flu-lead-linkages-to-end-access-disparities-webinar.

6. OTHER CROSS-SECTOR PARTNERSHIPS:

- **Harlem Children's Zone** – The Harlem Children's Zone (HCZ), is an innovative program started in New York city as a pilot in the 1990's. HCZ's mission is to break the cycle of intergenerational poverty with comprehensive, wrap-around programming that builds up opportunities for children and families to thrive in school, work, and life. HCZ's mission centers around the belief that the most powerful way to fight poverty is to invest in every opportunity for people to rise above it.

  Programs offered range from early childhood, education, and career programs to community outreach and wellness initiatives.

  The HCZ Community Benefits Support program helps Harlem residents access government resources, provides free legal services and financial counseling. Enrollment support is provided through a city wide provider portal offering a range of social services programs by a culturally responsive team that helps families fulfill concrete needs and overcome barriers impacting their financial health. Residents receive support through the benefit screening, enrollment, and recertification processes for government services including SNAP, TANF, Disability Rent Increase Exemption, Senior Citizen Rent Increase Exemption, Section 8, Utility Assistance, Immigration Support, Legal Aid and several other benefit programs and services. HCZ started as a movement to transform Central Harlem and has now grown into a vision for breaking the cycle of intergenerational poverty across the world. Since its founding, it has expanded to serve more than 22,500 children and families annually within an area composed of a ninety-seven block zone.

  For additional information and guidance on how to replicate the HCZ model.

- **HIV Care and Youth - Qualitative Evaluation of Social Media and Mobile Technology Interventions Designed to Improve HIV Health Outcomes for Youth and Young Adults Living With HIV: A HRSA SPNS Initiative.** (SAGE Journals – Health Promotion Practice: Ronald A. Brooks, PhD, Omar Nieto, BA, Dallas Swendeman, PhD, MPH, and others. Published August 6, 2020) ❙ doi.org/10.1177/1524839920938704.

  This study was an innovative approach designed to improve medical care engagement, retention, and medication adherence to achieve viral suppression among youth and young adults living with AIDS (YYALH). Forty eight young adults living with HIV (YYALH) ages 18 to 34 years participated.

  A majority of YYALH belong to racial/ethnic, sexual, and gender minority groups and are less likely to be engaged in HIV care, adhere to their medications, and achieve viral suppression compared to older adult populations. Unfortunately, to date, most interventions addressing barriers to HIV care, have been developed and evaluated specifically for adult populations, leaving a gap in HIV care interventions designed for the unique needs of YYALH. Since social media and mobile technology (SMMT) offer innovative opportunities for improving engagement and retention in HIV care, the authors designed HIV care interventions to target social media and mobile technology (SMMT) platforms, primarily favored by youth and young adults. The overall findings from this study suggested that SMMT-based interventions have the potential to increase engagement and retention in care, support YYALH in adhering to medication, and help them adjust to their diagnosis.

  The authors concluded that public health practitioners working with younger populations should consider adoption of SMMT-based models as a viable option to reach and engage young people in their clinical or prevention programs. The implication of this practice is far reaching and could be used to support young people in managing other chronic health issues (e.g., diabetes, cancer, lupus), particularly where they may feel isolated or alone, and where ongoing engagement in health care is critical. ❙ doi.org/10.1177/1524839920938704.

- **The Reinvent South Stockton Coalition** – RSSC aims to empower its residents to transform community through improving safety, education, housing, jobs, and health. RSSC is a public-private nonprofit initiative committed to empowering the residents of South Stockton, CA, through collective impact. RSSC partners with over 60 different public agencies, local businesses and non-profit Community-Based Organizations (CBOs) to improve the lives of residents in and around the South Stockton Promise Zone. ❙ rsscoalition.org.

- **The Corporation for Supportive Housing** – For nearly 25 years, CSH has been the national champion for supportive housing, demonstrating its potential to improve the lives of very vulnerable individuals and families. CSH has earned an award-winning reputation as a highly effective, financially stable Community Development Financial Institution (CDFI), with strong partnerships across government, community organizations, foundations, and financial institutions. CSH is advancing innovative solutions, using housing as a platform for services to improve lives, maximize public resources, and build healthy communities. CSH is working to ensure housing solutions are accessible to more people in more places. ❙ csh.org.

- **Health Improvement Partnership-Cuyahoga (HIP-Cuyahoga)** – HIP-Cuyahoga is a committed and diverse group of more than 100 community partners who have come together as the HIP-Cuyahoga Consortium to build opportunities for residents in Cuyahoga County, Ohio, to have a fair chance to be healthy and reach their full potential. ❙ hipcuyahoga.org.

7. LESSONS LEARNED:

The Promising Practices discussed above all have certain fundamental traits in common, that ensured their success. These are summarized below:

- All partners in these promising practices understood the purpose and shared the mission/ vision enthusiastically.
- Community needs were clearly defined from the beginning, at the planning stage, and there was consensus regarding the needs to be prioritized.
- Partners were selected strategically, there was buy-in at the highest level and they were at the table.
- Potential collaborators and partners were selected representing all sectors of the community, and those who were directly impacted, the consumers of the service, were in leadership roles.
- Considerable effort went into achieving buy-in from all partners prior to the start of the project.
- Open and frequent communication between partners ensured mutual respect, built trust and nurtured strong personal relationships.
- Sharing of resources helped close "gaps" in services and avoided duplication.
- Cross-agency training helped mitigate the impact of staff turnover and ensured effective teamwork and continuity.
- The more successful programs had varied funding sources – state, federal and private.
- Programs that built in staff training, review and change in processes and systems were more successful in sustaining their program over a longer period of time.
- Programs that had good data collection systems and comprehensive program evaluations were able to demonstrate program impact and other outcomes more successfully – improving their prospect for long-term sustainability and ongoing financial support.
- Use of technology and innovative approaches was more successful with hard-to-reach groups such as youth.
- Some of the largest and most successful collaborations had local Foundations, Hospitals and Universities involved.
- Integrating data systems between healthcare and housing providers continued to be a challenge for all the programs and efforts are ongoing to find a resolution.

Strategically navigating all three phases of a collaboration – planning, implementing and evaluating – is critical for success and long-term project sustainability, however, the people implementing the plan must not be overlooked. If they are not passionate about wanting change, if they do not support the effort, then the collaboration will not succeed. As Peter Drucker, the well-known management consultant and writer famously said, "Culture eats strategy for breakfast." Creating a powerful and empowering culture within the collaboration will contribute to its success.

APPENDICES

GLOSSARY OF TERMS

AAA | Area Agencies on Aging

ACA | Affordable Care Act

AHA | American Hospital Association

ARPA | American Rescue Plan Act

BPHC | Bureau of Primary Health Care

CAA | Community Action Agency

CARES Act | Coronavirus Aid, Relief, and Economic Security Act

CBNP | Community-Based Non-Profit

CDC | Centers for Disease Control and Prevention

CHC/HC | Community Health Center/Health Center

CHW | Community Health Worker

CSH | Corporation for Supportive Housing

CLAS | Culturally and Linguistically Appropriate Services

CMTO | Creating Moves to Opportunity

CoC | Continuum of Care

CRS | Congressional Research Service

CSH | Corporation for Supportive Housing

CSS | Community Support Services

DOE | Department of Energy

DOT | Department of Transportation

EHV | Emergency Housing Voucher

EOA | Economic Opportunity Act

FEMA | Federal Emergency Management Agency

Flu LEAD | Flu Linkages to End Access Disparities

FPG | Federal Poverty Guidelines

FQHC | Federally Qualified Health Center

FSS | Family Self-Sufficiency Program

FTA | Federal Transportation Administration

FUP | Family Unification Program

HCV | Housing Choice Voucher

HOPWA | Housing Opportunities for Persons With Aids

HRSA | Health Resources and Services Administration

HUD | Housing and Urban Development

IHBG | Indian Housing Block Grants

IHEC | Inter-departmental Health Equity Collaborative

ITSP | Individual Training and Service Plan

JPI | Jobs Plus Initiative

LIHEP | Low-Income Housing Energy Assistance

MDRC | Manpower Demonstration Research Corporation

MOA | Memorandum of Agreement

MOU | Memorandum of Understanding

MTW | Moving to Work Program

NACHC | National Association of Community Health Centers

NAHASDA | Native American Housing Assistance and Self-Determination Act

NCHPH | National Center for Health in Public Housing

NN | Neighborhood Networks Program

NNCC | National Nurse-Led Care Consortium

OEO | Office of Economic Opportunity

OMB | Office of Management and Budget

OMH | Office of Minority Health

ONAP | Office of Native American Programs

OPIH | Office of Public and Indian Housing

PATH | Place-based Approach to Health

PBRA | Project-Based Rental Assistance

PCC | Program Coordinating Committee

PCMH | Patient Centered Medical Home

PCWA | Public Child Welfare Agency

PHA/HA | Public Housing Agency/ Public Housing Authority

PHPC Section 330(i) | Public Housing Primary Care Program

PSH | Permanent Supportive Housing

PHS | Public Health Service

ROSS | Resident Opportunity and Self-Sufficiency

RRH | Rapid Re-Housing

SDOH | Social Determinants of Health

Section 202 | Supportive Housing for Seniors

Section 811 | Supportive Housing for Persons with Disabilities

URD | Urban Revitalization Department

USDA | United States Department of Agriculture

USICH | U.S. Interagency Council on Homelessness

VA | Veterans Administration

VASH | VA Supportive Housing

WAP | Weatherization Assistance Program

WHO | World Health Organization

WIC | Women Infants and Children nutrition program

YHDP | Youth Homelessness Demonstration Program

REFERENCES

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State Agency Systems Collaboration at the Local Level: Gluing the Puzzle Together, The Staff Perspective: Gabriella Santoro Rado, Doris Hamner & Susan Foley, Doris Hamner, PhD Originally published 7/2004. Institute for Community Inclusion | communityinclusion.org.

HUD Portal | portal.hud.gov/hudportal/HUD?src=/program_offices/public_indian_housing/ program%20s/ph/hope6/css/resources.

Community Action Agencies | capslo.org/what-is-a-community-action-agency.

Strategy Tools for Community Problem-Solving - The Urban Institute Issue Brief – June 2017 - Developing Housing and Health Collaborations: Opportunities and Challenges | Brenda C. Spillman; Josh Leopold, Eva H. Allen, Pamela Blumenthal. June 4, 2017.

Cross-Sector Collaborations And Partnerships: Essential Ingredients To Help Shape Health And Well-Being (Health Affairs) | Vivian L. Towe, Anita Chandra, Laura Leviton, Jennifer C. Sloan, Margaret Tait and Tracy Orleans. NOVEMBER 2016 Free Access | doi.org/10.1377/hlthaff.2016.0604.

Community Problem-Solving Project @MIT.

Congressional Research Service website provides a comprehensive Overview of Federal Housing Assistance Programs.

The Deming Cycle of PLAN- DO -STUDY-ACT (PDSA) is an excellent method for continual improvement of a process or service without spending months planning and discussing.

Diversity, Equity and Inclusion: National Partnership for Action: HHS Action Plan to Reduce Racial and Ethnic Health Disparities, 2011; and The National Stakeholder Strategy for Achieving Health Equity, 2011.

Race, Ethnicity, Culture, and Disparities in Health Care – Institute of Medicine.

Evaluation: Tools and Tips on Evaluation on The Centers for Disease Control and Preventions' web site | cdc.gov/eval/guide/introduction/index.htm.

Federal Housing Assistance Programs: The Congressional Research Service Overview on Federal Housing Assistance Programs and Policy publication dated March 27, 2019.

Final Report of the National Commission on Severely Distressed Public Housing.

FSS Fact Sheet | Provides general Family Self-Sufficiency program information.

FUP Fact Sheet | Provides general information on the Family Unification program.

FUP Awards All Years | Provides a list of PHAs that have been awarded FUP vouchers.

Health Impact Assessment: A Tool to Help Policy Makers Understand Health Beyond Health Care. Annual Review of Public Health 2007; 28:393-412. Retrieved October 26, 2010. Available from | annualreviews.org/doi/abs/10.1146/annurev.publhealth.28.083006.131942.

Healthy People 2020 MAP-IT - Tool Kits (Mobilize, Assess, Plan, Implement, Track). Information about HUD and its programs is available in English and Spanish at | hud.gov | espanol.hud.gov.

Healthy People 2020.

RESOURCES TO SERVE THE UNHOUSED

United To End Homelessness Blog.

Reducing Homelessness With the Housing First Model — Does It Work? By Deborah H. Siegel, PhD, LICSW, DCSW, ACSW, Social Work Today, Vol. 17 No. 5 P. 18 (2021).

Housing First Program - Tsemberis, Kent, & Respress, 2012.

Health Impact Assessment: A Tool to Help Policy Makers Understand Health Beyond Health Care. Annual Review of Public Health 2007; 28:393-412. Retrieved October 26, 2010.

Housing Futures | A blog on housing strategies for cities around the globe.

HUD Collaborations.

HUD Exchange - an on-line platform for providing program information, guidance, services, and tools to HUD's community partners, including state and local governments, nonprofit organizations, Continuums of Care (CoC's), Public Housing Authorities (PHA's), tribes and partners of these organizations.

HUD Portal: HUD web site provides a central location for continually updated links to news, research, reports, guidance, best practices, and other materials related to the provision of community and supportive services for HUD-assisted households.

JOBS PLUS | Helping Public Housing Residents Find and Keep Jobs: A Guide for Practitioners Based on the Jobs-Plus Demonstration. For information about creating a Job-Plus program.

Legal Perspective: Bringing lawyers onto the health center care team to promote patient & community health (NCMLP's Health Center MLP Toolkit, October 2020) MAP-IT Toolkit - A Framework for Implementation.

MAP-IT is a framework that can be used to plan and evaluate public health interventions to achieve Healthy People 2020 objectives. The MAP-IT framework will help you create your own path to a healthy community and a healthier Nation.

MAP-IT SDOH | Link to a Tool kit to learn how to analyze problems, think critically, and generate solutions.

Meetings: Conducting efficient meetings takes practice and ensures that collaborators stay engaged and goals are achieved. The following links provide tips on conducting successful meetings.

- managementhelp.org/misc/meeting-management.htm
- nytimes.com/guides/business/how-to-run-an-effective-meeting
- hbr.org/1976/03/how-to-run-a-meeting

MOUs for partners.

Mobilizing Residents | Tips for mobilizing residents.

MTW Expansion.

Designing & Directing Neighborhood Change Efforts: How to Be More Intentional and Effective. Choice Neighborhoods Resource Guide: Michael Schubert, Principal of Community Development Strategies.

National Center for Health in Public Housing.

National Health Care for the Homeless Council.

National Nurse-Led Care Consortium.

PHA listings by State.

Prevention: The National Prevention and Health Promotion Strategy. The National Prevention Strategy: America's Plan for Better Health and Wellness, June 2011. Social Determinants of Health: Resources regarding the impact of the social environment.

Secretary's Advisory Committee Social Determinants of Health Report

The Community Guide's Model for Linking The Social Environment To Health | Anderson, LM, Scrimshaw, SC, Fullilove, MT, Fielding, JE, Task Force on Community Services.

Urban Institute Issue Brief – June 2017 -Developing Housing and Health Collaborations: Opportunities and Challenges | Brenda C. Spillman, Josh Leopold, Eva H. Allen, Pamela, Blumenthal. June 4, 2017

World Health Organization, Commission on Social Determinants of Health. Closing the Gap in a Generation: Health equity through action on the social determinants of health.

Joint PIH/CPD Notice on Promoting Partners to Utilize Housing as a Platform for Improving Quality of LIfe.

From the Ground Up: Creating Sustainable Partnerships between Public Housing Authorities and Workforce Investment Boards.

TOOLS

Collaboration | Alison Doyle, University of Strathclyde in Glasgow, discusses skills needed for effective collaboration MindTools.com has an excellent short quiz you can take to test your own listening skills.

Communication | The Greater Good Science Center of the University of California, Berkeley has an interesting quiz on how to "read" other people.

Diversity, Equity and Inclusion: Diversity Awareness Quizzes | An EdChange project by Paul C. Gorski.

Emotional Intelligence: MindTools.com has a fun quiz to test your emotional intelligence.

Goal Setting: Tips on defining purpose, addressing needs and setting goals at the following sites

- atlassian.com/blog/productivity/how-to-write-smart-goals
- articles.bplans.com/7-ways-to-set-team-goals-that-actually-work
- wrike.com/blog/science-backed-goal-setting-techniques-need-know-4-avoid-like-plague

Health Impact Assessment: A Tool to Help Policy Makers Understand Health Beyond Health Care. Annual Review of Public Health 2007; 28:393-412. Retrieved October 26, 2010.

Healthy People 2020 MAP-IT Tool Kits (**M**obilize, **A**ssess, **P**lan, **I**mplement, **T**rack) Services

HUD Portal: HUD web site provides a central location for continually updated links to news, research, reports, guidance, best practices, and other materials related to the provision of community and supportive services for HUD-assisted households.

Implementation: MAP-IT Toolkit | **A Framework for Implementation**

MAP-IT | A framework that can be used to plan and evaluate public health interventions to achieve Healthy People 2020 objectives. The MAP-IT framework will help you create your own path to a healthy community and a healthier Nation.

Memorandum of Understanding | Samples for partners.

National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care.
| thinkculturalhealth.hhs.gov/clas.

PIH Notice 2011-51 includes several sample documents that can be used as a reference.

Partnership Assessment Tool for Health | Nonprofit Finance Fund, CHCS, Alliance for Strong Families and Communities | www.chcs.org/media/Partnership-Assessment-Tool-for-Health_-FINAL.pdf.

Problem Solving: MAP-IT SDOH | Link to a tool kit to learn how to analyze problems, think critically, and generate solutions.

Trust Building Activities For Co-Workers/Collaborators.