LOCAL IMPLEMENTATION OF FEDERAL STRATEGIC PLANS: THE ROLE OF THE HEALTH CARE FOR THE HOMELESS PROGRAM IN *OPENING DOORS*

Katherine Fox Nagel

A dissertation submitted to the faculty at the University of North Carolina at Chapel Hill in partial fulfillment of the requirements for the degree of Doctor of Public Health in the Department of Health Policy and Management of the Gillings School of Global Public Health.

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Approved by:

Thomas C. Ricketts

Francis Afram-Gyening

Suzanne Havala Hobbs

Darlene M. Jenkins

Bryan Weiner

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ABSTRACT

Katherine Fox Nagel: Local Implementation of Federal Strategic Plans:
The Role of the Health Care for the Homeless Program in *Opening Doors*
(Under the direction of Thomas C. Ricketts)

Background Care for the homeless coordinated in communities across multiple sectors and services is essential given the complex nature of their problems and environments. *Opening Doors* is the first comprehensive national strategic plan to prevent and end homelessness at the community level. It is a joint action plan for federal agencies and local and state partners. This study explores factors that drive successful implementation of a federal plan at the local level, specifically focusing on the feasibility of local implementation of *Opening Doors* and the role of the federal Health Care for the Homeless program.

Methods This study addressed the overarching research question: *How best can local communities support implementation of federal public health strategic plans?* A systematic literature review was conducted to determine characteristics of successful local community health improvement partnerships. Key informant interviews were also conducted with selected leaders of Health Care for the Homeless organizations and local government homeless services directors. These provided insights into perceptions, programmatic strategies and barriers to community-based collaboration, coordination of homeless services and implementation of *Opening Doors.*

Results Findings provided a Framework for Successful Community Partnerships – a checklist of 'must-haves' for local health-related partnerships working together on community

health improvement. Data suggest that local communities will not support federal plans without required resources or incentives, appropriate alignment and recognition of local priorities and efforts, and/or expected compliance or enforcement.

Conclusions The success of *Opening Doors* will depend on successful recognition of the reality of local priorities and alignment of funding to support its goals.

Dedicated to Sean, James and Emerson

For my grandmother, parents, siblings and the ever-expanding Burns-Fox-Nagel family

In honor of my grandfather, Kenneth Jones Burns, Jr. (10/3/26–11/9/12)

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LIST OF ABBREVIATIONS

ACA	Affordable Care Act
AHAR	Annual Homeless Assessment Report
ARRA	American Recovery and Reinvestment Act
CoC	Continuum of Care
ED/CEO	Executive Director / Chief Executive Officer
FQHC	Federally Qualified Health Center
GAO	Government Accountability Office
HCH	Health Care for the Homeless
HEARTH	Homeless Emergency Assistance and Rapid Transition to Housing
HHS	Department of Health and Human Services
HMIS	Homeless Management Information System
HRSA	Health Resources and Services Administration
HUD	Department of Housing and Urban Development
IRB	Institutional Review Board
NACHC	National Association of Community Health Centers
NEOCH	Northeast Ohio Coalition for the Homeless
PCMH	Patient Centered Medical Home
PHS	Public Health Service
SAMHSA	Substance Abuse and Mental Health Services Administration
SMI / SPMI	Severe Mental Illness / Severe and Persistent Mental Illness
USICH	United States Interagency Council on Homelessness
VA	Department of Veterans Affairs

DEFINITION OF TERMS

HEALTH

"Health is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity."[1]

HOMELESSNESS

As outlined by the National Health Care for the Homeless Council, there is more than one definition of homelessness and different federal agencies use different definitions to determine eligibility, service delivery and funding.[2] Health centers funded by the U.S. Department of Health and Human Services (HHS) use the following definition, as does this dissertation:

> *A homeless individual is defined in section 330(h)(4)(A) as "an individual who lacks housing (without regard to whether the individual is a member of a family), including an individual whose primary residence during the night is a supervised public or private facility (e.g., shelters) that provides temporary living accommodations, and an individual who is a resident in transitional housing." A homeless person is an individual without permanent housing who may live on the streets; stay in a shelter, mission, single room occupancy facilities, abandoned building or vehicle; or in any other unstable or non-permanent situation. [Section 330 of the Public Health Service Act (42 U.S.C., 254b)]*
>
> *An individual may be considered to be homeless if that person is "doubled up," a term that refers to a situation where individuals are unable to maintain their housing situation and are forced to stay with a series of friends and/or extended family members. In addition, previously homeless individuals who are to be released from a prison or a hospital may be considered homeless if they do not have a stable housing situation to which they can return. A recognition of the instability of an individual's living arrangements is critical to the definition of homelessness. (HRSA/Bureau of Primary Health Care, Program Assistance Letter 1999-12, Health Care for the Homeless Principles of Practice)*

CHAPTER 1: Introduction

Homelessness is a significant problem affecting the health of urban populations. The Handbook of Urban Health proposes studying urban health both by describing the health of urban populations and understanding how the determinants and characteristics of cities affect health.[3] Further, the ecological model of public health focuses on exploring health through the linkages across social, physical and political contexts; the interaction of which is only magnified in urban cities.[4 5] This approach is essential when exploring the health of vulnerable populations, such as the homeless who tend to congregate in the urban core of cities of all sizes; according to the National Coalition for the Homeless, 70% of the nation's homeless are found in cities.[6] Populations living in areas of concentrated poverty experience significant health disparities. The combination of poverty, its concentration, and a lack of services are thought to be the major drivers of health disparities, which further perpetuate poverty.[7]

Coordinated delivery across the multiple health sectors and services for the homeless within a community is essential given the complex nature of the environment in which they live and the complexity of their problems. From the perspective of a community health center, this set of services includes primary, specialty and emergency medical care; mental health care; social services; and shelter and housing services. The homeless are a vulnerable population with especially poor health outcomes and comorbidities. Homelessness is the "…result of a complex interaction between individual vulnerabilities and the structural forces in the urban environment."[8] In his 2009 doctoral dissertation exploring health care utilization of Cleveland's homeless population, Evan Cecil Howe found that "Health care utilization in the homeless

population involves seeking care from multiple health care providers. In order to more effectively structure care, these service providers should increase joint planning and communication and examine ways to design systems of care that will direct individuals to appropriate and cost-effective sources of care."[9]

Opening Doors, or "the Plan", is the first comprehensive national strategic plan to prevent and end homelessness at the community level. It was authored by the United States Interagency Council on Homelessness (USICH), a coalition of 19 federal agencies responsible for coordinating the federal response to homelessness, following a directive from Congress to develop such a plan in the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act. *Opening Doors* is structured as a joint action plan for federal agencies and local and state partners concerned with homelessness. The Plan is divided into five themes supporting four goals and the ultimate vision of ending homelessness in the United States.[10] USICH presented the Plan to President Barack Obama and Congress in June 2010.[11]

According to the National Coalition for the Homeless, "Homelessness results from a complex set of circumstances that require people to choose between food, shelter, and other basic needs. Only a concerted effort to ensure jobs that pay a living wage, adequate support for those who cannot work, affordable housing, and access to health care will bring an end to homelessness."[12]

Dissertation Aims and Research Question

A bold federal strategic plan such as *Opening Doors* relies on local implementation to achieve its goals. As such, the purpose of this study is to explore factors that drive successful implementation of a federal plan at the local level. Specifically, this study will explore the feasibility of local implementation of *Opening Doors* as it applies to the Health Resources and

Services Administration (HRSA) funded Health Care for the Homeless (HCH) Program, the community health center grantees funded to provide comprehensive care to homeless persons, serving more than 1.1 million in 2012.[13] This dissertation focuses on the Plan's themes and objectives specific to leadership, collaboration and health care (*Opening Doors* Theme 1 and Theme 4), further narrowed based on relevancy to Care Alliance Health Center, a federally qualified health center (FQHC) providing care to the homeless and those living in and around public housing in the Greater Cleveland community.

Through a systematic literature review and interviews with local homeless service organization leaders, I will answer an overarching research question, *How best can local communities support implementation of federal public health strategic plans?*, through the following study steps:

1. Review academic literature to determine characteristics of successful local community health improvement partnerships
2. Conduct key informant interviews to outline the status of local implementation of *Opening Doors*, including perceptions, programmatic strategies and barriers to implementation
3. Define a role and make recommendations for the HCH Program, and specifically outline recommendations for Care Alliance Health Center and the Cleveland community

As the only Cleveland-area health center designated by the federal government to provide health care to the homeless, Care Alliance has an opportunity to make a significant impact on health care utilization for individuals that both complements other proactive local initiatives and can improve residents' health and economic well-being. Locally, there is a push for more enhanced collaboration among homeless service providers as a result of the evolving, more

comprehensive needs of Cleveland's homeless population (the largest in Ohio), a state of Ohio initiative to designate community behavioral health providers as 'Health Homes' for Medicaid patients by integrating primary care, and the federal emphasis on permanent supportive housing as a solution to ending chronic homelessness. Coordination of health, housing and human services is at the core of the Plan, yet Cleveland has not signed on as an *Opening Doors* Community; it is an aim of this study to help determine why.

Background

Residents of Cleveland, Ohio's poorest neighborhoods are victims of the "urban health penalty" – a term that describes the greater prevalence of health problems in inner-city areas, particularly among the urban poor.[14] Minority populations in urban neighborhoods have significantly higher rates of chronic and fatal diseases, reflecting marked disparities in community health, socioeconomics, and educational attainment. One large-scale epidemiologic study found that the urban poor in northern cities like Cleveland and Detroit have higher rates of morbidity and mortality than the national average.[15] In the greater Cleveland region, for example, life expectancy is 89 years in Lyndhurst, an eastern suburb, versus just 64 years in Hough, an inner-city neighborhood.[16] These neighborhoods are 8 miles apart. There are many reasons for this inequity, including limited access to nutritious foods, lack of employment opportunities, and general feelings of hopelessness.[17]

Compounding this issue is the fact that our nation's health care system struggles to adequately care for our inner-city populations whose higher rates of chronic disease and mental illness are amplified by a lack of access to affordable, quality health care. In addition, the current 'system' is characterized by segmented delivery and financing of sectors relating to health – social services, public health, behavioral health, and primary care. This disconnect results in

isolated service delivery that fails to integrate the person and their social context into their evaluation and care process. From a patient perspective, it is time consuming and challenging to navigate this landscape of care, even for those with familiarity of the health system. Furthermore, for those who lack education and health knowledge, are uninsured, homeless and may also lack transportation, this environment appears alien and unsupportive.

The deteriorating economic climate during the great recession has affected many communities across the country and led to an increase in unmet need for affordable health care. The economic recession hit Cleveland especially hard, and recent estimates place poverty levels in the city upwards of 35%. There are roughly 52,000 residents of public housing in Cuyahoga County and an estimated 4,000 individuals experiencing homelessness on any given night in the county.[18] [19] Over the last few years, the local media, namely *The Cleveland Plain Dealer,* has reported on local health care systems as they shut down or reduce their urban operations and focus their expansion in the suburbs, where more patients are insured (including the county hospital system MetroHealth, the Cleveland Clinic, and University Hospitals). Those hospitals that do remain in urban areas provide care to the uninsured primarily through their Emergency Departments have steep co-pays and often difficult-to-navigate charity care policies or patient financial rating systems. Combined with significant cuts to behavioral health, education, transportation and safety-net services, these factors have increased the strain on the existing capacity of organizations like Care Alliance and pressed the need for creative community partnerships to serve our patient populations effectively.

Furthermore, with the high cost of health care directly contributing to and exacerbating poverty, an individual's financial challenges can then spiral to include lost savings, bankruptcy, eviction, and ultimately homelessness.[20] Evidenced by a 2007 Kaiser Family Foundation study,

"Despite substantial health need, low-income adults without insurance coverage have less access to primary care and preventive services and greater unmet need due to cost . . . Medical bills can have a significant impact on low-income adults' financial situations because low-income adults who are uninsured or have Medicaid often experience difficulties paying basic living expenses, which leaves them less able to pay unpredicted health expenses."[21] Primary health care clinics like Care Alliance change this scenario so that individuals can access appropriate, high-quality, affordable health care.

Cuyahoga County's Homeless Population

Historically, Cuyahoga County, Cleveland's surrounding county, far outpaces the state in total numbers of general and chronic homeless people. In 2012, of the 2191 homeless persons in Cuyahoga County, 375 were chronically homeless, representing the highest in the state.[22] Table 1 describes the homeless population in Ohio comparing the eight urban Continua of Care to the rural, 80-county Balance of State Continuum of Care.[23] Despite a consecutive three-year decline (2010-2012), Cuyahoga County has the highest percent of homelessness in Ohio at 16%. Cuyahoga County's share of Ohio's homeless population (16%) is higher than its share of Ohio's total population (11%).[24] According to the Northeast Ohio Coalition for the Homeless (NEOCH), the numbers are even higher: "There are more than 22,000 people homeless every year or 4,000 to 4,300 homeless every night in Cleveland. In 2011, estimates show 22,500 people were homeless [(doubled up and shelter users)] in Cuyahoga County..."[25]

Table 1. *The Homeless Population of Ohio*

Continuum of Care	Total # of homeless persons	% of Ohio's homeless population	% of Ohio's total population
Cuyahoga County	2,191	16%	11%
Hamilton County	1,654	12%	7%
Franklin County	1,434	10%	10%
Montgomery County	1,081	8%	5%
Lucas County	977	7%	4%
Summit County	813	6%	5%
Stark County	482	3%	3%
Mahoning County	224	2%	2%
Balance of State	5,121	37%	53%

Research shows that individuals experiencing homelessness have a life expectancy as low as 41 years, are three to six times more likely to become ill and three to four times more likely to die than individuals with homes.[26] [27] This includes presentation of a wide range of co-occurring and complex illnesses, which are exacerbated by a homeless person's inability to access care to remedy illness. Preventive health care falls low on a person's priority list when faced with finding a safe place to sleep, struggling with untreated mental illness or dealing with the fallout from assault or other trauma.

Other barriers to care facing individuals experiencing homelessness include chronic substance abuse and severe mental illness. Cuyahoga County has the highest percentage of individuals who are homeless and severely mentally ill (SMI) or chronic substance abusers, despite a 7% decrease in 2010.[28] In 2010 approximately 40% of Cuyahoga County's homeless population struggled with chronic substance abuse.[29] Mental illness may cause people to push away from caregivers, often making it even more difficult for an individual experiencing homelessness to receive medical treatment and for health care personnel to provide it effectively. Additionally, due to the transient nature of the homeless population, it is challenging to sustain the long-term treatment required to manage mental illness as well as other physical health issues.

Research indicates that individuals with severe mental illnesses and individuals with substance abuse disorders experience poor health outcomes. Those with schizophrenia and other psychotic disorders are two to three times more likely to have cardiovascular and metabolic diseases, have a 20% shorter life expectancy and are twice as likely to die earlier than individuals in the general population.[30] [31] Yet, when individuals with these illnesses are able to obtain supportive housing, their health and stability improve dramatically. One example is the Hospital to Home project in Minneapolis, where participants placed in supportive housing used emergency rooms less, had fewer inpatient hospital stays and higher ratings of self-sufficiency.[32]

Common lifestyle factors associated with homelessness are detrimental to the homeless population's health and can hinder access to care. Lifestyle factors may include prolonged exposure to severe weather, walking great distances to obtain services, living in communal environments and reduced access to care due to a lack of health insurance or personal identification. As a result, individuals experiencing homelessness are at high risk of contracting or exacerbating serious health conditions, are often treated at later stages of disease, and have higher mortality and chronic morbidity than individuals with access to consistent health care.

The Federal Response: The Health Care for the Homeless Program

In the mid-1980s in response to a rapidly growing homeless population across the country, the Robert Wood Johnson Foundation, Pew Charitable Trust and U.S. Conference on Mayors launched an initiative to demonstrate a new way of reaching out to this disenfranchised population – through health care. In 1984, based on the work of Philip Brickner, MD and St. Vincent's Hospital in New York City, "Health Care for the Homeless" programs were funded in nineteen cities across the country: Albuquerque, Baltimore, Birmingham, Boston, Chicago, Cleveland, Denver, Detroit, Los Angeles, Milwaukee, Nashville, New York, Newark,

Philadelphia, Phoenix, Saint Louis, San Antonio, Seattle, and Washington DC.[33] The overarching goal of the HCH Demonstration Project was to increase the availability of health care and social services for homeless people through enhanced coordination across street outreach, integrated primary care and behavioral health and social services. Care was delivered in teams comprised of physicians, nurses and social workers. Long-deemed successful, results of the project are documented in peer-reviewed journals and the following books:

- *Under the Safety Net: The Health and Social Welfare of the Homeless in the United States*, Philip W. Brickner et al, eds. New York: United Hospital Fund, 1990.
- *Address Unknown: The Homeless in America*, James D. Wright. New York: Aldine de Gruyter, 1989.

Unfortunately, much of the homeless population in the United States continues to live without governments' safety net of insurance coverage, mental health benefits, housing assistance programs and social welfare services, mainly due to eligibility criteria, illustrated by the following key findings of the demonstration project:

- Poverty is identified as the ultimate cause of homelessness: eliminate poverty, eliminate homelessness
- Most homeless individuals deemed eligible are in fact receiving social welfare benefits; the issue is the criteria itself removes the homeless from consideration

Most importantly, the original HCH Demonstration Project laid the groundwork for the federal government's Stewart B. McKinney Homeless Assistance Act of 1987, the first major legislation and infusion of federal dollars in local communities across the country to address access to health care for the homeless.[34] The McKinney Act's Title VI formally established The Health Care for the Homeless (HCH) Program under Section 330 of the Public Health Service (PHS) Act, responsible for the primary health care needs of the homeless.[35] The HCH Program was

then reauthorized in 1996 under section 330(h) of the PHS Act (Health Centers Consolidation Act), and still provides funding for over 200 program grantees today (reauthorized again in 2002, 2008, and most recently with the authorization of the HEARTH Act).[36]

The National Association of Community Health Centers (NACHC) describes the Health Care for the Homeless program this way: "The HCH program emphasizes a multi-disciplinary approach to delivering care to homeless persons, combining aggressive street outreach with integrated systems of primary care, mental health and substance abuse services, case management, and client advocacy. Emphasis is placed on coordinating efforts with other community health providers and social service agencies."[37]

United States Interagency Council on Homeless and *Opening Doors*

The 1987 McKinney Act also established the Interagency Council on Homelessness (renamed United States Interagency Council on Homelessness, USICH, in a later reauthorization), "an 'independent establishment' within the executive branch to review the effectiveness of federal activities and programs to assist people experiencing homelessness, promote better coordination among agency programs, and inform state and local governments and public and private sector organizations about the availability of federal homeless assistance."[38] USICH is comprised of 19 federal agencies responsible for carrying out its mission "…to coordinate the federal response to homelessness and to create a national partnership at every level of government and with the private sector to reduce and end homelessness in the nation while maximizing the effectiveness of the Federal Government in contributing to the end of homelessness."[39]

The most recent reauthorization of the McKinney Act in May 2009, the HEARTH Act, updated the Department of Housing and Urban Development (HUD) definition of homelessness,

called for the development of a strategic plan (*Opening Doors)*, and emphasized the federal government's support of permanent supportive housing as a key intervention to ending chronic homelessness. This represents a shift from funding individual programs that manage homelessness to developing coordinated, evidenced-based practices that work to end homelessness. For those experiencing chronic homelessness—defined as at least one year of continuous homelessness or at least four separate episodes of homelessness over three years and a disabling condition—permanent supportive housing is the proven approach to ending their homelessness and helping them regain their health and stability. This approach is a key strategy of *Opening Doors.*

The architects of *Opening Doors,* USICH sought external expertise during the Plan's development, receiving input from over 750 individuals representing advocates, consumers, researchers and leaders in the homeless field. In addition, public comments were accepted. Input was sought to generate local buy-in from the beginning, as USICH's goal was to develop a strategic plan that would be incorporated in local responses to ending homelessness. Documentation of the process is catalogued and available on USICH's web site (http://usich.gov/opening_doors/building_the_plan/). Following this intensive development phase, *Opening Doors* was presented to President Barack Obama and Congress in June 2010, and two annual updates have been released.

Opening Doors outlines targeted, solutions-driven goals within a roadmap for joint action and priorities for USICH agencies. The intent is to guide local programs and budgets and stresses cost-effective use of federal funding by aligning program activities with the following goals and themes, with progress tracked through nationally-collected measures. The goals, themes and measures are listed in Table 2.

Table 2. *Goals, Themes and Measures of Opening Doors*

Goals	
1. Finish the job of ending chronic homelessness by 2015 2. Prevent and end homelessness among Veterans by 2015 3. Prevent and end homelessness for families, youth, and children by 2020 4. Set a path to ending all types of homelessness	
Themes	
1. Increase leadership, collaboration, and civic engagement 2. Increase access to stable and affordable housing 3. Increase economic security 4. Improve health and stability 5. Retool the homeless crisis response system	
Measure	**Data Source**
Change in the number of individuals experiencing chronic homelessness	HUD Annual Homeless Assessment Report to Congress (AHAR) point-in-time measure
Change in the number of Veterans experiencing homelessness	HUD AHAR point-in-time count
Change in the number of households with children experiencing homelessness	HUD AHAR point-in-time count
Change in the total number of people experiencing homelessness	• Department of Education data on homeless school-age children • Data from the Department of Veterans Affairs (VA) on homeless Veterans • Broader economic indicators around poverty and the gap between housing costs, incomes, and available affordable housing
Change in the number of permanent supportive housing units (nationally)	• HUD annual housing inventory charts • Homeless Assistance Grants Continuum of Care (CoC) process
Change in the number of households exiting homeless assistance programs with earned income and/or mainstream benefits	• HUD grantee Annual Progress Reports • HUD Homeless Assistance Grants • Participation in Medicaid, Supplemental Nutrition Assistance Program, Supplemental Security Income and Social Security Disability Insurance, and Temporary Assistance for Needy Families

For the vision and goals of *Opening Doors* to be realized, local implementation must be achieved. In 2011, USICH established the Opening Doors Across America[40] campaign to encourage communities to implement the plan locally. Specifically, USICH recommends communities should:

1. Align local efforts with Opening Doors: Adopt the four goals in *Opening Doors*.
2. Set targets and measure results: Set incremental targets and use data to measure progress.
3. Act strategically: Collaborate, invest, and act on strategies that are proven to make an impact.
4. Partner: Convene state and local interagency councils to coordinate activities and resources and participate with USICH and jurisdictions across the country to collaborate and succeed in ending homelessness.

On the "Resources" section of their web site, USICH has included a number of toolkits to aid local communities. Among these is "Local and Community Strategic Planning", which calls on communities to align existing planning endeavors and/or develop community strategic plans with the goals and strategies of *Opening Doors.*[41] Also on the web site are examples of how local communities are implementing the Plan. However, despite providing this guidance, there is not a list of participating communities, and it is unclear the number of communities that have either signed on to Opening Doors Across America or are working collaboratively to implement the Plan itself.

While improving health care and health status is a component of the Plan, with the recommended strategies for this goal clearly outlined, the specific role of the HCH program in its implementation is not. Not only does this leave room for interpretation, but also discourages participation in local implementation efforts, especially with a backdrop of uncertain federal funding, competition for time and resources, and an ever-increasing demand for services. Organizations that should be involved include community health centers and FQHCs,

specifically those with the HCH designation; Emergency Departments of hospitals in urban areas; subsistence and social support agencies; and municipal and county government. Stakeholders represent individuals from these organizations, in addition to the urban planning departments, and in a broader sense, the urban area's external image since perceptions of the aggressiveness of the homeless can negatively impact the image of residents and visitors.

The Local Response: Care Alliance Health Center

Care Alliance is a nonprofit, Federally Qualified Health Center (FQHC) focusing on the unique health care needs of the homeless, individuals living in public housing, and the underserved for over 25 years. Our mission is to provide high-quality, comprehensive medical and dental care, patient advocacy, and related services to people who need them most, regardless of their ability to pay. Supporting individuals to take charge of their health enables them to obtain or maintain stable housing and increases their self-esteem and employability, as witnessed by our track record and success stories.

Care Alliance's history begins in the mid-1980s in response to a rapidly growing homeless population across the country as one of the original HCH demonstration projects, described above. In 1985, Care Alliance first emerged as "Cleveland Health Care for the Homeless." In 1993, Care Alliance became an independent, nonprofit organization. In 1998, we extended our target population to include those living in public housing, expanding our health care services to another medically underserved population. In 2000, through funding provisions of the Ryan White Care Act, we added services for individuals living with HIV/AIDS including confidential HIV testing and treatment and counseling for HIV positive patients. In 2002, we added comprehensive dental services to work further toward serving our patients holistically.

Today Care Alliance operates three clinics in Cleveland, one downtown and two within public housing estates on the east and west side of town, and a series of strategically-located outreach clinics. We continue to strive to meet the individual challenges facing our patients with services beyond the scope of primary medical and dental care. When treating patients, we offer supportive resources such as short-term mental health and substance abuse counseling, medical case management, eligibility support, and patient assistance program enrollment. The Care Alliance homeless outreach team provides basic street-level primary care, resources for housing and even simple hygiene items, clothing, and blankets to patients at shelters, treatment centers, and homeless campsites to build trust and develop an entry point to care. Through hard work and dedication to the needs of the Cleveland community, Care Alliance has become a well-respected and integral member of the local system of safety-net providers.

Programs, Services and Patient Needs

There is significant need for affordable, accessible care among Care Alliance's target patient populations. As a result, much of the care provided is reactive and of urgent importance for patients' lives. In 2012, Care Alliance served 9,600 patients through over 35,000 unique visits. At Care Alliance, 94% of patients live below 100% of the Federal Poverty Level, 79% have no health insurance and more than half of our patients are experiencing homelessness. Our patient base continues to be characterized by a high percentage of minority male patients. Of the medical patients seen by a provider in 2012, 47% had at least one chronic disease diagnosis, including asthma, chronic bronchitis, hypertension, diabetes and heart disease. In addition to the many challenges that come with managing a chronic illness, lacking stable housing brings on additional challenges such as trying to manage a medication regimen and eating a balanced diet.

As our patient data from 2012 suggests, most of our patients do not have the financial means to pay the full cost of the comprehensive services. Care Alliance charges for services on a sliding fee scale based on income, often providing care without any reimbursement. We also assist patients with free or low-cost prescriptions. While our medical department continues to encounter a high demand for services, our dental department in particular has experienced a greater demand than can be met. Oral health continues to be the number one unmet health care need for uninsured Northeastern Ohioans.

Connecting individuals to health care and supportive services is vital to increasing economic stability and independence. The services that Care Alliance provides include primary medical care; preventive, restorative, and rehabilitative dental care; wrap around services such as benefit assistance and pharmaceutical assistance, support for managing chronic illnesses like diabetes and hypertension, and care coordination or medical case management. Most Care Alliance patients have gone years without regular medical care. They may come to the clinic for an illness or pain that can no longer be ignored, only for us to uncover ongoing, unchecked health issues. While Care Alliance clinical staff are adept at treating these conditions, the path to health and stability frequently requires patients learning a new way to obtain medical care while addressing broader social, physical, environmental, and economic factors impacting health. We deliver care through the Patient Centered Medical Home (PCMH) model with an increased emphasis on care coordination to support our patients and address the underlying social determinants of health.

For populations with fewer health issues and few compounding challenges like lack of income, housing, and employment, care coordination is mostly limited to helping individuals understand their care and use it appropriately. Care Alliance has innovatively applied care

coordination and the PCMH model to homeless populations, ensuring patients are in stable housing, have access to food, have personal identification, and are managing their chronic illnesses. Care Alliance has excelled at this application of care coordination, particularly for our homeless patients who are overwhelmingly chronically ill and have little stability in their lives.

Growth and Expansion

Over the last year, Care Alliance responded to our patient needs and the changing face of health care by implementing clear and efficient programs and strategies aimed at enhancing and expanding patient-centered care for our patients, culminating in Level III Recognition as a Patient Centered Medical Home by the National Committee for Quality Assurance. Currently, we are engaged in a number of strategic initiatives to ensure holistic and quality care for our patients as we enter a phase of immense growth and expansion.

Care Alliance has made ambitious plans for the future which include constructing a new 30,000 square foot clinic in the Central neighborhood, and renovating our Riverview Tower Clinic in Ohio City. These new sites are poised to add over 60 additional staff and serve over 15,000 new patients. In addition Care Alliance recently implemented an Electronic Dental Record, fully integrated with our existing Electronic Medical Record (EPIC). We are hosting our first residents as part of a partnership with the University Hospitals Case Medical Center Department of Family Medicine to train the next generation of providers committed to urban health. We continue to build partnerships that support better, more holistic health care such as our primary care-behavioral health integration initiatives with community mental health organizations.

As we are confident that affordable health care will remain a great need in our community, Care Alliance recognizes the need for an organizational strategy that promotes the

expansion of our services and builds our capacity with strategic foresight. We are well aware that all these initiatives must synergistically work together or they will compete against one another for valuable time and resources. As such, we launched a strategic planning process in January 2013. Working with nationally-recognized health care consultants John Snow, Inc., Care Alliance laid out a six-to-nine month process to work through these new initiatives, design a very detailed short-term (1-2 year) action plan, and develop an overarching five-year strategic plan. We are currently in the process of finalizing the deliverables. Three priorities emerged as a part of this process:

1. Stay True to the Homeless Mission
2. Meet Unmet Need
3. Maximize Current Capacity

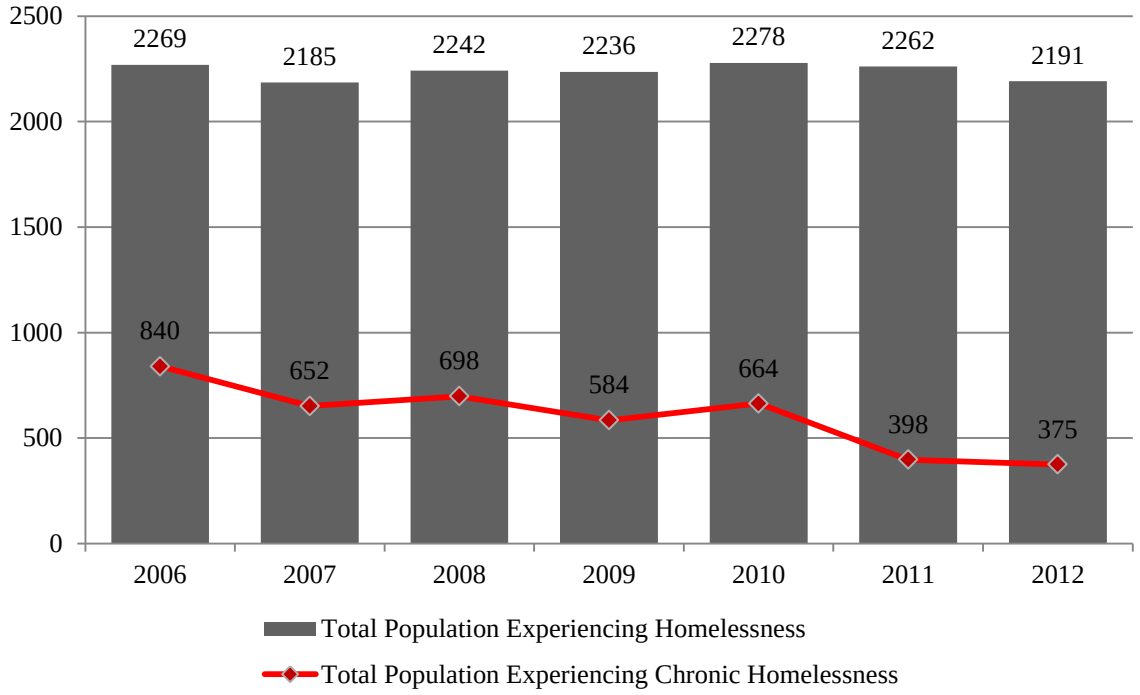
The Care Alliance strategic planning process focused on long-term sustainability of operations, with contingencies for potential changes in the health care environment. Care Alliance is committed to continuing to identify opportunities to improve efficiency and effectiveness through collaborations with outside organizations, sophisticated use of electronic health records and other emerging health technologies, and the systematic adoption of best practices for chronic disease prevention and management.

Cuyahoga County Housing First Initiative

The Cuyahoga County Housing First Initiative was started a little over a decade ago in response to a dramatic increase in street homelessness and overflowing public shelters in our community. Enterprise Community Partners, along with the Sisters of Charity Foundation of Cleveland and the City-County Office of Homeless Services, created a plan to bring the permanent supportive housing model to Cuyahoga County and take it to scale.

The Housing First Initiative has been very successful—to date, creating 471 permanent supportive housing apartment units with another 105 units under production. The outcomes have been as good as or better than similar programs in other cities, with 73% of residents remaining in their apartments, 25% moving on to other permanent housing in the community and less than 2% returning to homelessness. As further evidence of the Housing First Initiative's impact, chronic homelessness in Cuyahoga County has decreased by 62% since opening the first building in 2006, according to Cuyahoga County Point In Time count data, as shown in Figure 1.

Figure 1. *Chronic Homelessness in Cuyahoga County*[42]



Programs, Services and Resident Needs

The Housing First Initiative creates permanent supportive housing targeted to chronically homeless persons in Cuyahoga County. In Housing First permanent supportive housing, the emphasis is on helping individuals first attain and then maintain housing, including understanding the rights and responsibilities of tenancy, while providing the intensive services

and health care needed to achieve stability and, ideally, independence. Barriers to entry into Housing First are low, focused instead on moving people into housing. On-site housing-based case management services are flexible, client-driven and voluntary. Services offered through permanent supportive housing typically include health care, substance abuse treatment, mental health treatment, employment counseling, connections with mainstream benefits like Medicaid, and many others. Permanent supportive housing is identified as an evidenced-based practice and is actively promoted by HUD, USICH and the Substance Abuse and Mental Health Services Administration (SAMHSA). Research indicates that this combination of long-term housing and wrap around services leads to improved residential stability and reduction in psychiatric symptoms.[43]

FrontLine Service (FrontLine), a community behavioral health organization dedicated to serving the homeless, is the lead service provider and coordinator. Other service providers working closely with FrontLine across the Housing First Initiative are the AIDS Taskforce of Greater Cleveland, providing case management and a comprehensive array of services to persons who are HIV-positive or at risk of HIV/AIDS, and the Louis Stokes Cleveland VA Medical Center, providing case management services including crisis intervention, illness and medication management, life skill development and employment services to veterans.

The Housing First Initiative prioritizes those persons with the greatest need for permanent supportive housing as evidenced by the length of time spent in shelters or on the streets and the severity of disability/vulnerability. This is a data-driven, formalized process, using street outreach data and shelter data compiled through the Homeless Management Information System (HMIS), as well as a comprehensive housing assessment of the individual's barriers to housing. The assessment tool yields a score that determines placement on the priority list for housing.

The assessor works to understand the level of functioning, the illness severity, and the overall vulnerability in order to complete the assessment and obtain the score. Chronically homeless individuals with the highest scores are those who receive priority and are offered the next available unit. The following are the characteristics of current Housing First residents:

- Males – 67%
- Average Age – 51 years old
- African-American – 66%
- Veterans – 19%
- Severe and Persistent Mental Illness – 78%
- Severe Alcohol or other Drug Dependency – 36%
- Chronic Physical Health Issues – 50%
- HIV-positive – 10%
- Average Days Homeless Prior to Move-In – 700 days
- Average Income at Entrance – $294
- Employment Rate at Entrance – < 1%
- Past Criminal Justice Involvement – 70%

According to a March 2012 analysis by Abt Associates, 40% of Housing First residents have Severe and Persistent Mental Illness (SPMI) and are enrolled in Medicaid, 20% of Housing First residents are dually-eligible for Medicaid and Medicare, 15% of Housing First residents have SPMI, are currently eligible for Medicaid but are not yet enrolled, and 25% of Housing First residents have substance use disorder as their primary diagnosis and are not currently eligible for Medicaid.

Partnering for a Healthy Community

According to Care Alliance and FrontLine data, among six Housing First properties, only 26% are currently connected to Care Alliance. A smaller number of residents are known to use the Free Clinic, Neighborhood Family Practice or Northeast Ohio Neighborhood Health Services—the other Cleveland FQHCs. The vast majority is not connected to a primary care provider at all and often only end up admitted to a hospital or in an emergency room when their

conditions reach a crisis stage. For three Housing First properties where the data is available, 43 residents had 819 medical encounters over the past 12 months. This is roughly 19 medical encounters per person in one year, demonstrating the severe need for care. Finally, with the June 6, 2012 rule change in the Health Center Program, formerly homeless residents of permanent supportive housing are eligible—*for the first time*—to receive Health Center services funded under Section 330(h) for an indefinite period.

Over the last two years, the partnership between Care Alliance, FrontLine and Housing First has exploded and now includes the traditional referral partnerships; shared staff; a SAMHSA funded primary care, behavioral health and housing integration project (FrontLine overseen); and implementing a state-funded mobile clinic (CA overseen). Numerous joint funding proposals have been submitted as have abstracts for conference presentations. Based on the results of this study, this level of community collaboration is a differentiator of the Cleveland community. As we have looked nationally for best practices, we have found few examples of distinct organizations with this level of collaboration.

Conceptual Framework

The following logic model in Table 3 was developed for this study to graphically depict the process by which *Opening Doors* may reach its goals. This logic model serves as a starting point to outline the conceptual framework of this dissertation.

Table 3. *Opening Doors Logic Model*

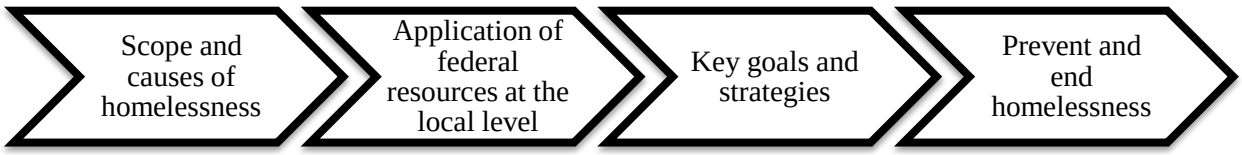
Issue		
Over 640,000 Americans are homeless on any given night. It is necessary to align housing, health, education, and human services to prevent homelessness. *Opening Doors* strives to align the homeless community across the country around a core set of goals, themes and measures to ultimately end homelessness.		
Inputs	**Outputs**	**Outcomes – Impact**
Federal investment and Leadership • HEARTH Act • USICH/Opening Doors • Funding: American Recovery and Reinvestment Act (ARRA), Annual Administration Budgets, Affordable Care Act (ACA) **Federally-identified key goals and strategies:** • Coordinated leadership • Strengthened local systems • Program coordination and simplification • Comprehensive interventions • Improved access to services • Better understanding of the barriers to those services **Community innovation and best-practice approaches from State and Local Stakeholders** • State and Local Governments • Non-profits, faith-based and community organizations • Philanthropy/Foundations • Private Sector	**Process: Alignment around goals, strategies and objectives of *Opening Doors*** • Mobilize the community (local/state and then with federal) • Harness public-resources • Implement cost effective, community-tested and comprehensive solutions **Measure: Changes in** • Individuals experiencing chronic homeless • Veterans experiencing homelessness • Households with children experiencing homelessness • Permanent supportive housing units • Households exiting homeless assistance programs with earned income and or/mainstream benefits	**Outcomes for the Community:** • Streamlined experimentation • Innovative solutions to scale • Improved Data Collection **Outcomes for the Homeless:** • Housing Stability • Coordinated service delivery • Increased educational attainment and academic performance • Improved health status – socially, emotionally, and physically **Goals:** • End chronic homelessness by 2015 • Prevent and end homelessness among Veterans by 2015 • Prevent and end homelessness for families, youth and children by 2020 • Set a path to ending all types of homelessness

Narrowing to Health

As mentioned, homelessness is a significant problem affecting the health of urban populations. For those organizations providing health care to the homeless, there are unique needs that must be considered as health falls low on a priority list when you do not know where you will next sleep or eat. Local collaboration of multiple health, social service and municipal entities including law enforcement is key to serving the comprehensive needs of the homeless. Furthermore, addressing the unique needs of the homeless requires coordination of services across local community organizations, especially when providing health-related services. Effective community partnerships and collaboration are essential to this coordination of services and to efforts to implement *Opening Doors* at the community level. This collaboration and coordination are important parts of a conceptualization of a solution.

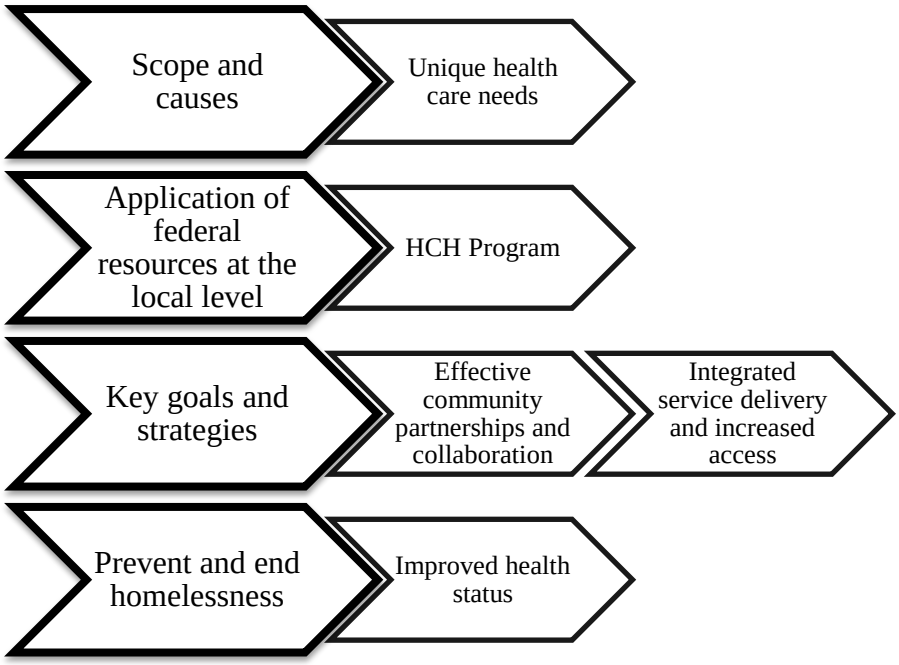
Applying the logic model in Table 3, the following process in Figure 2 is that in which *Opening Doors* assumes to reach its vision and goals, and includes the collaboration and coordination mentioned above.

Figure 2. *Opening Doors Process*



Next, to develop the conceptual framework guiding this study, in Figure 3 below, the cycle of health and homeless is integrated with the Figure 2 process.

Figure 3. *Conceptual Framework*



This conceptual framework (Figure 3) then supports the following research questions:

1. How is this being done in local communities?
2. What are examples of best practices and community-tested interventions?
3. What are barriers that prevent integrated service delivery? Effective collaboration?
4. What are the overarching key goals and strategies for HCH?
5. And finally, how does all of this relate to *Opening Doors?*

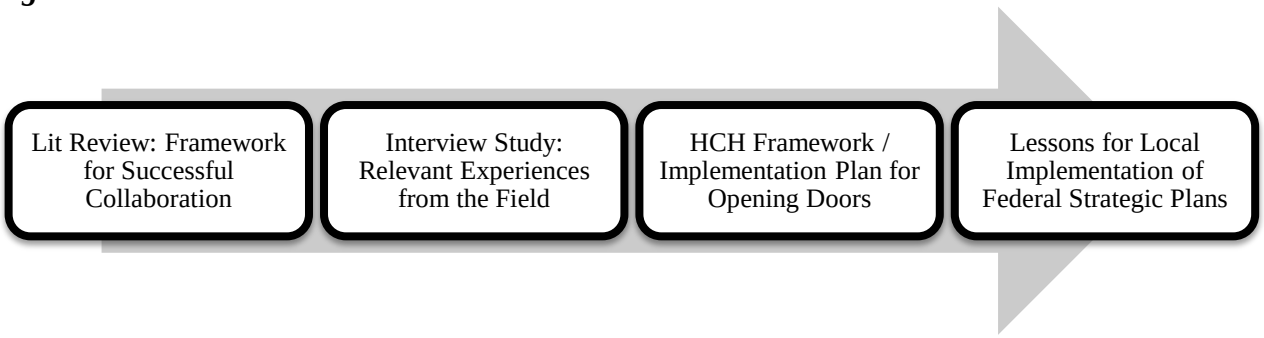
Each step of the dissertation strives to answer these questions while addressing the overall Research Question and related aims, as outlined in Table 4.

Table 4. *Dissertation steps to answer the research questions*

Inputs	Outputs	Outcomes
Tools for effective collaboration on health issues: • Systematic review of academic literature on characteristics associated with successful local collaborations or partnerships. Observations and lessons extracted from resulting articles will comprise a framework by which to evaluate the potential for successful local implementation of *Opening Doors*. Community innovation and best-practice approaches from Local Stakeholders: • Qualitative interview study, building on the framework established in literature review, to dig deeper into awareness and implementation of *Opening Doors* in local communities. o The Executive Director or Chief Executive Officer (or designee) of select health care for the homeless providers will be interviewed to determine the awareness and relevance of *Opening Doors* at the local level. o The local government Office of Homeless Services (or equivalent) in the same city, traditionally responsible for coordinating the local community's homeless service response and/or Continuum of Care, will be interviewed to augment the HCH perspective.	1. List of effective 'tools' for collaboration 2. Determine awareness of Opening Doors (in general) in select local communities 3. Knowledge of what is being done in local communities around select themes of Opening Doors 4. Identify barriers to service integration and/or delivery	Defined role of HCH Program in Opening Doors Recommendations for stakeholders (local, state, federal)

Further, to answer the questions raised for this dissertation, I have identified a four step process, illustrated in Figure 4. This outlines the process and the structure of the dissertation with chapters dedicated to each component.

Figure 4. *Dissertation Process*



CHAPTER 2: Review of the Literature

As outlined in Chapter 1, addressing the unique needs of the homeless requires coordination of services across local community organizations, especially when providing health-related services. Effective community partnerships and collaboration are essential to this coordination of services and to efforts to implement *Opening Doors* at the community level. The first study step of this dissertation will be accomplished through a systematic review of academic literature on characteristics associated with successful local collaborations or partnerships. Observations and lessons extracted from resulting articles will comprise a framework by which to evaluate the potential for successful local implementation of *Opening Doors*. I have focused on this aspect of the scientific literature in an effort to identify peer-reviewed supported characteristics that could inform the inner workings of community-based health partnerships to support local implementation of *Opening Doors,* and ultimately, improve the health of the homeless.

Methods and Search Strategy

A literature search of peer-reviewed journal articles with a population health focus relevant to the homeless was performed with the assistance of the Care Alliance Urban Health Fellow to answer the following research question: *What are characteristics of successful local community partnerships or collaborations responsible for implementing national strategies or federal strategic plans?* For this literature search, the key concepts related to the research question are defined as follows:

- Partnerships or collaborations (or coalitions, alliances or similar related descriptor, all often used inter-changeably) represents a group of local agencies, organizations and/or individuals working together to improve the health of their community
- National strategies or federal strategic plans was expanded to include community partnerships or collaborations working together to address a public health issue of national significance

The goal of this literature search is to build from the characteristics outlined in the literature a framework of essential factors that could help guide the work of community health improvement-focused partnerships or collaborations.

Multiple searches were done for the literature review, primarily using PubMed and Google Scholar. Searches were first done using Google Scholar and the Tulane University Libraries SearchAll master database search tool to help narrow search terms and finalize inclusion criteria. The SearchAll master database tool was used initially as it accesses many major academic and peer-reviewed journal databases and database libraries at one time. The searches "hits" were quite large, despite narrowed search terms and limiting the search to after 2000, due to the scope of these databases, as well as Google's search formula. The vast majority of the hits yielded were not relevant, and like a regular Google web search, the most relevant results based on the search algorithm were returned first. The results became noticeably less relevant to the search terms and research question after reviewing the first few hundred titles. As such, these two high-volume search tools provided a worthwhile launching point into a more focused assessment of the literature – a first step before working with more focused databases, such as PubMed and PsychInfo, which followed.

Searches encompassed various search term combinations, including singular and mixed terms, from the following pool: national/federal/U.S. plan/strategy; strategic plan; strategic planning; strategic alliance; collaboration; coordination; local; implementation; success; successful characteristics; non-profit. While general search terms were used initially, results were immediately reviewed for relevance to the health field. The following criteria needed to be met for inclusion in this literature review:

1. U.S.-based and appear in a peer-reviewed journal after 2000 to identify more recent community health improvement efforts
2. Focus on a health topic relevant to the homeless
3. Discuss the experience, plans or strategies implemented by a community partnership at the local level
4. Outline partnership characteristics of success

There was a language restriction of English and species human.

Results

The search strategy resulted in a total of 78 abstracts reviewed, 31 selected for full article analysis and seven included in the literature review, as outlined in Table 5 below. All search results were first reviewed by title based on a perception of relevance to the research question, and 78 abstracts pulled to review for alignment with inclusion criteria. This process was manual, and again, decisions were made by the author based on a perception of relevance to the literature review's inclusion criteria, outlined in the list above, primarily the second and third criteria.

Following the abstract review, 31 articles were accessed via the UNC Library System and fully reviewed for inclusion against the criteria, as well as reviewing the article references (snowballing). Following this process, seven articles were selected for inclusion in the literature

review. From each selected article, the outlined elements associated with successful local partnerships were recorded. If an included article outlined an evaluation tool or mechanism to measure the partnership, in addition to the key success factors, this was captured as well.

Exclusions were mostly due to the final two criteria – articles did not focus on the work of cross-community partnerships and/or did not outline characteristics of success. Two articles represented the 'archetype' article satisfying all inclusion criteria and presenting a discussion of key factors needed for successful community partnerships, Roussos and Fawcett[44] and Shortell et al[45]; both articles are discussed in detail in the Key Findings. Of note, included in the literature review by Roussos and Fawcett, is a useful definition of a collaborative partnership (page 369):

> *A collaborative partnership in public health is an alliance among people and organizations from multiple sectors working together to improve conditions and outcomes related to the health and well-being of entire communities*[46]

The seven articles selected for inclusion identified factors or characteristics associated with successful partnerships or collaborations focused on public health initiatives. As outlined in Table 6 below, these characteristics were extracted (Factors/Characteristics Column) and evaluated based on applicability to health-related partnerships in general and then to Opening Doors specifically (Strength of Study Column). The strength of study was determined according to the scale outlined in Table 7.

Table 5. *Literature Review Search Strategy*

Searches	Initial Search Results	Title/Abstract Review	Article Review	Total Included
Google Scholar and Tulane SearchAll				
“strategic alliance” + “collaboration” + “inter-agency”	556	1	1	1
“strategic alliance” + “collaboration” + “local”	13200	5	4	2
“strategic planning” + “local” OR “non-profit”	354000	4	1	0
“strategic planning” + "local" + "health"	132169	11	5	0
“successful” + “strategic plan” OR “national strategy” + “health”	17100	5	4	0
successful + "strategic plan" + "evaluation" + "health"	42000	7	5	0
Pub Med Search				
federal plan + local implementation	44	7	1	0
national plan + local implementation	288	5	1	0
strategic plan + local	396	3	0	0
strategic planning + evaluation	727	11	1	1
Pub Med Search - Reviews Only				
successful partnerships	77	7	2	0
federal plan + local implementation	5	0	0	0
national plan + local implementation	20	1	0	0
strategic plan + local	13	0	0	0
aspects + success + partnership	3	0	0	0
PsychInfo Search				
federal plan + local implementation	9	0	0	0
national plan + local implementation	31	3	1	0
strategic plan + local	56	4	2	0
strategic planning + characteristics + health	37	1	0	0
successful + collaboration + health	435	3	3	3
TOTAL	**561166**	**78**	**31**	**7**

Table 6. *Included Studies*

Article (Reference)	
Factors / Characteristics	**Strength of Study**
(1) Merrill JA, Deegan M, Wilson RV, Kaushal R, Fredericks K. A system dynamics evaluation model: implementation of health information exchange for public health reporting. *J Am Med Inform Assoc* 2013;0:1-8. doi: 10.1136/amiajnl-2012-0001289	
1. Do not assume implementation expertise 2. Undiscovered work will emerge in the implementation process 3. Contingency plans are needed to ensure steady progress on multi-stakeholder projects that are interdependent, especially when funding questionable 4. Leadership, consistent champions and communication essential 5. Managing timelines	moderate
(2) Chuang E and Wells R. The role of interagency collaboration in facilitating receipt of behavioral health services for youth involved with child welfare and juvenile justice. *Child Youth Serv Rev.* 2010 December 1; 32(12): 1814-1822. doi: 10.1016/j.childyouth.2010.08.002	
1. Jurisdiction--designation of agency accountability 2. Shared information systems--level of cross-agency access to administrative databases 3. Overall connectivity--number of ties connecting each agency (e.g. discussion and information sharing, development of inter-agency agreements and MOUs, joint planning or policy formulation for service delivery, cross-training of staff, joint budgeting or resource allocation)	strong
(3) Roussos ST and Fawcett SB. A review of collaborative partnerships as a strategy for improving community health. *Annu Rev Public Health.* 2000. 21:369-402.	
1. Having a clear vision and mission 2. Action planning for community and systems change 3. Developing and supporting leadership 4. Documentation and ongoing feedback on progress 5. Technical assistance and support 6. Securing financial resources for the work 7. Making outcomes matter	strong

Article (Reference)	
Factors / Characteristics	**Strength of Study**
(4) Shortell SM, Zukoski AP, Alexander JA, Bazzoli GJ, Conrad DA, Hasnain-Wynia R, Sofaer S, Chan BY, Casey E, Margolin FS. Evaluating partnerships for community health improvement: tracking the footprints. ***Journal of Health Politics, Policy and Law,*** **Vol 27, No 1, February 2002.**	
1. Managing partnership size and diversity 2. Developing multiple approaches to leadership 3. Maintaining focus 4. Managing conflict 5. Recognizing life cycles 6. Redeploying or patching resources	strong
(5) Lee MY, Teater B, Greene GJ, Solovey AD, Grove D, Fraser JS, Washburn P, Hsu KS. Key processes, ingredients and components of successful systems collaboration: working with severely emotionally or behaviorally disturbed children and their families. ***Adm Policy Ment Health*** **(2012) 39: 394-405. doi 10.1007/s10488-011-0358-8**	
The following processes and ingredients must be present in order for challenges to be overcome and for collaboration to be successful: 1. Establishing and maintaining trust 2. Agency representatives beings responsive, reliable, consistent and realistic about roles and expectations 3. Delivering effective and realistic treatment outcomes	moderate-strong
(6) Donaldson LP. Collaboration strategies for reforming systems of care: a toolkit for community-based action. ***International Journal of Mental Health,*** **vol. 34, no 1, Spring 2005, pp.90-102.**	
Based on research examining the dynamics, operations and outcomes of 40 coalitions, Mizrahi and Rosenthal (ref 8) identified four factors associated with successful coalitions: 1. Competence - knowledge, skill and savvy of coalition leadership 2. Commitment - to the effort 3. Contributions - what members are able and willing to make 4. Conditions - political and economic environments	moderate

Article (Reference)	
Factors / Characteristics	**Strength of Study**
(7) Macy RJ and Goodbourn M. Promoting successful collaborations between domestic violence and substance abuse treatment service sectors: a review of the literature. *Trauma Violence Abuse* 2012 13: 234 originally published online 16 August 2012. doi: 10.1177/1524838012455874	
Effective interagency collaborations require multidimensional strategies at various levels, including the provider, director, agency, and policy levels: 1. cross-training 2. colocation and cross-consultation 3. assigning interagency liaison 4. establishing and maintaining positive, productive working relationships at all agency levels 5. establishing or changing state-level policies to promote collaboration	weak

Table 7. *Determining the Strength of Study*

Strength of Study	Description
Weak	Factors had little relevance outside of article topic and would not apply to *Opening Doors*
Moderate	While the factors were relevant outside the topic of interest and to public health in general, they would not apply to *Opening Doors*
Strong	Factors were relevant to public health and *Opening Doors*

Key Findings

As mentioned above, the goal of this literature search is to build from the characteristics outlined in the literature a framework of essential factors that could help guide the work of community health improvement-focused partnerships or collaborations. This section details the steps to build this framework from the seven included articles.

Following extraction of the factors from each of the seven articles, all articles were re-checked for inclusion of each factor. This was in an effort to determine importance, based on inclusion across articles, and to identify factors that could be grouped based on similarity into more broadly-defined categories. Once the factors were grouped according to similarity and function, they were then categorized based on an essential strategic planning activity, reflecting the content of the articles reviewed in this literature search. Table 8 depicts the process just described.

The result of this process is the Framework for Successful Community Partnerships (Framework), outlined in Table 9 below. It proposes a checklist of 'must-haves' for local health-related partnerships working together on community health improvement. The categories are meant to be broad in an effort to increase the likelihood of generalizability to public health related strategic plans implemented at the local level, and in turn, the usability and acceptance of the Framework.

Table 8. *Identified Factors from Included Articles*

Factor (grouped)	Included Article							Categorized
	1	**2**	**3**	**4**	**5**	**6**	**7**	
Subject matter expertise	X		X	X	X	X	X	ALL
Flexibility	X			X	X			Purpose and Commitment
Leadership	X	X	X	X	X	X	X	Leadership
Communication	X		X	X	X	X		Communication
Managing timelines	X							Leadership
Accountability		X		X	X		X	Accountability
Shared systems		X	X	X				Planning / Operations
Connectivity		X	X	X	X	X	X	Purpose and Commitment
Funding / Financial resources	X	X	X	X	X			Funding / Resources
Clear vision and mission			X	X		X		Purpose and Commitment
Action planning		X	X	X		X		Planning / Operations
Documentation / Ongoing feedback			X	X				Planning / Operations
Technical assistance and support			X	X				Planning / Operations
Outcomes			X	X	X			Planning / Operations
Focus				X	X			Purpose and Commitment
Trust and commitment			X	X	X	X	X	Purpose and Commitment
Defined roles and responsibilities		X	X	X	X		X	Accountability
Contributions				X		X	X	Funding / Resources
Understanding external environment	X		X	X		X		Leadership

Table 9. *Framework for Successful Local Community Partnerships*

Category	Description
Leadership	Included in all studies, to be successful, a partnership needs to have a defined leader, supported and recognized both internally and externally. The leadership should have extensive knowledge of the issue and the external environment within which the partnership is working.
Purpose and Commitment	The purpose and commitment of the partnership includes both a clear vision and mission (purpose) and the commitment of the partners to that stated purpose given their individual expertise. The purpose provides focus for the partnership as well as a favorable cost-to-benefit ratio ensuring individual members remain connected to one another and to the partnership. This will allow for flexibility of contributions by the individual members that are focused on the greater good of the partnership and reflective of subject matter expertise of the individual members.
Communication	Clear and consistent communication, internally and externally, of the purpose of the partnership and benefits to the community. Communication helps to establish the partnership as the established subject-matter experts.
Accountability	Accountability goes hand-in-hand with establishing clearly defined roles and responsibilities, and includes accountability of individual members, leadership, and in some instances, the community the partnership serves.
Funding / Resources	Funding and resources enable the partnership to do the work. This likely includes pooled financial resources, in kind contributions of members and joint fundraising.
Planning / Operations	Planning and operations represents the actual work of the partnership, including development, implementation and technical assistance. A feedback process, with a shared information system for data collection and analysis, should also be included to allow for outcomes measurement and continuous improvement.

In addition to the included articles, there is much academic and theoretical support for the Framework categories.[47] [48] [49] [50] [51] The categories are interdependent, and while it is not to be assumed, it is essential that all partnership members bring subject-matter expertise as an underlying factor across the Framework and work of the partnership. Based on this literature review, all of the Framework categories are viewed as necessary to a successful partnership, sustainability of a partnership and overcoming common barriers seen in partnership work. The Framework outlined in Table 9 captures a partnership with committed and knowledgeable leadership and membership who can make necessary changes for the good of the whole in an adaptable environment given change and/or internal or external pressures.

As mentioned above, if included in the article, I noted evaluation tools for assessment or measurements of successful partnerships. One of which, Network Theory, deserves further discussion to emphasize the underlying connectivity needed in a partnership as well as the inter-connectedness of the Framework categories. Chuang and Wells[52] explored Network Theory, specifically the level of connectivity between organizations on the likelihood of youth receiving services. While this proved insignificant in this study, and was noted as a limitation, the paper outlines the line of literature in Network Theory that looks at "strong" vs. "weak" ties (or connections) between people and organizations and the impact on success. Research also looks at "holes" in the network structure formed through the connections. It is the weak connections and holes in the connections that likely lead to breakdowns in communication and productivity, regardless of funding or a strong purpose.

In Roussos and Fawcett, the authors included a set of recommendations for community partnerships for *Enhancing Practice (page 391-2).*[53] These recommendations provide support for

the analysis above in establishing the Framework for local community coalitions to emulate in striving for success. The recommendations are quoted here:

> Recommendations for Enhancing Practice with Collaborative Partnerships
>
> 1. A partnership should frame and communicate a clear vision and mission that is broadly understood (not just by health-related professionals). The mission should define the problem and acceptable solutions in such a manner as to engage (not blame) those community members most affected and not to limit the strategies and environmental changes needed to address the community-identified concern.
> 2. Ongoing action planning should identify specific community and system changes to be sought to effect widespread behavior change and community health improvement.
> 3. The core membership of a partnership should develop widespread leadership, engaging a broad group of members and allies in the work of community organization, mobilization, and change. Important and sustained environmental change is more likely when leaders emerge from and engage multiple community sectors in facilitating change within their own peer group, organizations, and context.
>
> Source: Roussos & Fawcett

Two studies are particularly relevant with regards to the local implementation of *Opening Doors*. Also included in the Roussos & Fawcett review is a set of recommendations to *Set Conditions for Success*, quoted below.[54] These recommendations should be considered both by organizations like USICH when putting forth a strategic plan such as *Opening Doors* and by the local community partnerships responsible for its implementation.

> Recommendations for Setting Conditions for Success
>
> 10. Identification of human and financial support for doing the work of community change and public health improvement should begin early and continue throughout the life of a partnership. It should support those actions that effect the environmental changes most valued by the local community and those more likely to influence population-level outcomes. When multiple organizations are represented in a partnership, decisions on allocating human and financial resources should reflect a sharing of risks, resources, and responsibilities for the common work.
> 11. A collaborative partnership should have access to support and technical assistance for enhancing the core competencies of its members relevant to different stages of the partnership development (e.g. community assessment, action planning, mobilization, and intervention; generating resources to sustain the effort).

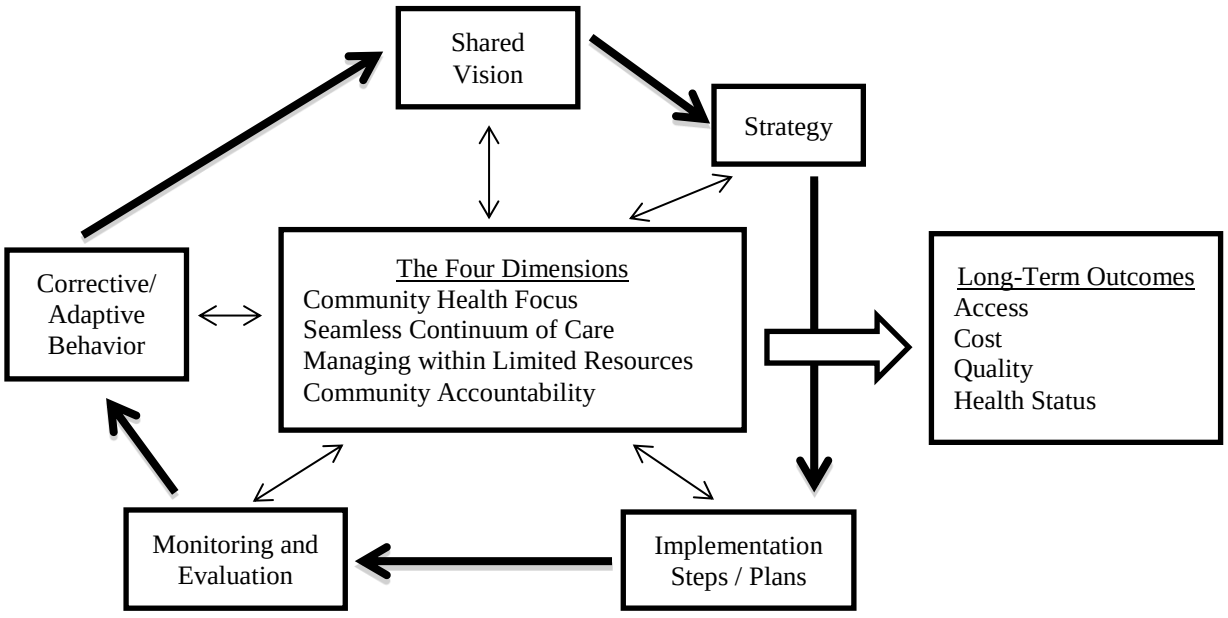
12. Communities and grant makers should help make (often delayed) outcomes matter through communications, resource allocation, recognition and celebrations, and systems of rewards and accountability.
13. Efforts should focus on building the capacity of community-based initiatives to address issues that matter to local people over time (e.g. $\geq$ 10 years), across concerns (e.g. from physical activity to youth development), and across generations of dispersed leadership (e.g. leadership teams integrated by age and experience).
14. Finally, we must transform the conditions under which efforts to improve health and well-being occur, including those broader social determinants (i.e. social ties, social class, and income inequality) that lead to unequal outcomes.

Source: Roussos & Fawcett

The second article, Shortell et al,[55] is a midstream process evaluation of 25 community partnerships associated with the Community Care Network Demonstration Program, "designed to increase the ability of public-private partnerships to address community health improvement issues that require cross-sector collaboration." Their Operational Mode of Action (Shortell et al, Figure 1, page 53), recreated below in Figure 5, provides a visual depiction of the how a vision and management model work together to accomplish the goals of such a partnership.

The Four Dimensions in the middle of the model capture the vision, and the management model moves around in support of that vision. As stated by the authors, "the vision helps to set program direction – where the footprints are intended to go. The management model fills in the footprints by providing clues as to the weight and speed of action taken and mapping the twists and turns along the way."[56]

Figure 5. *Model of Action, Figure 1, Shortell et al*



While the Framework in Table 9 is proposed based on the results of the literature review, further research is needed to determine its true effectiveness in predicting success of local health-related partnerships.

Limitations and Quality of Results

The literature search was limited to academic, peer-reviewed journal articles and may then be missing key elements that can be described journalistically or in original documentation of programs that do not make it to publication in academia. Initial searches attempted to limit the focus of a local partnership to implementing federal strategies or plans, and this needed to be expanded to simply a focus on a population health topic. To develop the Framework proposed in Table 9, a core assumption – and a limitation – was that the factors extracted from one included article could also be raised in a different, included article in the same way (as suggested in Table 8), and further, that the factors themselves were then generalizable to all of public health. Furthermore, many search results focused on issues in international development, especially

economic and human development, that are not relevant in the U.S. context. For example, throughout the search, there were a number of articles focusing on the Millennium Development Goals; most notably the Jeffrey Sachs-led analysis of why the world is failing to reach these global development goals and proposed steps to do so.[57] While it is likely there are parallels to be drawn from what may be one of the largest scale, top-down strategic plan requiring multiple levels of bottom-up (local) implementation, it was left outside the scope of this literature search. Finally, the Framework (Table 9) is a direct result of the content of the studies included in this literature search; its efficacy, in theory or practice, has not been tested.

It is important to note that health improvement efforts have been driven by community-wide action groups and organizations long before the work outlined in this literature review. It is an assumption that the more recent academic research reviewed in this study is reflective of the early precursors of the community health improvement field, community health centers as a whole and the HCH Program specifically.

Implications

The literature review was used to propose the Framework for Successful Community Partnerships outlined in Table 9, which is further discussed below, and it will also be incorporated in the next phase of the dissertation research, the key informant interviews. Following the analysis of data provided by key informants, key drivers and barriers of community collaborations, coupled with the body of literature exploring why federal policies often are not implemented at the local level, are further explored in the Discussion Chapter.[58]

As outlined in Chapter 1, USICH recognized the importance of local community commitment and implementation to the success of Opening Doors and sought to provide technical assistance and support to local communities though Opening Doors Across America

and the local strategic planning toolkit. To start to determine the likelihood of success of local implementation of *Opening Doors,* the Framework (Table 9), can also be applied to USICH's *Opening Doors*, as outlined Table 10.

Table 10. *Literature Review Framework applied to Opening Doors*

Category	USICH / Opening Doors Alignment
Leadership	Supported by President Obama, Congress and driven by USICH
Purpose and Commitment	Evident in the vision and goals
Communication	USICH web site and email listserv reinforcing *Opening Doors*
Accountability	USICH and its member organizations
Funding / Resources	Stated commitment to provide existing funding although no new funding designated
Planning / Operations	Strategies

Explored at a very basic level, USICH appears to satisfy the Framework. However, the ability of each of the factors to permeate from the federal level to the local level is unknown as there is no public documentation of commitment and implementation in communities across the nation. This is likely due to a lack of connectivity across communities (or even within communities) and accountability from the local level to USICH. As Network Theory has shown, this would limit the success of the plan as a whole to accomplish its stated goals and objectives.[59] [60] The next study step of this dissertation process, a qualitative interview study, attempts to dig deeper and explore the status of local implementation of the Plan.

CHAPTER 3: Original Data Collection Methodology

Building on the Framework proposed as a result of the systematic literature review, a series of key informant interviews with HCH organization and local government homeless service leaders was next conducted to answer the primary Research Question and determine the role of the HCH Program in the local implementation of *Opening Doors.*

Study Participants

Two groups of study participants were recruited to participate in the study:

1. The Executive Director or Chief Executive Officer (ED/CEO or designee) of select Health Care for the Homeless grantees (group: HCH)
2. Local Government Continuum of Care or Homeless Service Leaders (group: housing)

To select the key informants, the HCH organizations were identified first, by applying the criteria outlined in Table 11, in the order below.

Table 11. *Key Informant Inclusion Process*

Inclusion Criteria	Cities/Organization Meeting Criteria
Original site of the HCH Demonstration Project	19 cities
HRSA 330(h) funded community health center	27 organizations
Total patients served in 2011 is greater than or equal to 9,000 (roughly equivalent to Care Alliance; per UDS* data)	19 organizations (8 excluded)
More than half (50%) of total patients served in 2011 are homeless (per UDS data)	9 organizations (10 excluded)
**UDS – Uniform Data System, a system used by HRSA to track performance of all grantees*	

After applying the inclusion criteria, nine organizations remained. Care Alliance was excluded, as the principal investigator is the Chief Administrative Officer and the CEO is a member of the dissertation committee. One additional HCH grantee was excluded as it was not

listed among HRSA grantees in the 2011 UDS Report for all health centers. Table 12 describes each city and HCH organization selected for inclusion in the study. Once the HCH organization was identified, the appropriate local government leader responsible for coordinating the local community's homeless service response in the same city was identified. All identified participants had equal access to and potential for participation in the study.

Table 12. *Potential Key Informants by City*

HCH Demonstration Project Site	City Size+	Total Homeless Population^	HRSA Funding Stream*	Total Patients	Total Homeless Patients
City A	Medium	3854	HCH	9,189	100%
City B	Medium	5607	HCH	14,534	100%
City C	Large	6710	HCH	12,232	10,257 (86%)
City D	Medium	6358	HCH PHPC	13,055	11,228 (86%)
City E	Large	56,672	HCH	9,726	100%
City F	Medium	1432	CHC HCH	12,207	10,599 (86%)
City G	Medium	8830	HCH	24,132	100%

+ Medium 500,000-1,00,000 population; Large >1,000,000
^ Source: January 2012 Point in Time Count CoC Homeless Populations and Subpopulations Reports (a standard data source although considered gross underestimates of a homeless population)
**HRSA Funding Stream:*
HCH – Health Care for the Homeless, 330(h)
PHPC – Public Housing Primary Care, 330(i)
CHC – Community Health Center, 330(e)

Participant Recruitment, Privacy and Consent

The principal investigator sought approval from the UNC-Chapel Hill Institutional Review Board (IRB) prior to initiating the interviews. An exemption was granted by the IRB on July 5, 2013 (see Appendix A). Recruitment was conducted via telephone and e-mail contact. In each city, the HCH CEO/ED was contacted first as, in some cities, they assisted with identifying the housing key informant. The recruitment steps were as follows:

- Participants were initially contacted by the principal investigator via email or telephone. This communication included basic background on the study and a request for a telephone interview, not to exceed one hour.
- If accepted, a telephone interview was scheduled based on the participants' availability, and the consent form was emailed for signature, indicating approval to participate and be audio recorded. Once signed, the consent forms were returned to the principal investigator, who then counter-signed, scanned, and emailed the document back to each participant.
- Prior to the interview, an email was sent to each participant outlining the logistics of the interview, as well as the interview guide and the *Opening Doors* fact sheet.

Recruitment and interviews took place during the months of July-September, 2013. The HCH group was recruited, scheduled and interviewed prior to any outreach to their housing counterpart. This was due to the lack of connection of the principal investigator to the housing side at the local level in each city, and the need to rely on the HCH contact to assist with identification of the appropriate individual. Of the seven HCH contacted, one declined to participate due to time constraints (City G). This then removed the city from inclusion in the interviews in an effort to have consistency in the recruitment process and the role of the housing group to augment the information provided by the HCH group. Of the six housing contacted, one agreed to participate but subsequently did not respond to requests to schedule the interview (City B).

A total of 11 individuals were interviewed for the study, between August and September, 2013, as outlined in Table 13. All key informants were senior level decision makers for their organizations, with six of the informants the ED/CEO of the organization and five informants a

high ranking official directly responsible for homeless services. On average, the informants served almost 15 years in their current position (a collective 162.5 years for their organizations).

Table 13. *Key Informant Interview Dates*

City	HCH Interview	Housing Interview
A	August 7, 2013	August 23, 2013
B	August 2, 2013	Lost to Scheduling
C	July 26, 2013	September 6, 2013
D	August 2, 2013	August 27, 2013
E	July 24, 2013	August 8, 2013
F	August 9, 2013	September 5, 2013
G	Declined to Participate	Was not contacted

Participants were asked in advance for permission to audio record the interview for later transcription. All but one participant agreed to be audio recorded. Through both written and verbal communications, all participants were assured that information would be reported in the aggregate. Confidentiality of the data was further assured by removing any identifying information (name, organization, location, other contact information, or any information that could be used to identify an individual) from the interview transcript. All written and electronic documents related to the key informants were stored as follows:

- Hard copies of the written consent forms were stored in a locked cabinet in the principal investigator's office. Electronic copies were saved in a file on the principal investigator's password-protected laptop.
- Digital audio recordings of the interviews were saved in a password-protected file on the principal investigator's password-protected laptop.
- Interview notes and transcripts were combined in one electronic document for each interview and stored in files on the principal investigator's password-protected laptop.

- Any handwritten notes taken during the interview were destroyed once combined with the interview transcript.

All records will be destroyed or deleted after the acceptance of the dissertation.

There was minimal to no risk to participants aside from a breach of confidentiality, which every effort was made to avoid, as outlined above. Further, the principal investigator was the only individual with access to the identity of the key informants. There was no monetary or explicit non-monetary incentive to participate in this study. In addition, there were no costs to the subjects, other than their time. For recruitment communications and written consent form, please see Appendix B and C, respectively.

Interview Format

A standardized interview instrument of open-ended questions was included in the IRB submission and approval. The interview instrument was pre-tested by conducting a mock interview with the CEO of Care Alliance, a member of the dissertation committee with professional expertise related to the research question and study aims.

The interview questions were developed incorporating the results of the literature review (Framework, Table 9) and specific content of *Opening Doors*. The Framework is comprised of several categories that relate to community collaboration, identified in the literature as characteristics of success. These categories were used to develop interview questions to further explore their significance. Given the broad scope of the Plan as a whole, the key informant interview questions focused on content of *Opening Doors* specifically related to leadership, collaboration and health, given the relevance to the literature search results, community-based collaboration and Care Alliance. The authors of *Opening Doors* divided the Plan's content into "Themes" and "Objectives" (see *Opening Doors* Summary:

http://usich.gov/resources/uploads/asset_library/Opening_Doors_1_Page_Summary.pdf). Table 14 outlines the specific *Opening Doors* content used to develop interview questions as well as the rationale for selection.

Table 14. *Selected Opening Doors Content*

Opening Doors **"Theme"**	***Opening Doors*** **"Objective"**	**Rationale**
Increase leadership, collaboration, and civic engagement	n/a	• Literature search alignment, as well as community partnerships/collaboration focus • Focus here to outline real-world application in Cleveland and other communities (via HCH providers)
Improve health and stability	Integrate primary and behavioral health care services with homeless assistance programs and housing to reduce people's vulnerability to and the impacts of homelessness	• Aligned with Care Alliance scope of practice • Focus here to determine 'how' this can be done given the present demands on HCH providers

The goal of the interview was to understand the key informant's experience and knowledge of the application of the Plan. Interviews were conducted in a semi-structured manner as it was important for key informants to speak freely in addressing each questions based on personal relevance and application. When necessary, factors found through the literature review (Tables 7-9) were named specifically to probe additional information during the interview when exploring drivers of and barriers to successful collaboration and implementation. Please see Appendix D for the Interview Guide.

All interviews were conducted in the same manner. The interview guide was shared in advance of the interview in an effort to provide the key informants time to prepare and raise concerns or ask questions of the principal investigator prior to the interview. The principal investigator telephoned each participant at the scheduled time, read through the study and

privacy assurances, and again provided time for questions. In an effort to remain consistent across interviews, the interview guide was followed closely, with follow up questions and probes being asked for detail and clarity, as necessary. Reordering of questions occurred when there was a logical reason to do so based on answers to previous questions.

Notes were taken during the interview to capture main points and observations, and later incorporated in the interview transcripts. As mentioned, all interviews except one were audio recorded and later transcribed. Digital audio recordings in password-protected files were emailed to a hired transcriptionist. Once transcribed, the transcriptionist emailed the transcript to the principal investigator as a password-protected document. The transcripts were then verified by the principal investigator against the digital recording and, at that time, any remaining identifiers – including individual and organization names and geographic locations (city, county, state) – mentioned throughout the interview were removed from the transcripts. The transcriptionist was made aware of the requirements of the study confidentiality.

Data Analysis

The de-identified transcripts were printed and coded by hand by the principal investigator and three members of the Care Alliance External Affairs team. The conceptual framework of this study (Figure 3) served as such for the coding scheme, with the *Opening Doors* process (Figure 2) representing the concepts by which emerging themes and codes were sorted. The *Opening Doors* logic model and the 'cycle of health and homelessness' (outlined in Table 3 and Figure 3) provided initial themes, and the literature search Framework categories (Table 9) provided the only initial codes.

The coding team looked for descriptors in the data (statements made or examples provided by key informants) which aligned with or supported the conceptual framework. The

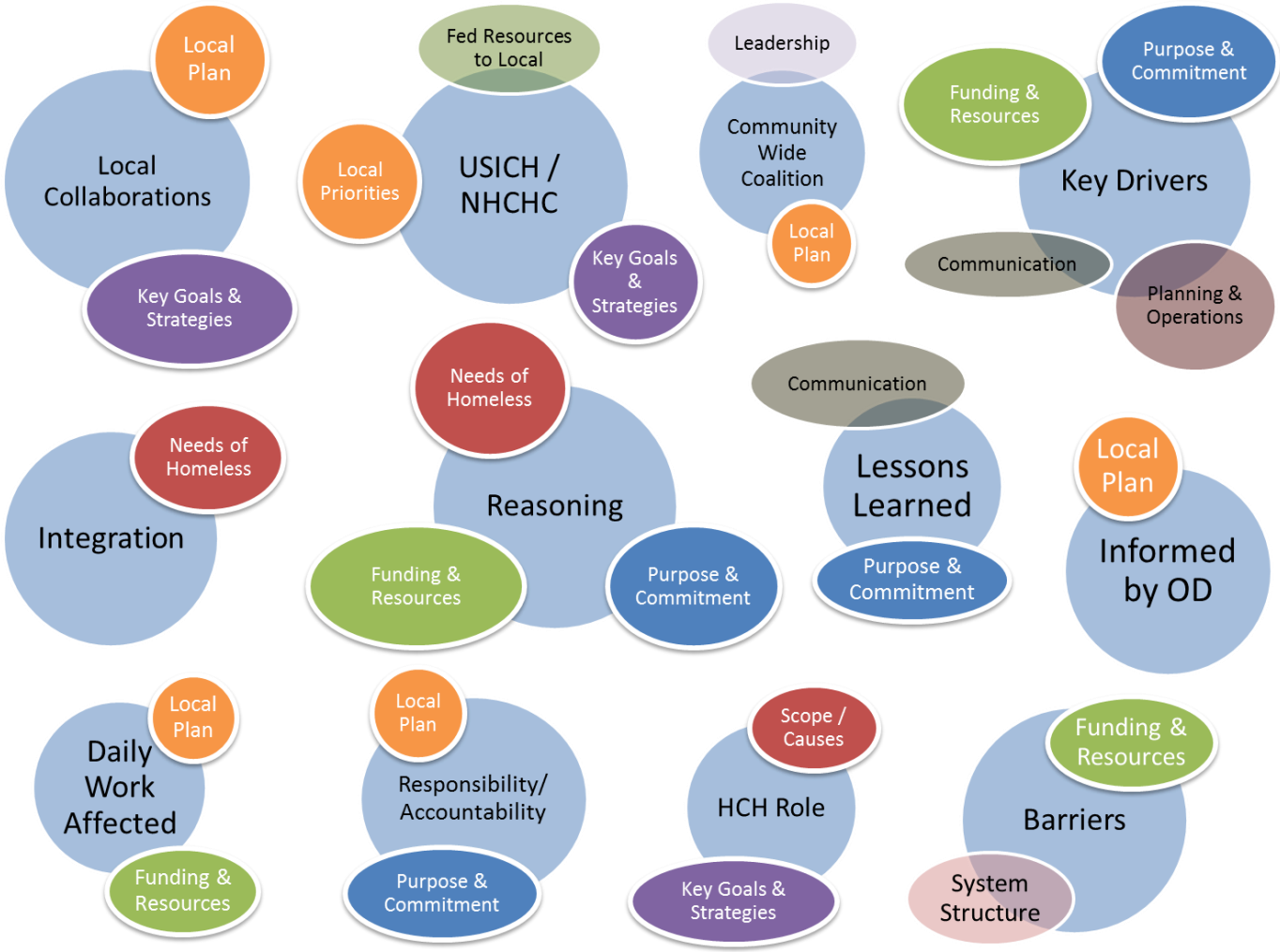
team analyzed each descriptor, based on consistency, frequency and stated importance, to identify emerging codes. The team met on two occasions to discuss each interview transcript individually, then across interviews by question, and finally to further refine the groupings of codes into themes and an initial data coding scheme. The principal investigator then conducted the final content analysis of each interview to finalize the coding scheme that emerged during the interviews, as outlined in Table 15.

The codes for each question were analyzed first overall, then across the HCH and housing groups for differences, and finally by the city size (medium or large). The use of this study's conceptual framework to build the coding scheme was supported through this process as the examples from the interviews and emergent codes and themes in the data aligned with these five concepts (Table 15). Furthermore, when analyzing the codes across questions, much overlap was seen, as illustrated in Figure 6 below. Each grouping in the Figure represents a topic of interview question(s) asked in the interview (the anchor, light blue / larger circle) with the surrounding bubbles capturing the corresponding codes of participant answers. These codes are color-coded across each question to capture the overlap.

Table 15. *Final Coding Scheme*

Concepts	Themes	Codes
Scope and Causes of Homelessness	Over 640,000 Americans are homeless on any given night. It is necessary to align housing, health, education and human services to prevent homelessness.	Macroeconomic pressure, integration, social determinants, needs of homeless, supportive services
Application of Federal Resources at the Local Level	Implementation of Federal programs such as HEARTH, ACA, HCH, USICH/*Opening Doors*, HUD/CoC	Federal compliance, Federal mistrust
Key Goals and Strategies	Effective community partnerships and collaboration/program coordination are needed	Leadership, Purpose and Commitment, Communication, Accountability, Funding / Resources (includes human), Planning / Operations (includes data)
	Integrated service delivery/comprehensive interventions is the preferred method of serving the holistic needs of homeless people	Integration examples, best practices, internal integration, scope/cause
	Better access to services and understanding of barriers is needed at the local level	Key drivers and barriers
	Strengthened local systems will help support local homeless services responses	System Structure, Collaboration
	Coordinated leadership across a local community is necessary	Leadership, Collaboration
Local Priorities / Plans	Local priorities and plans are the priorities of local communities/partnerships	Local Rules
Improved Health Status	Local partnerships are committed to improving the status of their homeless population	Purpose and Commitment

Figure 6. *Overlap of codes, grouped by interview question topic*



CHAPTER 4: Results

The key informant interviews sought narrative information on selected aspects of *Opening Doors*, including general awareness, practical application and barriers to implementation, and examples of community collaboration and coordination of homeless services. The interviews were analyzed to characterize the status of local implementation of *Opening Doors*, to surface opinions on the likelihood of its implementation, and identify opportunities and need for technical assistance. Related to the application of the Plan and selected themes to the daily work of key informants, the analysis looked for examples of programs and policies and drivers and barriers to success for community partners, within organizations and specific to the Plan. These interpretive frames or topics were derived from the conceptual model. However, additional themes were explored as they emerged from the interview summaries and analysis.

Following analysis, the interview data was captured as codes, based on the coding scheme as outlined above (Table 15). These codes and participant quotes are used to report the study findings. Results are first grouped by the study's Key Findings, next outlined specific to *Opening Doors*, and finally any differences between groups are presented.

Key Findings

Five Key Findings emerged as a result of this study, listed in Table 16, and described in greater detail below.

Table 16. *Five Key Findings*

Key Findings
1. The top priority identified by key informants is eliminating homelessness by providing for the *Holistic* needs of homeless people
2. Communities are working together to better serve homeless people, just not directly on *Opening Doors*
3. The categories comprising the Framework proposed in the Literature Search were supported, and the descriptions of each refined and enhanced by the interview data
4. Organizations prefer to be internally integrated, if possible
5. Local priorities dominate in programs, especially where there are resource constraints

Finding #1: Top Priority is the Cause and Holistic Needs of Homeless

Overall, all participants are deeply dedicated to the cause of eliminating homelessness, with their commitment expressed in responses to many of the questions as well as by the number of years spent working in the field. It was stressed on numerous occasions that the needs of the homeless are complex and must be addressed holistically. Furthermore, participants felt strongly that success in serving this population is entirely reliant on the ability to provide the necessary supportive services, which often are not funded appropriately at the federal level, directly impacting the ability to provide services at the local level. This was mentioned throughout the course of interviews as a driver, barrier, purpose for collaboration, funding requirement and policy initiative. The following are verbatim excerpts from interviews that support this finding:

"When we are working with people who are experiencing homelessness, we are working with some of the people with the most complex health, and when I say health I mean the big H, including mental health, substance abuse…the most complex health needs of almost anyone in the United States…yet we are linking these people with these complex needs to organizations that are funded in the most limited way and with the fewest resources to really meet their needs." (Participant CH1S)

"The needs are really profound and the ability to fill those needs are not frankly apparent about where the funding is going to come from…just on the surface, if we have 45% of our patients with either a diagnosis of schizophrenia or bipolar illness, we don't have the capacity, nor have we ever had the capacity, to care for that burden of illness for our patients."

"[Reduction of resources include] the federal budget with sequestration, cuts in the homeless budget, cuts in the section 8 housing assistance budgets, section 811 into two programs and other public housing and other mainstream housing sources… those are all being cut while we are seeing the impact of [the reduction of resources] in our community with… access to housing being reduced." (Participant DH1O)

"[The federal cuts] put the county in a very rough situation because the shelter providers are saying HUD will not fund these programs anymore and unless [local government] does it, they will have to close." (Participant IH2I)

"HUD several years ago made the conscious decision to pull away from service funding and started funding projects, bonus projects anyway, at 80% housing and 20% case management services, and you can't really fund quality services with that kind of funding structure. And none of the other agencies that are part of USICH stepped up to fill that void with case management dollars." (Participant AH2A)

Many organizational decisions are made in an effort to improve services for the homeless. Participants were asked to provide reasoning used by their organizations when determining with whom to collaborate. The majority of key informants stated the needs of the homeless and shared mission and vision as must have factors for collaboration. Furthermore, when asked specifically about integration initiatives, referral partnerships were established based on augmenting the internal services an organization provides.

"Sometimes it is shared goals and shared philosophies…so where we overlap, we'll work together, collaborate." (Participant NH1K)

"We will try to get state agencies or local agencies who have resources or should have an interest because we are serving similar populations to come together in terms of addressing particular needs of the homeless population." (Participant DH1O)

"Some of these [partnerships], in terms of how we collaborate or who we collaborate with is sort of home-grown. We just recognize it internally and do a needs assessment. …We hold up that request [to collaborate] to our mission." (Participant BH1S)

Serving the needs of the homeless was also evident in personal leadership characteristics as well, as participants mentioned commitment to the cause as a personal leadership trait needed

to advance collaborative efforts in their communities. In fact, one participant felt that experience working directly with the homeless was an essential leadership trait.

"I'm a nurse by background, so I've had a lot of experience working with our patients both clinically as well as just from an administrative perspective. It's relational, right? You build trust and you build relationships." (Participant BH1S)

"I think you need to have as much experience as you can directly working with this population. That's made a big difference in a lot of our local leaders that have kind of in their past lives worked kind of on the streets and had direct working experience with homeless individuals, I think it's really important." (Participant DH1O)

"The good financial people say 'no margin, no mission.' People like me say 'if you have a good mission, you'll drive a good margin.' A leadership trait for a person who is working in the field of homelessness and all of the related support services needs to be more mission-oriented than margin-oriented… and to be willing to be creative and to collaborate and to communicate effectively in order to bring results." (Participant MH1N)

When participants were asked if they felt a sense of responsibility or accountability to *Opening Doors*, many participants responded that they felt a sense of responsibility and accountability to the homeless individuals they serve.

"Only to the extent that there are, I mean not to the Plan itself, only to the extent that there are common goals in terms of that we all want to end homelessness for all populations." (Participant DH1O)

"I don't feel a sense of responsibility to [Opening Doors]; I do feel a great sense of responsibility to the homeless men, women, and children we serve, as well as to the larger homeless community and the homeless services community here in (this city)." (Participant NH1K)

Finally, across all questions, it is important to note that some of the interviewees really emphasized it was "their" homeless population – specific to time and place within their community as it relates to their city, their culture, their demographics, their history, their politics.

"I have been doing this type of work for twenty years. I know our needs even though they are constantly evolving and knowing what's on the ground here is much more important to me than a federal plan." (Participant NH1K)

"Homelessness to me, although with certain national qualities, is a local issue. I would suggest that one of the things [national organizations] can do… is better understand the local circumstances… the moments of truth are local." (Participant MH1N)

Finding #2: Communities are Working Together to Eliminate Homelessness, Just Not on *Opening Doors*

All participants are a part of a community collaboration working together on homeless initiatives. In fact, most participants mentioned there were a number of homeless collaborations in their communities, often with loose coordination across collaborations, with focuses varying from direct service, outreach, coordinating services, advocacy and local plans.

"Our program is all about collaboration with the community, and in fact, we would just be a shadow of ourselves if we didn't have the level of collaborations that we have." (Participant BH1S)

"We are working on… trying to have a kind of large continuum of services and housing, giving clients as many options as possible to meet their needs. We're really looking at person-centered care issues, meeting folks where they're at, giving them flexible services to meet their individual needs." (Participant IH2I)

"We're represented in about 40 community coalitions, task forces, discipline-specific groups throughout the area. So we do an awful lot of community coordination. Then, programmatically, we have a range of collaborative partnerships with shelters, supportive housing organizations, the city, other health care organizations and so forth." (Participant BH1D)

"Another reason why we tend to collaborate is if we notice a gap. Like we are always looking for clients that are living in a shelter that are looking to move into permanent housing and to connect with services in the community that will help them maintain independent lives in the community." (Participant EH1E)

Leadership of collaborations varied, with City Hall, the Continuum of Care (CoC), or a committee serving most often in the leadership role. Within the collaborations, the importance of having diverse partners and establishing buy-in early was mentioned in a number of interviews. In addition, one participant stressed the importance of preparing the next generation for

leadership to ensure longevity of the work.

Finally, when asked if local communities are working together to implement *Opening Doors*, most responded that while their community is working together, it is not to implement the Plan. It was mentioned that, if anything, the local CoC may be affected by *Opening Doors*, typically by working to aligning their strategies around the Plan's goals, as they relate to HUD funding. That said, in answering this question, most key informants mentioned they are working together to implement their local plan.

"Well, the community is working together to address homelessness, it's not necessarily working to implement Opening Doors. We are working through the Continuum of Care process and through a local 10 year plan to end homelessness; both of which preceded Opening Doors." (Participant DH1O)

"I think that Opening Doors and the philosophy and the direction that the city is moving are consistent with one another. But, I wouldn't say that Opening Doors is stated explicitly as an area of focus for this city." (Participant BH1S)

"I look at Opening Doors in my day to day work, really as informing me… I can use it to say 'Okay, these are the priorities of the government, where do they dovetail with ours' instead of saying 'I'm going to dovetail my priorities with what the federal government had said.'" (Participant NH1K)

Finding #3: Results of the Literature Search were Supported and Enhanced

The interviews asked a number of questions related to leadership characteristics, barriers to collaboration, and specific to integration initiatives, key drivers, barriers and lessons learned. The purpose of asking these questions both in general and specific to integration was two-fold: first, to uncover specific examples of named themes of *Opening Doors* in practice, and second, to determine alignment with the literature review proposed Framework (Table 9). Overall, this Framework was further supported, and in many instances, enhanced by the interview data. Participants named a number of characteristics in response to these questions, and frequency of mention was used as the measure of analysis. The coded results are presented below as word

clouds generated using the "Wordle" on-line application (www.wordle.net). This type of summarization is supported by Johnny Saldana in *The Coding Manual for Qualitative Researchers* as providing a visual depiction of the most salient words in select text, as in its output, the size of the word reflects its frequency of mention.[61]

Each and every participant answer was coded and entered as input in the "Wordle" on-line application to create the word clouds (a participant could provide multiple answers for each question). The tilde character (~) was used between words to ensure an entire phrase was captured verbatim. In the resulting word cloud, the tilde becomes the space between the words. The application's 'Language' setting was also adjusted so common words, including three letter words, would not be removed. As stated on the web site, Wordle uses a specific algorithm, developed and owned by IBM Corporation, whereby the size of a word in the resulting word cloud is proportional to the number of times that word is entered as input (the source codes are copyright of IBM Corporation and not publically available).[62]

Leadership Qualities

Participants were asked the following question:

What leadership qualities (personal and organizational) do you feel are needed to advance collaborative initiatives addressing homelessness in your community? *Follow Up: What specific aspects of leadership do you rely on to advocate on behalf of your organization or patients in the community – or what is your personal leadership style?*

The question was designed to be broad so as to cross the categories outlined in the Framework. In many instances, participants mentioned that the personal and organizational characteristics overlapped or were the same. As shown in the word cloud in Figure 7, purpose and commitment, multidisciplinary systems thinkers and communication were mentioned by key

informants most often. Personal characteristics mentioned included courage, trust and creativity. All characteristics named by participants in answering this question were entered in the Wordle on-line application to create the Figure 7 word cloud.

Barriers to Collaboration

Participants were asked the following question:

What are barriers preventing collaboration across homeless-focused organizations in your community? *Follow Ups:* *What are common issues that arise in the course of your work that prevent community collaboration?* *How have you addressed these issues?* *Could you tell me a story or give me an example of how one of these barriers affected your work and what you did to address it?*

As above, this question was designed to be broad so as to cross the categories outlined in the literature review Framework. A similar reduction of the interview responses was done using Wordle. As shown in the word cloud in Figure 8, competition, funding and resources and philosophy of care were mentioned most often by participants. Philosophy of care includes the different points of view that can be taken when serving the homeless, meaning religious or caring for specific subpopulations or representing a specific discipline such as primary care or behavioral health. This is especially relevant to this study given the subpopulation focus of *Opening Doors*, which has also been reflected in resource alignment. The most common personal characteristic named as a barrier was fear.

Figure 7. *Leadership Qualities Word Cloud*

Figure 8. *Barriers to Collaboration Word Cloud*

Specific to Integration

Participants were also asked a series of questions related to their experience working on a specific collaborative effort, integration initiatives defined as efforts to integrate primary care, behavioral health care and housing. Table 17 below outlines the key drivers, barriers to integration and lessons learned that were either named verbatim or could be captured within that code by participants when answering these questions. The codes or characteristics are listed in order of frequency of mention (high to low).

Table 17. *Key Drivers, Barriers and Lessons Learned from Local Integration Initiatives*

Key Drivers	Barriers	Lessons Learned
Purpose and Commitment	Funding and Resources	Communication
Needs of Homeless	System Structure	Purpose and Commitment
Planning and Operations	Trust	Accountability
Funding and Resources	Competition	Needs of Homeless
Communication	Federal Compliance	Relationships
Leadership	Open and Transparent	Diverse Partners
Accountability	Politics	Buy-In
Overall Systems Control	Narrow Focus	Leadership
Federal Compliance	Data	Trust
	State Regulations	Open and Transparent
	Fear	Planning and Operations
	Relationships	Funding and Resources
	Accountability	Creativity
		Resourcefulness

Table 18 below illustrates the overlap seen across these questions, and how often a code or characteristic is used as both a key driver and a barrier. Characteristics were first sorted alphabetically, and then in descending order based on the number of participant mentions.

This section is perhaps best summarized by a participant:

"I think of the three aims of health care reform, and I think that those are essentially kind of the drivers…providers really want the individual to have a better experience of health care, we want to see improvements at the population level in health outcomes, and ultimately we all know that we have got to contain these costs, they are consuming more and more of our GDP and they are going to have a drag on our economy over time and that too is a moral imperative." (Participant CH1S)

Table 18. *Overlap of Key Drivers and Barriers*

Leadership Qualities	Barriers to Collaboration	Key Drivers	Barriers to Integration	Lessons Learned
Purpose and Commitment	Purpose and Commitment	Purpose and Commitment		Purpose and Commitment
	Funding and Resources	Funding and Resources	Funding and Resources	Funding and Resources
Communication	Communication	Communication		Communication
	Turf/Competition		Competition	
Needs of Homeless	Philosophy of Care	Needs of Homeless		Needs of Homeless
Courage	Fear		Fear	
		Overall Systems Control	System Structure	
	Accountability	Accountability	Accountability	Accountability
Open and Transparent	Lack of Transparency		Open and Transparent	Open and Transparent
		Planning and Operations		Planning and Operations
Relationships	Relationships		Relationships	Relationships
Trust			Trust	Trust
Data-Driven	Data		Data	
Creativity				Creativity
Experienced	Experienced			
		Federal Compliance	Federal Compliance	
Political Will	Politics		Politics	

Finding #4: Organizations Prefer Internal Integration, if Possible

A stated *Opening Doors* Theme is to 'Integrate primary and behavioral health care services with homeless assistance programs and housing to reduce people's vulnerability to and the impacts of homelessness' (*Opening Doors*, Theme 4). Key informants were asked a series of questions related to their experience working on integration initiatives, as it is both emphasized in the Plan and an example of local collaboration.

Many of the organizations represented in the interviews are internally integrated, at least with two of the three services (primary care, behavioral health, housing), and then establish referral partnerships to ensure comprehensive care. These partnerships are primarily driven by the needs of the homeless as supported by local data. If it can be accomplished, internal integration, and staffing an integrated care team, is seen as ideal as opposed to providing the services through partnerships. The following excerpts provide examples of how this was expressed by participants.

"I look at it in two ways: two key drivers. One, I think anytime you can have overall system control, I think you have much more success in integrating those services. If you don't have overall system control, if you can have some body…that can at least set the overarching goals and the direction… we can influence folks to move in that way to integrate those services." (Participant EH2O)

"We have evolved to provide a range of services under one roof and we leverage funding sources from a range of places. As far as our own service delivery, we've built over the last 25 years or so that capacity in house to provide all of those resources and to leverage all of those potential funding sources." (Participant BH1D)

"What we have seen over time is because of the lack of resources within the mainstream systems that we've had to expand our own level of integrated health services within the organization and to develop our own housing to ensure that the housing was available to homeless individuals who would have otherwise been screened out… We've found that when there is a separation in those responsibilities and in different organizations, gaps occur. When services are provided though collaborative agreements as opposed to specifically funded with specific, well-defined roles and responsibilities and more important, accountability, there can easily be gaps and less than positive outcomes from that arrangement." (Participant DH1O)

For integration initiatives, regardless of internally or externally based, communication was emphasized by many key informants. The ability to discuss individual cases and plan a course of action together was essential to serving patients effectively.

> ***"I think that the thing that is driving people to the table… to have these conversations and to start to create the kind of partnerships we envision is having a positive impact on people's health care and an ability to drive those costs down. Whenever we get a little stuck, I always like to bring it back to why we are at the table, because usually we are stuck on how to do this… not on why." (Participant CH1S)***
>
> ***"Having regular case conferences really helps to ensure better integration. Sometimes that can be a real pain in the neck and sometimes it's not even practical, depending on how it's structured. If we work it out where the case conferences are effective and efficient and helpful for all parties, that is important." (Participant NH1K)***

"Planning and Operations" was also mentioned a number of times as a key driver, especially involving partners early and taking the time to work through all levels of a program before going live.

> ***"You really need to take the time to put together a quality program and make sure that you have the parts ready and available to go forward when the time comes…We would have had a much better success on a number of our projects had we been able to have all the pieces in place from the beginning." (Participant AH2A)***

Common barriers to integration mentioned were classified as "funding and resources" and the structure of the system within which organizations work (systems structure). At times, these overlapped. For example, Medicaid reimbursement was commonly mentioned as the solution to funding supportive services and in turn supporting integration efforts. However, in some States, Medicaid has not been expanded to be inclusive of the homeless (to incomes below 100% FPL) and/or the supportive services are often not billable. In some instances, state regulations also prevented integration.

"I'd say that there's a snowball's chance in hell that we would be able to reach [the goals of Opening Doors]. Primarily because there aren't the resources available in our community or in our nation to be able to achieve those goals… policy, resources, and the contributing factors to increase homelessness are all moving in the wrong direction to achieve those goals…" (Participant DH1O)

"The only thing anybody is pointing to with trying to get funding for case management is Medicaid billing, and there's enough problems with the Medicaid system that I don't necessarily want to rely on that, and then also trying to get a waiver for Medicaid billing." (Participant AH2A)

Finally, the discipline-specific philosophies traditionally associated with primary care, behavioral health and housing are quite different. When working on integration, these mental mindsets can often serve as a barrier. Another example provided by a key informant was a time where a health care person needed to do the job of a housing person. While intentions were good, in practice, it was actually limiting to the success of the program. To work through this, informants stressed communication and focusing on the purpose of the program and needs of the homeless.

"They've been terrific partners with us recently and that's been the biggest change overall with regard to integrating and housing…within the homeless services. Because they didn't come with the understanding that housing is health care, they didn't come with the understanding that providing holistic services to the client is going to make them a more successful tenant. They just came with the idea that, ok we just have to provide these to these homeless people." (Participant AH2A)

"We have worked really hard to develop a table, both literal and figurative (sic)***, around which all of those voices can be heard and feel that they are heard. That's been key to really making integration work and having time for that integration to work and take hold." (Participant BH1D)***

Finding #5: Local Priorities Rule, Especially Given the Lack of Resources

As evident throughout this Chapter, the most frequently discussed item across all questions and during the majority of the interviews was the local plan. Many local plans had been in place prior to the development of *Opening Doors*, and there is a sense of pride and

commitment towards these plans first and foremost. As mentioned previously, local plans often served as the purpose of community-wide coalitions, with well-defined and established leadership.

"We have our own local plan that was developed before the federal plan, and it's actually in its second phase, so it's plan 2.0, and it very closely mirrors the federal plan, and I would argue that it goes a little bit further." (Participant CH1S)

"We recognize that many of our priorities reflect those national priorities." (Participant EH2O)

"We have always talked about political will being an important piece and one of the things that we are seeing with the 10 year plan to end homelessness is that once the Mayor left to become Governor and the leadership of the mayor dissipated that some of the foundations of the 10 year plan and that community effort kind of fell apart and became somewhat dysfunctional. So part of leadership is consistency and continual commitment." (Participant DH1O)

The local plans are reflective of the local needs with solutions that have been vetted on the ground. Given shrinking budgets and competition for resources on one side and growing demand for services on the other, it is easier for communities to align around a locally developed plan than one that has been developed and dictated at the federal level. It was often mentioned that *Opening Doors* needs to have resources and be more reflective of local communities if it is expected to ever have any traction at the local level. As stated best by one participant:

"...dictation without provision leaves communities where they've always been and that's working on themselves." (Participant EH2O)

The cuts in federal funding negatively impacting the ability to provide the necessary supportive services locally was mentioned often throughout the course of the interviews, as mentioned, as a driver, barrier, purpose for collaboration, funding requirement and policy initiative. A number of participants mentioned the Affordable Care Act (ACA) and Medicaid funding as either the answer or the perceived answer within their community to long-term

funding for supportive services. A few spoke of the confusion that exists around reimbursable services, and how it is perceived these policies will help support ongoing projects.

"…The only thing that provides some glimmer of hope is the potential for implementation of the Affordable Care Act to expand healthcare and mental health resources for those who are homeless…" (Participant DH1O)

"We have a current system that is built around payments that come from treatment, not prevention. So we have a health care system that really pays providers only when someone is sick and only for the treatment of sickness. It is really quite a structural change to move from… to ask people to let go of what they know… to engage in new ways of getting reimbursed for their services." (Participant CH1S)

"Through the Affordable Care Act (the state) was able to expand Medicaid. There is a lot of work going on surrounding the implementation… I've noticed it is much different from the past when everyone worked in silos." (Participant HH2L)

Specific to Opening Doors

Participants were asked questions at the beginning and end of the interview about awareness, implementation, impact and potential for success of *Opening Doors.* All participants had heard of *Opening Doors.* However, the local communities represented in this study are not working together to implement *Opening Doors* directly. Inadvertently, by working on their local plans, these local communities may make strides towards the goals and strategies outlined in the Plan only where there is overlap with goals and strategies of the local plan or where federal funding dictates compliance. Specifically, when asked if their community is working together to implement *Opening Doors*, the most common response was: **"*No. We are working together to implement our local plan.*"**

Overall, participants felt that the Plan served as a guide, framework or a philosophy that could connect all homeless service providers. Given the overlap of responses when asked about the Plan's potential for success in their community, participant responses are summarized here:

Interview Question: What are your thoughts of the Plan's potential for success in your community? In reaching its goals overall? Please describe.

Summarized responses:

- *If people are thinking about it, good to very good…success with local vision and goals*
- *It has potential…needs resources*
- *Misalignment of resources and goals*
- *Fundamentally disagree with the subpopulation focus*
- *Goals are ambitious and it is resource limited*
- *Right vision…funding misalignment*
- *Lofty goals likely unattainable within stated time frames*
- *Admirable goals – intent is right*
- *Might work best in communities with limited local resources or stretch systems, or those without a local plan*
- *There is no one size fits all plan*

As illustrated above, coupled with the lack of resources, there is some disagreement at the local level as to the content or approach taken by *Opening Doors*. First, a number of communities are focusing on more preventive approaches to homelessness, which they feel are missing entirely from the Plan. There are a number of subpopulations that are emphasized in the Plan, and resources have been allocated accordingly, namely veterans and chronic homeless. There were a number of key informants who do not feel that focusing on specific subpopulations of the homeless is the right approach to ending homelessness. In fact, an unintended consequence of shifting resources across subpopulations is to increase homelessness in the other subpopulations or suggest that one population is more important than another.

"Those that don't get the services that they need now will become the chronically homeless over time. Ending the homelessness of those that fit that definition without also shutting off the faucet (so to speak) that is filling up the bathtub, we're just producing more people that will one day fit that definition." (Participant BH1D)

Furthermore, there were a few participants who drew on the early literature supporting the original Housing First model, a strategy of *Opening Doors*, whereby supportive services integrated in housing represents the foundation of the model and key to its success. However, as discussed previously, in practice, supportive services have been cut from much of the federal funding and therefore not as readily available. In practice, many permanent supportive housing buildings do not house or provide the level of access to supportive services as the original model deems necessary to achieve the successful outcomes. As best stated by an informant:

"They were spending hundreds of thousands of dollars on supportive services to take someone who has been on the street for 20 years with a 30 year heroin addiction and chronic mental illness and then all of a sudden you put that person in housing. All the phenomenal outcomes, which I absolutely believe that they were real… they occurred when you were essentially moving all of the supportive services into someone's house. And yet the federal policy really went to supporting Housing First that's literally housing with very little funding if any for the support services…and when you read the studies that they're based on it is all about bringing the support services in house." (Participant BH1S)

Perhaps most revealing in assessing the status of *Opening Doors* implementation at the local level are the responses to the following questions:

How does a strategic plan of this kind affect your daily work?
Do you feel a sense of responsibility or accountability to *Opening Doors*?

Participants stated that the Plan affects their daily work where it overlaps with the local plan, in advocacy efforts and from a funding and resource perspective. It was restated that the Plan has unrealistic goals and serves as a framework only. One participant even named the Plan itself as a barrier to daily work. Participants only felt a sense of responsibility and accountability

to the Plan given the commitment to the cause shared across all key informants. The most common response when asked about responsibility and accountability is summarized as, ***"I have a sense of responsibility and accountability to the homeless individuals that we serve."***

Finally, participants were asked to provide their thoughts on the role of the HCH provider in implementing *Opening Doors*, as well as what is needed to aide implementation from either USICH or the National Health Care for the Homeless Council (National Council), the national membership association of the HCH grantees. Advocacy, especially for the complex needs of the homeless and funding and resources; best practice sharing; and participating in local solutions were mentioned most often by participants as the appropriate role for HCH.

"I think that HCH have a responsibility to partner in their communities, to help move the agenda forward, the shared agenda forward, to do the advocacy work that the rest of us can't really do…" (Participant AH2A)

"At the leadership level, the health care for the homeless providers are able to share their experience of the people they serve within the community." (Participant CH1S)

"Highlight the relationship between homelessness and health care" (Participant EH2O)

Table 19 outlines the responses using the codes and general themes assigned by the author to interpret these responses, listed in descending order by frequency of mention.

Table 19. *Role of HCH*

Suggested Role of HCH
Advocacy
Scope / Causes Purpose / Commitment
Best Practice Sharing Resources
Convener Partnerships / Collaborations
Leadership Data / Planning and Operations System Structure / ACA

The suggested role is best summarized by a participant:

"I think that when we try to understand the role that we all play in the community, I think it's important to understand that we're not caring for the same patients as even the safety net hospitals…and I don't think necessarily that everyone understands the burden of illness and the cost of caring for the patients, and…I think we are in the unique position to be able to help say here's what the solution is. When you look at housing…we know that housing works for people and frankly it's just a right that should exist, but the HCH programs really play that unique role where we can bring services into the home, and we can help break the cycles of mental illness, and addiction, and inappropriate use or unproductive use of hospitals and EDs." (Participant BH1S)

Funding and resources, technical assistance and efforts that reflect local needs were requested of the National Council and USICH. The National Council should continue to provide a collective voice for how important health care is to housing stability, promoting a 'housing is health care' message. Furthermore, given the differences across federal agencies in addressing homelessness (definitions, eligibility), a call for USICH to better coordinate across the 19 federal agencies was made related to funding, services and policies.

"…strategic ways to find alternative funding resources for services." (Participant IH2I)

"From my perspective I feel alienated from USICH many times. I just feel like they've decided what they're going to do and to hell with what you at the local level have to say." (Participant EH2O)

"For HUD to keep saying that we need to reduce the amount of times that we have people in homelessness means that they really need to put forward more dollars, somebody needs to put forward more dollars to mitigate the poverty that's causing many of these people's homelessness." (Participant AH2A)

"When we bring up from the local level some of what appear to be competing interests between federal agencies, give us an avenue since you're an interagency council and you have all these main heads, nineteen of you sitting around a table, how about understanding how your different policies put us in a tough situation out here when they're not uniform when they're talking about the same thing." (Participant EH2O)

The following table outlines the responses using the codes and general themes assigned by the author to interpret these responses, listed in descending order by frequency of mention.

Table 20. *Need from National Council or USICH*

Stated Needs from National Council / USICH
Funding / Resources Aligning Federal Resources
Reflect Local Needs Strengthen Local Systems
Advocacy Best practice sharing Data / Planning and Operations
Communication Technical Assistance
Establish realistic goals and guidelines Scope / Cause

A few participants expressed strong opinions related to the role of USICH and *Opening Doors*, as summarized by participants:

"Things seem to just come from on high down, and there seems to be very little room for innovation…anything that's new is not going to have an evidence based all the time…theoretically you know it's going to work, but I'd just like to see more reflection of what we're dealing with for real at the local level." (Participant EH2O)

"Basically we need to hold [USICH] accountable and continue to advocate for strategies that are realistic and that address the real drivers of increased homelessness and the barriers to decreasing homelessness, which are more systemic and more resource-based than what their plan addresses. …We need to continue to point out where there are gaps in their approach and essentially to say to the emperor, the emperor has no clothes." (Participant DH1O)

Differences between Groups – HCH and Housing, Medium and Large Cities

Overall, there were not many differences between the interview groups; the results reported above did not vary substantively across the two key informant groups or by city size. On the Housing side, there was an emphasis on their role as a funder in the local community, and the pressure felt at the local level as a result of any decision made at the federal level, including funding and policy changes. Compliance with federal funding sources, namely HUD, and federal coordination and collaboration were also stressed, in addition to guidance on decisions as they often will be asked to explain or disseminate the information in the local community. The

disagreement with and unintended consequences resulting from the subpopulation focus was expressed more by the HCH informants. Housing key informants called on their HCH counterparts to be responsible, active advocates in their communities. Finally, there was not as much integration on the housing side. It was a goal to provide services on site, but funding and regulations often made this difficult. Integration was achieved more often through referral partnerships than the internal integration seen on the HCH side. Participants representing the large cities emphasized the need to coordinate services and resources based on data throughout the course of the interview.

CHAPTER 5: Discussion

The analysis of these interviews indicates that local communities are dedicated to serving their homeless populations and focused on their local priorities and solutions. Communities are working collaboratively to serve the homeless, typically driven by goals and solutions laid out in local plans. Local plans may align with the goals of *Opening Doors,* but this alignment is not automatic or necessarily related. Where this overlap exists, it is interpreted that the Plan is being implemented in local communities. With multiple community-wide collaborations and competition for resources, there is an opportunity for *Opening Doors* to serve as a uniting tool. However, without dedicated resources attached to its themes and strategies, Opening Doors will remain a 'pie-in-the-sky' guide and make little traction as a national framework or collaborative effort. The importance of integrating services to care for the homeless evident in the Plan is supported by this research. However, the results suggest this integration is more likely to be implemented internally by a single organization, instead of across community organizations, and then enhanced with referral partnerships if necessary. In light of the results of the literature search and interview data, this Chapter examines how the Findings (Chapter 4, Table 16) serve to answer this study's primary Research Question.

Study Step 1

Characteristics of Successful Local Community Health Improvement Partnerships

As explored in the literature review, much research has been done to outline characteristics of successful community health improvement partnerships. The participant interviews supported the notion that partnerships are a means to addressing health issues

collaboratively, aligning with existing literature. Their collective input detailed in Chapter 4, Finding 3 further expanded the Framework presented in Chapter 2 as outlined in the third column of Table 21, below.

Table 21. *Enhanced Framework, following key informant input*

Category	Lit Review Description	Participant Input
Leadership	Included in all studies, to be successful, a partnership needs to have a defined leader, supported and recognized both internally and externally. The leadership should have extensive knowledge of the issue and the external environment within which the partnership is working.	Leadership should be multidisciplinary systems thinkers and focus on developing the next generation of leaders.
Purpose and Commitment	The purpose and commitment of the partnership includes both a clear vision and mission (purpose) and the commitment of the partners to that stated purpose given their individual expertise. The purpose provides focus for the partnership as well as a favorable cost-to-benefit ratio ensuring individual members remain connected to one another and to the partnership. This will allow for flexibility of contributions by the individual members that are focused on the greater good of the partnership and reflective of subject matter expertise of the individual members.	Purpose and Commitment should reflect the needs of the target population, especially where it is complex and requires a multi-systems approach.
Communication	Clear and consistent communication, internally and externally, of the purpose of the partnership and benefits to the community. Communication helps to establish the partnership as the established subject-matter experts.	Communication needs to include active listening and feedback loops. Openness and transparency were mentioned as both organizational and personal traits, as well as both drivers and barriers.
Accountability	Accountability goes hand-in-hand with establishing clearly defined roles and responsibilities, and includes accountability of individual members, leadership, and in some instances, the community the partnership serves.	Accountability tracked closely with the results of the literature search, cited as a key driver and a barrier to both collaboration and integration.
Funding / Resources	Funding and resources enable the partnership to do the work. This likely includes pooled financial resources, in kind contributions of members and joint fundraising.	Funding / Resources should include cost incentives and human capital as well, with an emphasis on experience, expertise and development.
Planning / Operations	Planning and operations represents the actual work of the partnership, including development, implementation and technical assistance. A feedback process, with a shared information system for data collection and analysis, should also be included to allow for outcomes measurement and continuous improvement.	The key component of Planning / Operations is data, including the ability to share data across organizations and the need for decisions to be data driven.

Focusing on local partnerships as the mechanism to best address community health improvement has long been a strategy employed, researched and reported in literature including early government reports, academic journals and texts, as well as in Chapter 2 and referenced throughout this dissertation.[63] [64] [65] As such, the benefit of community collaboration is an accepted assumption in this dissertation. While the Framework above is an attempt to synthesize both literature and key informant data related to the necessary components of successful partnerships, it does not capture *how* these categories contribute to its success. The Framework holds value as a *descriptive* device, but it lacks any salient causal mechanism that can be used to *prescribe* how particular factors will or will not yield either success or failure.

In contrast, Lasker et al present such a causal mechanism.[66] In their paper on Partnership Synergy, the authors review the literature on collaborations and partnerships and present a method of measuring partnership effectiveness with *synergy* as the catalyst. Synergy is described as "the power to combine the perspectives, resources, and skills of a group of people and organizations…[and] the proximal outcome of partnership functioning that, in turn, influences the effectiveness of partnerships." The Framework proposed in this dissertation can be encapsulated within the term 'partnership functioning' and also mirrors the outlined determinants of partnership synergy. The difference, according to Lasker et al, is that synergy emerges from the determinants of successful characteristics and acts as the underlying force for success. As a next step to enhancing the work of local homeless service collaborations, and achieving partnership effectiveness, assisting with operationalizing partnership synergy, specific to the homeless issue, should be considered.

Study Step 2

Local Implementation Status of *Opening Doors*

As stated previously, *Opening Doors* will only be successful with local implementation, specifically by local communities collaborating effectively and working towards the Plan's outlined goals. While all key informants are aware of *Opening Doors*, the results of this study as outlined in Chapter 4, Findings 1, 2 and 5 indicate that communities are working together on their defined local homeless response, which may or may not coincide with the Plan. Therefore, we are no closer to understanding the true status of implementation of *Opening Doors* in and of itself. Further, the goals of *Opening Doors* are measured through existing data collection efforts, primarily through HUD or VA funded initiatives, so progress measured against *Opening Doors* is not necessarily a true indication of implementation at the local level, or indicative of a causal relationship between local efforts and the Plan.

As emphasized by the key informants, a homeless population is defined within the context of the local community; the population and service response are affected by local politics, culture, demographics and history. This supports a premise of Roland Warren's *Studying Your Community*. Community planning and intervention must reflect the defined needs and context of that community, reflective of time and place.[67] There is no one size fits all approach.

Opening Doors is described as a framework for local communities to help drive their local homeless response. However, shifts in funding have followed the Plan, which may or may not reflect the needs of all local communities. Therefore, as the results of this study suggest (Chapter 4, Finding 5), there needs to be adequate room within the Plan for adaptation based on local needs and priorities, and the funding should follow the local incentives. As indicated above,

the top-down approach that is assumed given the emphasis of federal policy and funding alignment does not currently trickle down and align appropriately at the local level. In terms of general public policy cycle modeling, an *implementation gap* has presented itself, where there is a noticeable difference between what the drafters of *Opening Doors* intended when formulating the Plan and what the actual policy outcomes entail upon evaluation.[68] In the absence of a Plan reflective of local needs and priorities, as well as the lack of incentives or funding to encourage communities to align or adapt, this implementation gap is the product of *bad policy execution*.[69]

Study Step 3

Role of HCH Program

The role of the HCH Program in implementing *Opening Doors* is complicated given the general distaste expressed by key informants in implementing *Opening Doors* outright at the local level. That said, the results of this study suggest this should be answered in two ways. Nationally, there is a role for the National Health Care for the Homeless Council (National Council) to play on behalf of all HCH grantees related to *Opening Doors*, and locally, it is essential for the HCH grantee to be involved, or perhaps lead, the local homeless service collaborative response.

The National Council represents the majority of HCH grantees funded through HRSA's Health Center Program. The work of the National Council includes research, training and advocacy. Given the collective voice, the National Council is viewed as the best option for influencing USICH to align *Opening Doors* with a more realistic local community response. This includes resource and incentive alignment, advocating to HHS and other federal agencies to fund supportive services, and overall, ensure the Plan can be more adaptable to local efforts. Furthermore, there is much excitement around ACA, Medicaid Expansion, and the potential

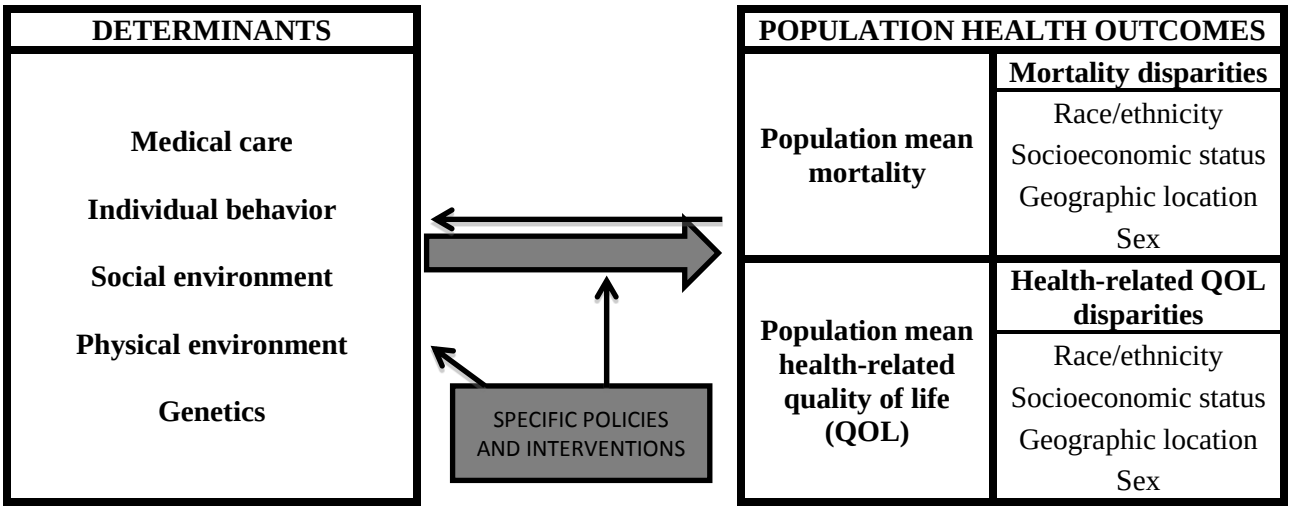
funding and/or reimbursement streams that may come with their implementation. In effect, ACA and Medicaid Expansion thus represent a legitimate "window of opportunity" for HCH providers.[70] In the wake of massive federal health policy transition, HCH providers stand to directly benefit financially and thus be enabled to strengthen its impact and voice through advocacy efforts. It is imperative that education be disseminated at the local level as to its potential impact on homelessness, outside of potentially insuring the uninsured. While this education has begun through efforts led by the National Council and USICH, it clearly has yet to permeate the local communities effectively.

At the State level, many HCH grantees rely on their State Primary Care or Community Health Center Association (or equivalent) to help advocate on regional or state-wide issues. In the late 1960s National Commission on Community Health Services Report Health is a Community Affair, the State government was identified as the most promising "partner in progress" among the levels of government given their autonomy, policy authority and scope of power.[71] It was suggested the State government could be best positioned to help cut through bureaucracy and waste, and efficiently delegate down to the local unit, the closest to the community (identified as local health departments in the report; in this instance, it would be the local Office of Homeless Services). While an early report, given the State ownership of Medicaid Expansion and its identification by informants as a potential game changer, their role in the homeless service response cannot be overlooked.

At the local level, in addition to staying true to the overarching mission of providing holistic care to the homeless, HCH organizations must participate in the local community-wide collaborations. In many communities, housing is the responsibility of local government and often the priority of a government-led community-wide response to homelessness, given the HUD

funding. As Kindig et al note, "The ultimate purpose of population health policy is to improve the health of individuals and populations by investments in the determinants of health through policies and interventions that influence these determinants."[72] The authors' *Figure: A Schematic Framework for Population Health Planning* (recreated below) provides a helpful framework for interpreting this study's results from a population health perspective.

Figure 9. *Population Health Planning, Figure, Kindig et al*



Source: Kindig et al, page 2082

This study's results suggest HCH is uniquely positioned to advocate responsibly and educate local leaders and the broader community on the relationship between health, housing and homelessness, likely one of the best illustrations of the importance of addressing key social determinants of health identified by Kindig et al, including medical care, social environment, physical environment, and individual behavior.

Leadership is identified by key informants as an important role for HCH, especially given local government's inability to participate in advocacy initiatives. HCH is uniquely positioned to partner with housing counterparts to serve the needs of the homeless in the community. Effective HCH leaders must ensure that advocacy efforts fall in line with the mission of the collaborative and are likewise supported by local needs assessment data. Aside from housing

partnerships, leadership is more generally identified as a necessary characteristic for any successful community partnership. However, leadership in the collaborative setting is different from that seen within one's own organization. As explored in Alexander et al, collaborative leadership requires systems thinking, vision-based leadership, collateral leadership, power sharing and process-based leadership.[73] In short, HCH leaders must be trained to be effective collaborative leaders, in addition to possessing the skills outlined in Table 21, above.

Research Question

How best can local communities support implementation of federal public health strategic plans?

The results of this study thus indicate the requirements, if you will, of federal plans to spur local implementation. This study illustrates that local communities will not support federal plans without the required resources or incentives, appropriate alignment and recognition of local priorities, and efforts and/or expected compliance or enforcement. Therefore, when prioritization and incentives are greater at the local level than the federal level, for collective implementation to occur, federal plans must reflect local priorities. Given a federal plan like *Opening Doors*, with no compliance outside of existing funding streams, unless the resources or incentives are there, local communities simply will not fully and meaningfully support such a federal plan unless it aligns (coincidentally or not) with the investments they have already made in their local priorities or the local plan.

As suggested above, and for the purposes of this dissertation, federal strategic plans are considered public policy efforts. At a general, though intuitive level, there will always be misalignment of priorities and resources given competition among policy issues. Put simply, "demands for public action tend to exceed any government's capacity to supply policy responses."[74] As addressed above in the reference to the policy cycle model, it can be argued that

Opening Doors experienced a critical implementation gap as a result of bad execution, represented by its misaligned priorities and lack of resources required for local implementation. In another sense, however, it is also possible that the creation of *Opening Doors* was simply a response to the perceived need for a broad national strategy, and the expectation at the federal level is not that it will be implemented outright. If the latter assertion is the case, we may simply be adhering to Lindblom's *incrementalist* view of public policy, which posits that: constraints of politics, time, cost, and complete information cloud policymaking at the federal level; conservative, though rational, policy decision making should be expected; beneficial and incremental, though not sweeping, policy impacts can be made as a result of existing government policies and programs.[75]

There is much to be learned about precisely why *Opening Doors* faces implementation troubles, or of the Plan authors' original intent, as well as what its future holds. The Plan's goals are supported by outcomes currently measured, and there are no additional resources provided outside of shifts in HUD funding given priorities. There has been limited movement to align the budgets of all the USICH federal agency members, especially HHS, around the *Opening Doors* tenets. In his paper on the role of politics in public health policy, Thomas Oliver states: "A final challenge in policy implementation lies in coordinating the different tasks, organizational cultures, and varying degrees of resources when multiple agencies have a responsibility for a given public health issue."[76] As this was perhaps the impetus to the development of *Opening Doors*, is failure to do so failure of the plan as a whole?

In their seminal work exploring the implementation of public policy based on an economic development project in Oakland, CA, Pressman and Wildavsky outline several key reasons why a federal policy coupled with an infusion of federal funding can fail at the local

level.[77] Over time, a key focus of their work is to consider not only implementation, but also and perhaps most importantly, evaluation, another step in the policy cycle and general policy development.

At the federal level, the Government Accounting Office (GAO) has the official responsibility for evaluating federal programs and policies to provide external assessment of the use of public resources as well as determining overall effectiveness. As the timeframes for completion of the initial goals close in on *Opening Doors*, USICH would be well served to employ the program evaluation framework outlined by the GAO to diagnose the true details of either success or failure of the Plan to date, as well as predict changes that may be needed for the Plan's future considerations. In addition, measures could be incorporated that then might guide and reinforce local community implementation. As outlined in their report, *Designing Evaluations*[78], this should entail:

1. Clarifying understanding of the program's goals and strategy;
2. Developing relevant and useful evaluation questions;
3. Selecting an appropriate evaluation approach or design for each evaluation question;
4. Identifying data sources and collection procedures to obtain relevant, credible information; and
5. Developing plans to analyze the data in ways that allow valid conclusions to be drawn from the evaluation questions.

Finally, local implementation of federal strategic plans has been successful when communities are expected to align program goals and funding proposals with the goals and objectives of the federal plan. For example, to receive federal HIV/AIDS funding, proposals need to clearly align with and outline a contribution to the tenets of the National HIV/AIDS Strategy. While Healthy

People 2020 provides benchmarks and long-term public health goals for communities to strive to achieve, any efforts to do so are locally driven and are so global, it is easy to generate local support.

Conclusion

In general, the results of this study are consistent with the canon that exists on community health and community health improvement partnerships. Specific to *Opening Doors*, however, the results are surprising in two ways. First, it was a concern of the principal investigator that there would be limited, to no knowledge of *Opening Doors* at the local level, and this would be revealed by the key informants. While this was not the case, the almost complete lack of interest in implementing *Opening Doors* was surprising at surface level. That said, in considering the Plan's lack of resources, enforcement and alignment with local priorities, this too is consistent with research exploring local implementation – or lack thereof – of federal plans, most notably the frequently cited writings of Pressman and Wildavsky.[79] It also hints at what Lipsky identifies as a core flaw with the expected *top-down* implementation of any federal policy, and why such large-scale policies do not always translate to successful implementation at *the bottom*, the most granular level of implementation. At the community level, "street-level bureaucrats" face more federal policy expectations than their resources permit them to complete, while federal compliance structures are not strictly enforceable enough to strip them of their freedom to implement such policies as is best for them and their particular locales.[80]

While the focus of this research was primarily local and the connection of local activity to federal policies, the role of State government should not be overlooked as I sought to identify all avenues of support and policy for homeless programs. A few informants mentioned the importance of the State as a partner, funder, and regulator as well as a target of advocacy efforts.

Despite the substantial federal and lesser state role in eliminating homelessness, ultimately, this research illustrates that homelessness must be solved locally. Supporting this notion are the following issues which underscore the key findings of this research and serve as the common, linking threads: federal mistrust, effects of macroeconomic pressures, and the need for supportive services. There is a general sense of mistrust of the federal government, in varying ways: from an inability to clearly provide guidance, to inadequate funding support, to misalignment of policies, funding and priorities. The effects of macroeconomic pressures are felt at the local level both individually and organizationally. For example the economic downturn and resulting federal policy and budgeting decisions contribute to homelessness and limit the organizations which serve them, doubly compounding the negative impact on homeless individuals. The study shows that supportive services are the key to assisting homeless individuals, as aligned with the public health social determinants approach. However, supportive services are not funded at an appropriate level and they are often cut from federal programs. Whether a result of political, institutional or macro-systemic pressure, this result only further fuels mistrust of the federal government as a broker and facilitator of such policy.

Based on this research, *Opening Doors* is at a crossroads in defining its identity at the local level. While the USICH web site outlines significant stakeholder input in the development of the Plan, the results of this study suggest the local implementation was not considered as a part of these initial conversations. In addition to a complete and systematic evaluation, not solely based on measures currently collected through existing sources for related but specific purposes, USICH must specifically determine how *Opening Doors* will best encapsulate local priorities and align funding to further its goals, or it needs to be sure the goals and strategies are broad enough that all communities can support them in some way. Without such exercises, or an

unlikely Kuhn-like paradigm shift at either the local or federal level, it is unlikely *Opening Doors* will realize nationally-sweeping success.[81]

Limitations

The first federal strategy to prevent and end homelessness, *Opening Doors* attempts to align 19 federal agencies and a country of stakeholders in a coordinated federal response to homelessness through measurable and achievable goals, realigned government resources and policies and technical assistance. It has been over three years since the initial release of *Opening Doors* in June 2010, and while annual updates have been released since that time, this study focuses on the original version. The Plan itself is designed to be broad-reaching; however, this study focuses on direct relevance to health care and leadership. Results and recommendations may not be generalizable to the Plan or the broader homeless service community.

The study is a qualitative design, with a small number of key informants selected from a purposeful sample. All the communities represented in this study are medium to large cities, and they do not geographically represent the entire United States. However, within the informant groups, "saturation" or agreement or repetition of themes and facts across all informants and between the two sub-groups was reached rather early in the interview process, and data were consistent across the interviews.

While the principal investigator made every effort to limit interview bias and keep interviews consistent and questions clear, there are different definitions within the homeless service community that might lead to nuanced differences in responses. HCH and Housing use different definitions of homelessness in program eligibility and implementation. Participants were quick to answer questions from the local perspective. Further, as the principal investigator works in the field, it is possible this affected the participant responses.

Finally, this research study is based on input from the local level only, as the goal was to obtain ground level insights and information related to a federal plan. Individuals at the federal level with responsibility for or knowledge of *Opening Doors* were not included in the study. Therefore, the study results rely on the participants' understanding of the Plan, which may not capture the intent or even content.

CHAPTER 6: Plan for Change

In early 2011, as a relatively new member of the Care Alliance Executive Team, I attended the opening of one of Cleveland's permanent supportive housing buildings. A USICH staff member was the keynote speaker, and I was exposed to *Opening Doors* for the first time. I came back and asked my boss, the Care Alliance CEO and a dissertation committee member, if he had ever heard of this strategic plan. He responded that aside from brief mentions from time to time, he certainly did not have a deep knowledge or understanding of the Plan, and further, as far as he knew, the community did not rely on it for collective action. I found it strange there was a national strategic plan to end homelessness that, for all intents and purposes, we at the local level knew nothing about and were not working together to implement. And that day, I embarked on this research.

Improving the Homeless Response System

With the interrelatedness of traditionally distinct silos required to end homelessness, locally and federally (top, down, across), the work of Donella Meadows can be helpful in understanding how best to structure a system-wide response to homelessness and identify the appropriate leverage points to serve as a plan for change. As Meadows states, "Folks who do systems analysis have great belief in leverage points. These are places within a complex system (a corporation, an economy, a living body, a city, an ecosystem) where a small shift in one thing can create big changes in everything."[82] As discussed throughout this dissertation, macroeconomic pressures are felt at the individual, organizational, local community and even federal level and affect the homeless 'system' – the definition, program eligibility and

enrollment, cross-discipline collaboration, service access and usage, funding – further perpetuating homelessness. This Chapter suggests improving the national homeless response (the system) through two leverage points: updating *Opening Doors* to reflect the results of this study (national plan for change) and strengthening the operations and partnerships of Care Alliance Health Center to improve the health of Cleveland's homeless (local plan for change). As such, two sets of recommendations and corresponding plans for change are proposed, together referred to as the Plan for Change (local and national). They provide top-down and bottom-up leverage points to influence the system, working together towards the goal of improving the health of the homeless.

The table below, Table 22, outlines how the national and local recommendations were derived from the Findings given the literature search and interview question data. Building on the Results and Discussion Chapters, three recommendations are proposed to position *Opening Doors* for more likely local implementation and are the focus of the national-level plan for change: reflect and encapsulate the reality of local plans and priorities; align funding and resources to incentivize local community participation; and conduct a complete and systemic evaluation, following GAO principles.

The results of this research do not support a recommendation for an agenda to implement *Opening Doors* locally. Rather, the data gathered and findings of this study can directly assist local communities in strengthening their homeless service response, specific to the HCH provider and the broader homeless services community. Therefore, the local recommendations are to: strengthen the internal operations of HCH providers, improve local collaborations, and share the best practices and lessons learned at the local level. By doing so, the local level contributes to strengthening the national response and improving the system.

Table 22. *Developing the recommendations for Opening Doors*

Research Question: How best can local communities support implementation of federal public health plans?				
Study Step	**Interview Question**	**Finding**	**Recommendations: National Level**	**Recommendations: Local Level**
Study Step 2	Reasoning Integration Responsibility/Accountability to OD	1. The top priority identified by key informants is eliminating homelessness by providing for the *Holistic* needs of homeless people	Opening Doors should reflect and encapsulate local plans and priorities Opening Doors / USICH membership should align funding and resources to incentivize local community participation Opening Doors needs a complete and systematic evaluation, following the GAO principles, to measure the impact of the Plan itself	Strengthen operations of HCH to support efficient delivery of holistic care to the homeless, internally and externally Use the Framework to strengthen local partnerships focused on solving homelessness Contribute to strengthening the national system by sharing best practices and participating in a shared advocacy agenda
Study Step 1, 2	Local Collaborations Reasoning Community Wide Coalition Daily Work Affected	2. Communities are working together to better serve homeless people, just not directly on Opening Doors		
Study Step 1	Reasoning Leadership Characteristics Barriers to Collaboration Key Drivers (Integration) Barriers (Integration) Lessons Learned	3. The categories comprising the Framework proposed in the Literature Search were supported, and the descriptions of each refined and enhanced by the interview data		
Study Step 1, 2	Integration Key Drivers (Integration) Barriers (Integration) Lessons Learned	4. Organizations prefer to be internally integrated, if possible		
Study Step 2	Informed by OD Barriers to Collaboration Key Drivers (Integration) Barriers (Integration) Daily Work Affected Responsibility/Accountability to OD	5. Local priorities dominate in programs, especially where there are resource constraints		
Study Step 3	HCH Role			
Study Step 3	Need from National Council or USICH			

National-Level Plan for Change: Influencing *Opening Doors*

The action steps comprising the national plan for change, outlined in Table 23 below, reflect the data collected in the literature review and key informant interviews. The national plan centers on building a national-level coalition, aligned around the results of this study, to influence USICH to update *Opening Doors* as per the recommendations. The first step towards doing so is to work with the National Council. As suggested by key informants, it is imperative the National Council serves in the leadership role, advocating on behalf of the HCH grantees to carry forward these recommendations to USICH to drive change at the national level.

With the support of the National Council, a shared vision can be built on the results of this study: to align resources and incentives, secure additional funding for supportive services, and overall, advocate for a USICH strategy that is more reflective of or adaptable to local efforts. Uniquely positioned to carry forward a more holistic 'housing is health care' message, as suggested by the results of this study, the National Council can then work to generate the support of its membership by disseminating the results, providing education and technical assistance opportunities to strengthen local coalitions, and advancing the conversation at national meetings and other venues.

Finally, this study supports a strategy of the Plan, *Opening Doors* Theme 1, Objective 2: capacity building and knowledge sharing, which provides an avenue to open discussions with USICH. In addition, this study includes input from both local health care and housing community leaders. However, given the small, purposeful sample, engaging the full membership of the National Council – through the working group, soliciting additional input and/or a membership survey – will strengthen the message.

Table 23. *Plan for Change: Opening Doors*

Goal: Influence national homeless service response to improve the health of the homeless		

Objectives:
• Establish the National Council as lead
• Disseminate study results
  o Ensuring successful community collaborations
  o Status and Future of *Opening Doors*
  o Applying lessons learned
• Generate buy-in and knowledge sharing
• Participate in national efforts to update response		

Activity	**Description**	**Timeline**
1. Meet with key leaders at National Council to present and develop dissemination strategy	Work with Darlene Jenkins to coordinate. Include John Lozier, Barbara DePietro. Involves: 1. Presentation 2. Support 3. Willingness to lend name/credibility *Lead: Care Alliance*	Early 2014
2. Directly disseminate results of study to HCH community	Determine focus of content: overall, framework for success, *Opening Doors*, lessons learned, messages for USICH. Call for additional input, work through National Council's research arm. Rely on network of National Council Involves: 1. Drafting white papers 2. Developing webinars 3. Creating content for newsletters and websites 4. Submitting and presenting at conferences 5. Producing toolkit *Lead: Care Alliance / National Council*	Immediately following Activity 1 (Q1-Q2), ongoing
3. Work with policy and advocacy arm of National Council to develop strategy to share with USICH	Identify additional potential partners to join in the effort and establish working group. Involves: 1. Draft position paper (incorporating existing position papers on ACA and Medicaid Expansion) from HCH perspective 2. Broaden to include local implementation pitfalls *Lead: Care Alliance / National Council*	Immediately following Activity 1 (Q1-Q2), ongoing
4. Meet with key leaders at USICH and explore feasibility of establishing working group to align implementation with local priorities or plans	Dependent on National Council staff for connection. Establish an identity for *Opening Doors* moving forward, role of local communities, etc. Involves: 1. Presentation 2. Willingness for open dialogue 3. Eventual buy-in 4. Align USICH partners 5. Establish solid TA plan *Lead: National Council / Working Group*	Immediately following Activity 3 (Q3-Q4)
5. Incorporate recommendations in Plan annual updates, framework, etc.	Recognize the Plan solely as a framework and mechanism to augment local plans (or, less-likely, attach resources to support its outright implementation). Additional stakeholder input will be required (focus groups, membership survey). *Lead: Working Group / USICH*	Plan for 2015-2016 update

Local Plan for Change: Strengthen Care Alliance and Cleveland Community

As mentioned previously, despite the substantial federal role in eliminating homelessness, ultimately, this research suggests that homelessness must be studied, addressed and solved locally. Local communities are currently working together to serve their homeless population, specific to locally identified needs, demographics, politics and histories. Therefore, a simultaneously-implemented local plan for change is necessary to influence the homeless response system. Reflecting the local recommendations, the local plan for change provides a roadmap for Care Alliance and the homeless service network in Cleveland to improve the holistic health of the homeless.

A key responsibility of my position at Care Alliance Health Center is to lead our strategic planning and partnership efforts. The UNC DrPH curriculum and dissertation process have provided me invaluable insight, useful theory and practical examples to adopt, adapt and grow as a leader at Care Alliance and within the Cleveland community. At Care Alliance, we looked at this research as an opportunity to better understand federal priorities and local experimentation and experience of homeless service providers across the country. From there, we can build and augment our strategic plan and map out our organizational priorities and strategy for growth.

Care Alliance is in the midst of strategic expansion. In April 2012, we won $5.5 million through two competitive federal capital expansion grants. We were the only health center in the state to receive both awards. Care Alliance is leveraging these federal dollars for a total infrastructure investment of $15 million in the Cleveland community. Over the next two years, Care Alliance will strategically expand to deliver our services to more of the lowest-income Cleveland residents through a renovation of our Riverview Tower Clinic and construction of a new Central Neighborhood Clinic. We will also be implementing a redesigned Homeless Outreach Program in early 2014, anchored by a state-funded mobile clinic.

Following a nine-month strategic planning process focused on our readiness and preparation for this growth, Care Alliance received the final deliverables from our national consultants with the following identified priority areas: a) stay true to the homeless mission, b) meet unmet need and c) maximize current capacity. Incorporating the results and recommendations of this study, the following action items are proposed for Care Alliance:

1. Strengthen internal operations, through an efficient frontline process including sliding scale implementation and open access scheduling, to improve practice efficiency and financial viability;
2. Redesign Homeless Outreach Program to successfully integrate street outreach, existing outreach clinics and new mobile clinic;
3. Focus on strategic initiatives, especially integration and workforce development efforts, redefine scope accordingly and constantly evaluate inner-workings of partnerships; and
4. Establish an integrated delivery system across primary care clinic and outreach locations, extended to community partners and supported by transportation network.

The study results suggest homeless organizations are most successful providing integrated services when overall systems control is achieved internally and partnerships are supportive in nature. However, we have long collaborated at the community level to ensure our patients receive the required services outside the scope of Care Alliance, as outlined in Table 24 below. Strategic partnerships focused on providing integrated services are not just a part of our business plan; they are the backbone of Care Alliance and the Cleveland homeless service community and essential to improving the health of Cleveland's homeless. Moving forward, by applying the Framework and key findings, this study provides a mechanism by which to evaluate our partnerships.

Table 24. *Care Alliance Partners*

Focus	Partner
Homeless and Public Housing	FrontLine Service Inc. Lutheran Metropolitan Ministries Drop-In locations Housing First Enterprise Community Partners Cuyahoga Metropolitan Housing Authority
Medical, Dental and Specialty Care	Cleveland Clinic Lab Services St. Vincent's Medical Center The MetroHealth System Cuyahoga Health Access Partnership Podiatry Services Physical Therapy Prevent Blindness Ohio AmeriCares Foundation, Inc.
Quality Improvement	Better Health *Greater* Cleveland John Snow, Inc.
Integrated Health (Primary Care and Behavioral Health)	FrontLine Service Inc. The Centers for Families and Children Beech Brook
Workforce Development	University Hospitals Case Medical Center Case Western Reserve University CSU/NEOMED Cuyahoga Community College Colleges and Universities
Neighborhood Revitalization	HUD Choice Neighborhood Promise Neighborhood Initiative

By serving those living unsheltered on the streets, to those transitioning out of homelessness via permanent supportive housing, to residents of public housing, we are able to support our patients along a continuum of care and walk with them on a journey to health and wellness. The local plan for change outlined in Table 25 is an effort to stay true to this vision. It is based on this study's results and local recommendations, reflects internal activities of Care Alliance, and strives to enhance our existing community partnerships and collaborations.

Table 25. *Locally-driven Plan for Change*

Activity	Supported by Research/ DrPH Program Curriculum	Action Steps for Change	Timeline
1. Finalize Strategic Action Plan (SAP)	Overall DrPH Program Curriculum, focus on Wells, Thomas class Literature Review Framework, especially planning and operations Interview Study Findings, learn from practical examples and focus areas from colleagues	1. Couple strategic planning findings with study results 2. Additional HCH site visits 3. Establish internal working group to draft implementation plan 4. Presentation to Board and Community Stakeholders 5. Measure performance against plan	Current / Ongoing
2. Implement strategic partnerships to enhance and strengthen community collaboration	Overall DrPH Program Curriculum, focus on leadership and Wells Literature Review Framework Interview Study Findings, focus on augmenting CA services, aligning community resources and shared mission/vision	1. Draft internal framework for measuring community partnerships/collaborations 2. Streamline oversight and implementation efforts 3. Leverage experience at the community level	Current / Ongoing
3. Contribute to best practice sharing and advocacy efforts (local, regional, national)	Overall DrPH Program Curriculum, focus on policy (Ricketts) Literature Review Framework Interview Study Findings, role of collective HCH voice	1. Share knowledge and experience through conferences, state and national association vehicles 2. Establish national workgroup through National Council 3. Disseminate study results	See Table 23, above
4. Collectively explore policy development for a streamlined locally-led, nationally-supported response to solving homelessness	Overall DrPH Program Curriculum, focus on policy (Ricketts) Literature Review Framework Interview Study Findings, homelessness must be solved locally	1. Partner with other thought leaders 2. Develop shared advocacy agenda	See Table 23, above

Implementation

Throughout this dissertation, and present in all study steps, the importance of leadership has emerged and been reinforced as a change agent. Bringing leadership principles to bear, we can most effectively implement the Plan for Change (local and national). Pulling from some of the key thinkers in the realm of leadership, Table 26 outlines the steps necessary to direct the efforts required to set the Plan for Change (local and national) in motion.

Table 26. *Implementation of the Plan for Change*

Step	Leadership Principle	Description/Activity
Generating shared leadership commitment from the National Council leadership and buy-in from membership	Gergen's Seven Lessons of Leadership[83]: Drive a shared vision focused on 'housing is health care' for National Council / HCH membership to improve Opening Doors	• Leadership Starts from Within – a simple reminder • A Central, Compelling Purpose – shared commitment to improving the health of the homeless • A Capacity to Persuade – vision integrated into messaging at every opportunity • An Ability to Work within the System – a promise to provide a supportive system • A Sure, Quick Start – within the plans for change • Strong, Prudent Advisors – maintaining stance and commitment, buy-in across membership • Inspiring Others to Carry on the Mission – empowering the coalition to carry out vision
Coalition building, locally and nationally	Kotter's Leading Change[84]: Develop a roadmap to guide the working group and local coalition	• Develop a strategy • Communicate it • Empower broad-based actions • Generate short-term wins • Consolidate gains and produce greater changes
Driving change effectively, internally and externally, and navigating the reality of implementation	Yukl's *Leadership in Organizations*[85]	• Participative leadership, delegation and empowerment (Chapter 4) • Skills linked to leadership effectiveness (Chapter 6) • Influence is the essence of leadership (Chapter 7) • Leadership in decision making groups (Chapter 11) • Strategic leadership by executives (Chapter 12)
	Harvard Business Review's 10 Must Reads on Leadership	• Level 5 Leadership: humility and will are key determinants (Collins)[86] • Be an effective executive: do the right thing(s) in the right way(s) (Druker)[87] • What leaders really do: leadership v management (Kotter)[88]

Finally, to effectively lead and implement a Plan for Change (local and national), all those involved will need to set aside existing operations and differences in philosophies of care, and instead focus on improving the health of the homeless holistically and collectively. Given the key findings of this study, it will be essential to embrace *servant leadership* to best care for the homeless and drive cross-organizational collaboration. As best stated by a participant:

"I think you need to have as much experience as you can directly working with this population. That's made a big difference in a lot of our local leaders that have kind of in their past lives worked kind of on the streets and had direct working experience with homeless individuals, I think it's really important." (Participant DH1O)

The Serving Leader Pyramid, an upside-down model of leadership, represents my personal leadership philosophy, and outlines the following actions and practices: [89]

- *Run to Great Purpose:* to do the most possible good, strive for the impossible. Sustain the self's greatest interest in pursuits beyond self-interest. (bottom of pyramid; first action; foundation)
- *Upend the Pyramid:* you qualify to be first by putting other people first. You're in charge principally to charge up others.
- *Raise the Bar:* to serve the many, you first serve the few. The best reach-down is a challenging reach-up.
- *Blaze the Trail:* to protect your value, you must give it all away. Your biggest obstacle is the one that hinders someone else.
- *Build on Strength:* to address your weaknesses, focus on your strengths. You can't become the best unless others do, too. (top of pyramid)

Implications

At Care Alliance, we have begun to augment the practical experiences shared in the interview study through site visits and follow up conversations to learn more from our HCH colleagues. It is unlikely that we will ever internally provide the full range of health, housing and social services needed to offer a 'one-stop shop' for our homeless patients given the makeup of our local community. Fortunately, we do have existing partnerships to ensure appropriate linkage to services.

Therefore, by implementing the local plan for change, applying the lessons learned through the literature review and interview data, and establishing a mechanism rooted in this research by which we effectively evaluate and execute our strategic partnerships, we can create and strengthen our existing network across the community, working together to serve the needs of Cleveland's homeless.

Given the ability to successfully move the local plan for change forward internally and across the Cleveland community, Care Alliance will be well-positioned to share our experience with the broader HCH and homeless service community and support the national-level plan for change. By working directly with the National Council on this effort, we will elevate the position of Care Alliance nationally among our HCH counterparts, advancing an internal, organizational goal. This plan thus offers great potential for lasting effects at Care Alliance and in the Cleveland community, and it will also influence the national homeless agenda.

The lessons learned from this research are not limited to the field of homelessness. Local communities will support federal public health plans when the goals, incentives and resources are aligned with their local priorities and response. As such, in addition to influencing the national homeless response system through a simultaneous top-down and bottom-up approach, the key findings of this dissertation have the potential to influence the broader public health field:

- The Framework provides a checklist to help strive for success that is relevant to a group of organizations working together on various health issues; and
- The Findings highlight avenues for effective local implementation, mainly aligning goals, incentives and resources with local priorities and resources.

With successful implementation of the Plan for Change (local and national), concrete examples of the results in practice will exist, lending credibility and real-world practicality to this dissertation. From there, this research has the potential to help strengthen community partnerships in general and inform authors of federal strategic plans how best to plan for local implementation.

APPENDIX A. UNC Notice of IRB Exemption

THE UNIVERSITY of NORTH CAROLINA at CHAPEL HILL

OFFICE OF HUMAN RESEARCH ETHICS
Medical School Building 52
Mason Farm Road
CB #7097
Chapel Hill, NC 27599-7097
(919) 966-3113
Web site: ohre.unc.edu
Federalwide Assurance (FWA) #4801

To: Kate Nagel
Health Policy and Management

From: Office of Human Research Ethics

Date: 7/05/2013

RE: Notice of IRB Exemption
Exemption Category: 2.Survey, interview, public observation
Study #: 13-2417

Study Title: Local Implementation of Federal Strategic Plans: The Role of the Health Care for the Homeless Program in Opening Doors

This submission has been reviewed by the Office of Human Research Ethics and was determined to be exempt from further review according to the regulatory category cited above under 45 CFR 46.101(b).

Study Description:

Purpose: To explore factors that drive successful implementation of a federal plan at the local level. Specifically, this study will explore the feasibility of local implementation of the federal strategic plan to prevent and end homelessness (Opening Doors) as it applies to the HRSA-funded Health Care for the Homeless (HCH) Program.

Participants: Leaders of HCH organizations and local government Office for Homeless Services (or equivalent department) in select U.S. cities.

Procedures (methods): qualitative interview study - key informant interviews

Investigator's Responsibilities:

If your study protocol changes in such a way that exempt status would no longer apply, you should contact the above IRB before making the changes. The IRB will maintain records for this study for 3 years, at which time you will be contacted about the status of the study.

Researchers are reminded that additional approvals may be needed from relevant "gatekeepers" to access subjects (e.g., principals, facility directors, healthcare system).

CC:
Thomas Ricketts, Health Policy and Management

APPENDIX B. Recruitment Communications

The following would be used for recruitment of key informants via email.
From: Kate Nagel
To: Potential Key Informant Interviewee
Subject: Request for Participation in Research Study on HCH – Key Informant Interview

Dear < Key Informant>:

I am contacting you with the hope you will join me in a research study focusing on the role of HCH in the implementation of *Opening Doors*, the federal strategic plan to end homelessness. I am currently pursing my Doctorate in Public Health at UNC Chapel Hill and will use the results of this research as both my dissertation and to provide recommendations to HCH, the National HCH Council, USICH and other homeless advocacy organizations.

If you are willing, I would like to set up a one-hour phone interview based on your availability. I will distribute background information including a fact sheet and the interview guide in advance of the interview. You will also receive a written consent form for your signature.

Please do not hesitate to contact me with any questions. Thank you, in advance, for your time and expertise.

Kate Nagel

The following would be used for recruitment of key informants via telephone.

- Hello < Key Informant>
- I am contacting you with the hope you will join me in a research study focusing on the role of HCH in the implementation of *Opening Doors*, the federal strategic plan to end homelessness. I am currently pursing my Doctorate in Public Health at UNC Chapel Hill and will use the results of this research as both my dissertation and to provide recommendations to HCH, the National HCH Council, USICH and other homeless advocacy organizations.
- If you are willing, I would like to set up a one-hour phone interview based on your availability. I will distribute background information including a fact sheet and the interview guide in advance of the interview. You will also receive a written consent form for your signature.
- Do you have any questions regarding the study or your role at this time?
- If not, I'd like to email you the background materials for your review and begin the process of scheduling an interview. Will you please confirm/provide your preferred email?
- Thank you, in advance, for your time and expertise.

APPENDIX C. Consent Form

University of North Carolina at Chapel Hill
Consent to Participate in a Research Study
Adult Participants

Consent Form Version Date: July 5, 2013
IRB Study # 13-2417
Title of Study: Local Implementation of Federal Strategic Plans: The Role of the Health Care for the Homeless Program in Opening Doors
Principal Investigator: Kate Nagel
Principal Investigator Department: Health Policy and Management
Principal Investigator Phone number: 216-965-8562
Principal Investigator Email Address: knagel@email.unc.edu
Faculty Advisor: Tom Ricketts, PhD
Faculty Advisor Contact Information: tom_ricketts@unc.edu

What are some general things you should know about research studies?

You are being asked to take part in a research study. To join the study is voluntary. You may refuse to join, or you may withdraw your consent to be in the study, for any reason, without penalty.

Research studies are designed to obtain new knowledge. This new information may help people in the future. You may not receive any direct benefit from being in the research study. There also may be risks to being in research studies.

Details about this study are discussed below. It is important that you understand this information so that you can make an informed choice about being in this research study.

You should ask the researchers named above, or staff members who may assist them, any questions you have about this study at any time.

Upon review, if you wish to take part in this study, please sign the "Participant's Agreement" on page 4 of this document. Please return the signed consent form prior to your scheduled interview to the Principal Investigator at the email address marked above or fax 216-298-5015.

What is the purpose of this study?

The purpose of this research study is to explore factors that drive successful implementation of a federal plan at the local level. Specifically, this study will explore the feasibility of local implementation of *Opening Doors*, the federal plan to end homelessness, through the lens of the federal Health Care for the Homeless (HCH) Program. You are being asked to participate in the study because you are a leader of an HCH organization or local government leader with responsibility for homeless services in your community.

The principal investigator is a student in the UNC Doctor of Public Health Program and also the Chief Administrative Officer of Care Alliance Health Center, a HCH grantee located in Cleveland, Ohio. The information collected as a part of this study is for dissertation research and also has the potential to inform future HCH programs and policies.

How many people will take part in this study?
If you decide to be interviewed for this study, you will be one of 14 interviewed for this research study.

How long will your part in this study last?
If you decide to participate in this study, you will be asked to participate in a telephone interview for no more than 60 minutes. Additional follow-up discussions may be required to clarify points from the initial interview.

As outlined in the detailed description of the participation process, the majority of your participation time in the study is participating in the interview itself:

1. You will receive an introductory letter and invitation to participate in the study, including an information/fact sheet explaining aspects of the study and your participation.
2. If accepted, interview dates and times will be coordinated via telephone or e-mail
3. Prior to the interview, a confirmation letter will be e-mailed to you with this consent form for your review and signature. Please sign the "Participant's Agreement" on page 4 of this document. Please return the signed consent form prior to the scheduled interview to the Principal Investigator at knagel@email.unc.edu or fax 216-298-5015.
4. You will participate in a 30-60 minute interview over the telephone.
5. If necessary, I will contact you with follow up questions or clarifications after the interview.

What will happen if you take part in the study?
If you take part in the study, you are agreeing to participate in a qualitative interview study via telephone. Participation in an interview for this study will involve the following steps:

- Review the background information and fact sheet to determine your interest in participating in this study
- Schedule a telephone interview
- Review, sign and return this consent form to the Principal Investigator prior to your scheduled interview
- Participate in a 60 minute telephone interview

At any time during this process, please contact the researcher listed on the first page of this form with any questions or concerns regarding your participation.

During the interview, you may choose not to answer a question for any reason. Following the interview, the researcher may contact you to clarify points from the initial interview.

What are the possible benefits from being in this study?
Research is designed to benefit society by gaining new knowledge. The benefits to you from being in this study may be through identification of programs and policies designed to improve the delivery of care to homeless persons in your community. You may not benefit personally from being in this research study.

What are the possible risks or discomforts involved from being in this study?
There are no known or expected risks to participating in this study. You are free to take breaks and/or terminate the interview at any time. There may be uncommon or previously unknown risks. You should report any problems to the researcher.

What if we learn about new findings or information during the study?
You will be given any new information gained during the course of the study that might affect your willingness to continue your participation.

How will information about you be protected?
The information provided through the interviews is confidential (i.e., not shared with anyone outside of the research team) and voluntary (i.e., not obligated to answer any question).

Privacy risks and confidentiality will be addressed as follows:

1. All interviews will be conducted via telephone based on your schedule and allowing for privacy.
2. Identification numbers, rather than names, will be used on research materials to identify participants and help ensure confidentiality. You will be asked to provide preferred contact information and identification.
3. Hard copies of data, interview tapes and recordings, and collateral materials such as consent forms will be stored separately in a locked cabinet in the office of the principal investigator. All interview data will be stored in password protected files on a computer in the principal investigator's office.

The study results will be presented in the aggregate and the names of the individuals kept confidential. Descriptors of all interviewees may be included, but in order to maintain confidentiality, names will not be included. Further, you will not be identified in any report or publication about this study. Although every effort will be made to keep research records private, there may be times when federal or state law requires the disclosure of such records, including personal information. This is very unlikely, but if disclosure is ever required, UNC-Chapel Hill will take steps allowable by law to protect the privacy of personal information. In some cases, your information in this research study could be reviewed by representatives of the University, research sponsors, or government agencies (for example, the FDA) for purposes such as quality control or safety.

If permitted, all interviews will be electronically recorded for later transcription. During the interview, you may request the recording be turned off at any time. Once the data is analyzed and the study completed, all recordings will be destroyed to ensure that no responses would be linked to an individual. Check the line that best matches your choice:

_____ OK to record me during the study _____ Not OK to record me during the study

What if you want to stop before your part in the study is complete?
You can withdraw from this study at any time, without penalty. The investigators also have the right to stop your participation at any time. This could be because you have had an unexpected reaction, or have failed to follow instructions, or because the entire study has been stopped.

Will you receive anything for being in this study?
You will not receive anything for taking part in this study.

Will it cost you anything to be in this study?
It will not cost you anything to be in this study.

What if you have questions about this study?
You have the right to ask, and have answered, any questions you may have about this research. If you have questions about the study, complaints, concerns, or if a research-related injury occurs, you should contact the researchers listed on the first page of this form.

What if you have questions about your rights as a research participant?
All research on human volunteers is reviewed by a committee that works to protect your rights and welfare. If you have questions or concerns about your rights as a research subject, or if you would like to obtain information or offer input, you may contact the Institutional Review Board at 919-966-3113 or by email to IRB_subjects@unc.edu.

Participant's Agreement:

I have read the information provided above. I have asked all the questions I have at this time. I voluntarily agree to participate in this research study.

_____ _____
Signature of Research Participant Date

_____
Printed Name of Research Participant

_____ _____
Signature of Research Team Member Obtaining Consent Date

_____
Printed Name of Research Team Member Obtaining Consent

APPENDIX D. Interview Guide

Key Informant Interview Guide: HCH and *Opening Doors*
IRB Study #13-2417

Welcome
Thank you for agreeing to participate in this interview to discuss the role of HCH in the implementation of *Opening Doors.* I am Kate Nagel, a student in the UNC Doctor of Public Health Program. I am also the Chief Administrative Officer at Care Alliance Health Center in Cleveland, Ohio. The information I collect as a part of this study is for my dissertation research and also has the potential to inform future HCH programs and policies.

I plan to disseminate and/or present portions of the dissertation, in which case the findings would become public. The interview will be completely confidential, and any information you provide will be released only as summaries. Your name will not be connected to your answers.

In order to fully capture your responses today, and as outlined in the consent form, I would like to record our conversation. If you would like to have me stop the recording at any point in our conversation, please let me know and I will stop the recording. You are free to not answer any question. Once the interview is transcribed, I will destroy the recording.

Introduction
The purpose of this interview is to learn more about the local implementation of *Opening Doors,* including practical applications, barriers to implementation and technical assistance need and opportunities. Two individuals from seven cities across the country – the leader of an HCH organization and local government leader with responsibility for homeless services –will participate in the interviews. The interview should take no more than sixty (60) minutes. I am happy to answer any questions you have about the research study or the interview.

Interview Questions
<u>Opening</u>
O-1 What is your job title?

O-2 How long have you been with <Organization>?

<u>Introduction</u>
I-1 Have you ever heard of Opening Doors, the federal strategic plan to end homelessness?

If no, do you have experience implementing other federal strategic plans and/or national strategies in your community? Which ones? What's worked? What hasn't? Why?

I-2 Opening Doors calls on local communities to collaborate on implementation. Is your community working together to implement Opening Doors? Are you involved? How so?

I-3 What are your thoughts of its potential for success in your community? In reaching its goals overall? Please describe.

Related to OD Theme 1 (leadership, collaboration, civic engagement). One of the themes of Opening Doors is to 'Increase Leadership, Collaboration, and Civic Engagement.' The next set of questions focus on how your organization works to do so in general in your community.

T1-1 Does your organization collaborate with other organizations focused on homelessness at the local level?

- *If so, with what other organizations?*
- *What do those collaborations look like?*
- *How did they develop?*
- *How long have they been going?*
- *What reasoning guides how you select organizations with which to collaborate?*

T1-2 Is there a community-wide coalition with a shared vision or mission working together on common goals? Is there a defined leader(s)? Who participates?

- *Has it been influenced by Opening Doors? How?*

T1-3 What leadership qualities (personal and organizational) do you feel are needed to advance collaborative initiatives addressing homelessness in your community?

- *What specific aspects of leadership do you rely on to advocate on behalf of your organization or patients in the community – or what is your personal leadership style?*

T1-4 What are barriers preventing collaboration across homeless-focused organizations in your community?

- *What are common issues that arise in the course of your work that prevent community collaboration?*
- *How have you addressed these issues?*
- *Could you tell me a story or give me an example of how one of these barriers affected your work and what you did to address it?*

For example, here are some barriers mentioned in the literature: lack of understanding of roles and responsibilities; silos or competition; limited funding or resources; IT, planning or operations challenges; etc.

Related to OD Theme 4 (primary care, behavioral health, housing integration). Another focus of Opening Doors is to 'Integrate primary and behavioral health care services with homeless assistance programs and housing to reduce people's vulnerability to and the impacts of homelessness.' The next set of questions is related to your experience working on integration initiatives.

T4-1 Does your organization currently work with community behavioral health organizations (or similar) and/or local housing organizations to integrate services for the homeless?

- *If yes, Why? Who are your primary partners? What were your primary motives for embarking on the integration project? How do you work with them? Will you share some of your experiences – both positive and negative?*
- *If not, why not? Have you tried it before – thought about collaborating, or started to do so with an organization, only to stop for some reason?*

This question may have been answered above – if so, is there anything you'd like to add that wasn't addressed in the above question?

T4-2 What are the key drivers of successful integration of primary and behavioral health care services with homeless assistance programs and housing?

- *Have you found particular factors of success that, when present, have led to more successful collaborations, for example strong or shared leadership, shared purpose and commitment, well-defined roles and responsibilities, etc?*
- *What do you need to effectively achieve integration?*

T4-3 What are the barriers to achieving integration of primary and behavioral health care services with homeless assistance programs and housing?

- *At any point during an integration project, did an issue(s) derail the project or present obstacles to the work at hand?*
- *How have you addressed these issues?*
- *Could you tell me a story or give me an example of how one of these barriers affected your work and what you did to address it?*

For example, here are some barriers mentioned in the literature: lack of understanding of roles and responsibilities; silos or competition; limited funding or resources; IT, planning or operations challenges; etc.

T4-4 What are any lessons learned from your experience working on integration initiatives that could help ensure success and/or avoid pitfalls in the future?

<u>Closing.</u> The final set of questions is about the implementation – or potential for implementation – of Opening Doors in your community.

C1 How does a strategic plan of this kind affect your daily work?

- *Does it at all?*
- *What do you need to advocate for its implementation?*

C2 Do you feel a sense of responsibility or accountability to Opening Doors? Why or why not?

- *If not, what would drive this for you? Additional resources, a clear connection of how your work drives its success?*

C3 What do you think is the role of HCH providers in implementing Opening Doors?

C4 What can – or should – national advocacy organizations (like the National Health Care for the Homeless Council, USICH, etc.) provide local communities to assist with the implementation of Opening Doors?

End Question

E Is there anything else you would like to add or you feel is important for me to capture?

Conclusion

Thank you for your time today to discuss the role of HCH and *Opening Doors*. If you are interested, I would be happy to share the results of my research when the final report has been approved and accepted by UNC. If you have any questions, or can think of any additional information you would like to share with me, please feel free to contact me at 216-965-8562 or you may email me at knagel@email.unc.edu.

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