Integrating to Improve Health:
Partnership Models between Community-Based and Health Care Organizations

Across the US, community-based organizations and health care entities are building new – and redefining existing – relationships with each other to deepen their impact on people's health and quality of life. This resource reflects common approaches organizations are taking to work together to improve outcomes. It delineates broad categories of **service model** (partner service delivery relationship), **financial relationship** (flow of funds between partners), **data** (exchange of information between partners), **partnership effects** (broader impact beyond individuals served), and **governance** (partnership management and oversight). Partnerships may begin with one approach and evolve to a different, or multiple approaches over time. While not all partnerships will fit neatly into the categories below, the matrix is intended to define common characteristics and to establish a unified language and framework for understanding and describing integration between community-based and health care organizations.

Advancing Community-Based Organization and Health Care Partnerships to Address Social Determinants of Health

Health care and community-based organizations (CBOs) across the country are increasingly working together to better address the root causes of poor health among low-income and vulnerable populations. To assist these efforts, there is a need to identify the financial, operational, and strategic considerations necessary to make these partnerships a win-win for all parties: consumers, the communities being served, health care providers, and CBOs. Through support from Kaiser Permanente Community Health, the Center for Health Care Strategies and Nonprofit Finance Fund collaborated to identify new strategies for advancing effective CBO-health care partnerships, building on work done under the *Partnership for Healthy Outcomes* project funded by the Robert Wood Johnson Foundation. This tool is part of a series highlighting and supporting diverse partnership models between CBOs and healthcare organizations.

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Who is this resource for?

- **Partners**: Health care and/or public health providers, administrators, and community-based organizations considering or currently engaging in partnerships with each other
- **Funders**: Public and/or private funders considering or currently supporting integration between community-based and health care organizations
- **Other thought leaders**: Researchers, planners, and policymakers

What are the goals of this resource?

- **For partners**: To provide a common understanding and definitions of partnership structures in planning, implementing, and/or replicating partnership
    - *Example: A community-based organization (CBO) sees its clients struggling with significant health issues while trying to find stable housing and healthy food. The CBO is considering partnering with a health system in order to address the social needs that impact their clients' health and well-being. They would like guidance on how CBOs are partnering with health systems, how leadership is defined, different ways to share data, and how these partnerships are supported.*
- **For funders**: To consider types of support through a framework of the range of partnership models
    - *Example: A funder may be considering supporting partnerships between community-based organizations and health care entities. This framework could address questions such as: How are partners defining leadership and financial structures that support their work together? What are potential effects of partnerships?*
- **For other thought leaders**: To inform the field of health partnership development and implementation
    - *Example: A researcher is looking at the population health impact of health care partnerships. The researcher would like to understand the range of partnership models and their core characteristics. The framework could address questions regarding how partners are relating to each other in terms of service delivery and the structures that govern the partnership.*

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SERVICE MODEL: how services within a partnership function and relate to each other

Partnerships can reflect a primary service and/or multiple overlapping services.

Type	Referral Service	Coordinated Service	Joint Service
Description	Partners link clients to services through sharing client information with each other, and/or providing clients with information about partner services that meet their needs.	Partners coordinate delivery of a complementary set of services for shared clients. Partners actively connect their services, often through roles that strengthen service linkages.	Partners provide services that are co-located and/or jointly staffed and together strengthen care connections and/or service linkages
Examples	In the Health Access Nurturing Development Services (HANDS) partnership, the Louisville Metro Department of Public Health and Wellness (LMDPHW) makes referrals to Family and Children's Place (F&CP) for home visitation services for new or expectant parents. F&CP assesses and addresses parents' needs as a family, develops a family plan, and makes home visits until the child turns three to provide information and linkages to services that support positive birth outcomes and healthy child development.	In the Transitional Respite Care program, Catholic Charities Spokane and Volunteers of America provide transitional care services for patients from Providence Sacred Heart Medical Center. When Medical Center providers discharge patients, social workers connect eligible patients to Catholic Charities, a community-based organization providing short-term housing, meals, and other services to individuals who are homeless. Each partner exchanges health and program-level information with the other in order to tailor care to the specific needs of individuals.	The Ruth Ellis Health and Wellness Center provides co-located services for the LGBTQ community through a partnership between the Ruth Ellis Center (REC) and Henry Ford Health System (HFHS). Primary care, behavioral health, and social services are located in a newly built site where staff from REC and HFHS work together to identify and address patient needs. Both partners participated in developing the center and planning the services provided.

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FINANCIAL RELATIONSHIP: how partnership activities and services are funded			
Partnerships may rely on a combination of funding approaches.			
Type	**Independent Sources or Grants**	**Service Contracts**	**Risk-Sharing or Outcomes-Based**
Description	Each partner may fund their participation through separate resources, or partners might share grants that support partnership activities and services.	Financial support varies based on completed activities and services. Formal agreements between partners define the amount of support provided via government or private fee-for-service contracts, or insurance reimbursement.	Partnership funding is partially or fully based on results. Partners may receive payments based on value, quality metrics, patient outcomes, and/or performance through Accountable Care Organizations, pay-for-performance, or other incentive-based payment models.
Examples	Hunger Free Colorado received initial funds from The Denver Foundation and Kaiser Permanente to address food insecurity among Coloradans, including creating a hotline that connects residents with federal, state and local food resources, such as the Supplemental Nutrition Assistance Program (SNAP) and Women, Infant and Children's Nutrition Services (WIC), and area food banks. Health care providers also screen patients for food insecurity and referring residents to Hunger Free Colorado for nutrition support. Additional grant funds cover ongoing costs of the hotline.	Eastern Virginia Care Transitions Partnership (EVCTP), working to improve health for seniors and reduce hospital and nursing home readmissions, is funded by agreements with health plans and health systems, as well as through government grants. Three health plans provide fee for service reimbursement for care transitions, care coordination, and in-home assessment support. Health systems provide funding for special projects such as enhanced chronic disease management and emergency department diversion.	The Bridges to Health Pathways program in Oregon focuses on improving client health and well-being. Pathways is a centralized system for care coordination, wherein Community Care Agencies (clinics, health departments, social service agencies) contract with a hub, the Columbia Gorge Health Council. These agencies help coordinate needed services for clients and their households. A portion of the payment to the agencies by the Council are contingent upon achieving evidence-based outcomes.

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DATA: how partners interact with data from their target population			
Partnerships connect data, with variation in usage, access, systems, and reporting.			
Type	**Reporting Only**	**Partial Access**	**Full Access**
Description	Partners report data to a central system or lead agency after services are provided. Partners review program-level data independently and/or together.	Partners share patient-level data with limited access to view full records and/or input data. Partners maintain separate systems to track data and provide regular program updates to each other.	Partners can fully view and input patient-data in real time, often through a joint data system. Partners regularly review program-level and/or outcomes data to inform decision-making.
Examples	In the Health Access Nurturing Development Services (HANDS) partnership, the community-based Family & Children's Place (F&CP) receives client referrals from a variety of sources. After each client encounter, HANDS submits data to the Louisville Metro Department of Health and Wellness (LMDHW) that includes, for example, progress towards goals, referrals provided, and client challenges (e.g., substance use, mental health/depression, access to transportation). Staff meet quarterly with the LMDHW to review outcomes, incidents, and accidents, and strategize on addressing client challenges.	Project Access NOW's Community Assistance Program (C3CAP) facilitates safe transitions from hospital discharge to home, connecting low-income patients to resources such as transportation and temporary housing. C3CAP has a secure, web-based platform that allows staff to screen for eligibility, make referrals to services, and provide vouchers to patients to pay for such services. The platform allows each health system partner to tailor screening tools and monitor data on their patients' use of community services.	In 2-1-1 San Diego's Community Information Exchange, participants (health systems, health plans, and community service providers) can choose from three tiers of service and support. Tier 3, the highest level, enables participants to view and share client information, use a Risk Rating Scale to assess client vulnerability, view progress receiving services and care, and make bi-directional referrals to community partners. Partner providers can share client data in this secure, cloud-based platform.

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PARTNERSHIP EFFECTS: beyond individuals served			
Partnerships may impact multiple levels of change.			
Type	**Partner Level**	**Community Level**	**Policy and/or Systems-level Change**
Description	Partners build their existing organizational capacity (e.g., staff, service, technological, network, financial) and/or establish new capacities.	The partnership develops new ways of working across and within the community, strengthening connections among service providers, with funders, between social service agencies and health systems, with academic research centers, and/or with government agencies.	The partnership advances policy changes, influences payment and financing models, and/or contributes to the evidence base of integrated approaches to inform research and practice.
Examples	Project Access NOW's Community Assistance Program connects eligible patients to an array of services and programs, using a voucher system, to ensure successful discharge from the hospital. Frontline hospital staff receive training and support to screen for patient social service needs and use the online referral platform. Through this data platform, health care partners monitor social service utilization and related costs, and evaluate patient outcomes. The data enables health systems to track utilization and monitor user activity.	Through 2-1-1 San Diego's Community Information Exchange (CIE), hospitals and service providers access their clients' histories, a comprehensive assessment and rating of risk level, and case management. The CIE provides community case planning, facilitates and strengthens care connections in the community, and reduces duplicated effort. 2-1-1 San Diego provides care coordination support to multiple health care partners and leverages the CIE to help with care coordination, making linkages with needed community supports and providing assistance with benefits enrollment.	Eastern Virginia Care Transitions Partnership (EVCTP) has achieved significant savings by reducing 30-day hospital readmissions rates. Based on this success, EVCTP has informed the state's approach to managing long-term services and supports. Furthermore, health plans and health systems in several other states, including Maine and Ohio, are partnering with local Area Agencies on Aging (AAAs) to coordinate and deliver in-home and community-based services.

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GOVERNANCE: norms, agreements, and processes that guide decision-making			
Governance structures outline different rules and accountability mechanisms across partnerships.			
Type	**Informal**	**Negotiated Agreements**	**Shared Accountability**
Description	The partnership functions without a formal governance structure. Partners operate without formal agreements on leadership structure.	The partnership has a leadership structure governed by formal agreements, with one organization serving as the lead or accountable party.	Partners share leadership and accountability (legal, financial, etc.) through formal agreements, possibly including a joint board and/or a distinct backbone entity.
Examples	Hunger Free Colorado has partnerships with health plans and medical providers to connect Coloradans to food insecurity resources. In lieu of a governance structure across partners, Hunger Free Colorado holds regular calls with partners to provide updates, share data and problem solve any challenges. Hunger Free Colorado also partners with counties and the state benefit system to share data on benefit access.	2-1-1 San Diego serves as a single access point for those in need of health and social services. For its Community Information Exchange (CIE), 2-1-1 San Diego is the lead partner, and network partners (e.g., hospitals, health plans, social service providers) sign agreements such as Memoranda of Understanding (MOUs) and/or Business Associate Agreements (BAAs) to participate.	The Ruth Ellis Health and Wellness Center, an integrated care model for the LGBTQ community, is governed by a joint board of the Ruth Ellis Center and the Henry Ford Health System. The partners follow an MOU that outlines the responsibilities and expectations for each organization, including services, meeting compliance standards, staffing, training, and bill collection.

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Advancing Community-Based Organization and Health Care Partnerships to Address Social Determinants of Health

This tool is part of *Advancing Community-Based Organization and Health Care Partnerships to Address Social Determinants of Health,* a project of the Center for Health Care Strategies and Nonprofit Finance Fund made possible through support from Kaiser Permanente Community Health. Resources include:

- **Case studies** featuring a partnership in Colorado that is improving access to nutritious food for vulnerable populations, a collaboration in San Diego, California that is using an online Community Information Exchange to allow health and social service providers to facilitate care coordination for at-risk community members, and a collaborative effort in Portland, Oregon that is seeking to improve care transitions from emergency and inpatient hospital settings for uninsured and low-income individuals,
- **Technical assistance resources** that can be used to establish a common language and framework among partnering organizations, articulate the value of collaborative relationships, and determine total costs for cross-sector partnerships.

To learn more, visit www.nff.org or www.chcs.org/cbo-collaborate.

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