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Diabetes and Residents of Public Housing

Diabetes is a chronic illness and a common diagnosis of adults living within public housing. According to the American Diabetes Association persons who have diabetes are at a much higher risk for complications such as cardiovascular disease, blindness, nerve damage, and kidney damage. The exact number of residents of public housing with diabetes is unknown, but it is widely believed to disproportionately affect this population. This issue of the Quarterly Information Bulletin will focus on the topic of diabetes and residents of public housing.

Grace Hill Neighborhood Health Centers' Better Self-Management Diabetes Program

By Leslie Lake, Project Supervisor- Chronic Disease, Grace Hill Neighborhood Health Centers, Saint Louis, MO

One of the ways Grace Hill Neighborhood Health Centers (GHNHC) addresses the health needs of residents of public housing with diabetes is through the Better Self-Management of Diabetes Program. The program provides Health Care Coaches that conduct health education, offer support toward positive lifestyle changes, navigate assistance applications, and advocate when the patient is unable.

GHNHC offers the Health Care Coach services to patients with diabetes, cardiovascular disease, asthma, women's health issues, cancer, or an interest to cease smoking. The Health Coaches provide chronic disease education, engage and empower patients in managing their health, and train neighbors in the community.

Patients with diabetes and an interest in the services of a Health Care Coach are enrolled in a Diabetes Module of eight visits. Each visit has clearly defined goals and objectives, which are addressed as the relationship between Coach and patient are established.

Topics discussed during the first visit include types of diabetes; a self, social service and family assessment; the patient's last eye, foot and dental exams; ensuring the patient has access to a glucometer; educating the patient on what the glucometer reading means, and working towards lifestyle change. Every visit includes reviewing and/or identifying lifestyle changes as an opportunity to develop self-management goals. The fourth visit discusses foot care, skin care, heart disease, preparing for diabetic emergencies, and followed by a patient test to measure their current knowledge of the diabetes standards of care.

Public housing residents are enrolled in these programs by provider referral, through the GHNHC Diabetes Hotline, by signing up for classes at one of the patient Wellness Centers, as a mammogram program participant, as a result of completing one of the community trainings or through a Health coach. Each participant is contacted by a coach and together, they assess the patient's level of interest in lifestyle change. The participant chooses which programs best meet their desired goals and this decision is honored and supported by the health team.

As a result of these efforts, there has been an increase in patients receiving two HbA1C tests within a 90-day period when previously, patients were getting tested a total of two times per year. Over 96 percent of patients with diabetes receive annual foot exams and now those in need of specialized foot care are visiting the Podiatrist. To date, 1,275 or 53 percent of Grace Hill patients with diabetes have set documented self-management goals of which 29 percent, or 363, have met or exceeded these goals.

For more information contact Leslie Lake at llake@gracehill.org ■

Inside

Whittier Street Innovative and Comprehensive Diabetes Program

By The Diabetes Team, Whittier Street Health Center, Boston, Massachusetts

Whittier Street has selected a multidisciplinary diabetes team and implemented the chronic care model as an innovative and quality improvement approach to managing and decreasing the complications of diabetes. The goal of our diabetes program is to improve the health outcomes for diabetic and pre-diabetic populations by expanding access to appropriate care and improving the quality of care. Since 2003, when the program began, it has extended, and improved both qualitatively and quantitatively. Today, our multidisciplinary team consists of a Diabetes Provider Champion, Diabetes Program Director, Certified Dietician, Diabetes Case Manager, Systems Analyst, Certified Diabetes Educator, Clinical Pharmacist, PharmD, and Manager of Quality Initiatives.

Our diabetes population is comprised of 398 patients. There are approximately 400 pre-diabetes patients whom we identify and contact every month. Pre-diabetes patients are identified by using diagnoses of morbid obesity and obesity, overweight, family history of diabetes or impaired glucose level. In order to prevent onset or slow the progression of diabetes we have implemented various interventions:

Diabetes Case Management and Planned Visits. The Clinical Case Managers facilitate planned visits to ensure that screening and treatment guidelines are addressed during the visit. They also assist the patient in identifying and following up on self-management goals, PHQ-9 screening for depression, referrals and community resource information. This enables providers to spend more time on patients' medical concerns. Staff involved in planned visits write a monthly report detailing the number of patients that are being seen for planned visits, as well as any issues that arise. In addition to these efforts, standing orders for referrals (e.g., eye exam, podiatry) and lab tests (e.g., A1c, micro albumin) have helped to improve access to lab and specialty visits, which all contributed to improved health outcomes. Patients are able to come in at their own convenience and can get their labs done before their visit (or any other day) without an appointment.

Diabetes Clinic. The Diabetes Multidisciplinary Clinic, open every Friday from 9am-12 noon, allows diabetic patients to receive comprehensive care by the diabetes care team consisting of providers, nurses, a clinical pharmacist and a dietician. During the clinic hours, walk-in dental and eye clinic for diabetic patients is also offered. In addition to these specialty services, each patient is seen by a clinical case manager who supports the self management process, PHQ -9 screening, help with referrals and community resource.

Medical Group Visits. We currently have 5 English and 1 Spanish speaking diabetes medical groups that meet every other month. A standardized curriculum was developed for the group visits, with pre and post tests to assess patient understanding of the topics. The table below demonstrates that all parameters were better for patients in group visits than for patients receiving standard care. The average HbA1c was 7.1% for the group patients' vs. 7.9 % for our other patients.

Diabetes Medical Groups vs. General Population

	Entire DM Population	Group Visit #1 Patients
Average A1c, %	7.93 %	7.9 %
Patients with 2 A1c values in 1 year (at least 3 months apart) %	60%	76.5%
Patients with BP < 140/90 %	82%	88.5%
Patients with LDL < 100 %	47.8%	60% Average LDL 73 mg/dl
ACE inhibitor or ARB use %	85.7%	90%
ASA or other antithrombotic use %	84.8%	89%
DFE exam in past year %	66.8%	82.5%
Foot exam in past year %	68%	84.1%
Microalbumin screened in past year %	70%	84%

Educational Groups On and Off Site. Various topics and teaching tools have been used at the group sessions including Diabetes Disease Process and Treatment Options, Using Medications Safely and for Maximal Therapeutic Effect, Incorporating Physical Activity into one's Lifestyle, Acute and Chronic Complications, Nutrition, Healthy Food Choices, Holiday Meal Planning, and Goal Setting/Assessment. We also work with patients to set individual goals using the SMART method (Smart, Measurable, Attainable, Realistic and Timely goals).

Diabetes Management Grocery Trip. The goal of this intervention is to increase patient knowledge of food items that raise blood sugar. Usually 2-4 patients attend and get educated on different groups of food items in different section of the grocery store that patients use.

Men's Health Group. During this time we discuss diabetes and how diet can affect and prevent being diagnosed with diabetes. Men present in this group also provide information on topics they are most interested in related to diabetes and diabetes prevention.

Home Visit. Home visits started a few months ago as a pilot intervention. It is designed to improve patient outcome by providing diabetes education at patient's home and reviewing patient diabetes meal plan, blood glucose readings, exercise program, and medications.

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National Diabetes Education Program: What's New

By David Bates, Associate Project Manager, The National Center for Health in Public Housing, Arlington, Virginia

The Road to Health Tool Kit

Designed for African Americans and Hispanics/Latinos at risk for type 2 diabetes, this tool kit provides materials to start a community outreach program reinforcing the message that type 2 diabetes can be delayed or prevented.

Capacity Building for Diabetes Outreach: A Comprehensive Tool Kit for Organizations Serving Asian and Pacific Islander Communities

This comprehensive tool kit is designed to help organizations strengthen capacity in eight core areas: community assessment, evaluation, organizational support, staffing, building coalitions and partnerships, funding, community outreach, and marketing. Examples are drawn from experiences in working with Asian American/Pacific Islander (AAPI) communities, but the work sheets and tools can apply to work with any community.

Five Ways Older Adults Can Be More Physically Active

Older adults are at an increased risk for type 2 diabetes – especially if they have a family history of the disease. Studies have shown that modest weight loss through healthy eating and increased physical activity is highly effective in preventing or delaying type 2 diabetes in people over age 60. NDEP provides five tips to help older adults be more physically active.

The Power to Control Diabetes is in Your Hands Community Outreach Kit

This online-only resource provides information about diabetes in older adults and suggests how to promote the Power to Control campaign through educational activities, media events, and promotional campaigns.

The National Diabetes Education Program is a partnership of the National Institutes of Health, the Centers for Disease Control and Prevention, and more than 200 public and private organizations. For more information go to: www.ndep.nih.gov

Quality of Life Health Services: Addressing Barriers, Improving Diabetes Outcomes

By Carrie Lowe, Clinical Nurse Manager, Quality of Life Health Services, Gadsden, Alabama

Approximately 10 years ago, Quality of Life Health Services, Inc. (QOLHS), in Gadsden, AL, embarked on a diabetes initative called the Diabetes Health Disparities Collaborative. The goal of the collaborative was to identify barriers to health care, decrease the incidence of diabetes, and to improve outcomes for those patients that were already diagnosed with the disease. We chose diabetes as its focus due the population of tenants that was utilizing public housing at the time. The incidence of diabetes, especially Type II Diabetes, among patients was rapidly increasing.

We assessed the barriers to health care that our patients had that would affect diabetic outcomes. These barriers included, lack of transportation, inability to pay for specialty care (i.e., foot care, vision, and dental), inability to pay for prescriptions, and lack of education on the disease itself.

Quality of Life addressed transportation first because we already had a van that could be utilized. Transportation to and from the clinic was provided to the public housing patients. They were also transported to all referral appointments at no additional cost to the patient.

The second barrier was prescription cost. Patients utilizing the public housing clinic were encouraged to apply for the Prescription Assistance Program in an effort to decrease or eliminate their prescription costs. The patients were also encouraged to use the QOLHS pharmacy for medications not obtainable from the Prescription Assistance Program, because the pharmacy offered patients a rate at least 40 percent lower than other area pharmacies.

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Housing Authority Perspective: Cuyahoga Metropolitan Housing Authority and Care Alliance Health Center Partnership

By Cortney C. Kilbury, Marketing Manager, Cuyahoga Metropolitan Housing Authority, Cleveland, OH

In 2000, in response to a growing demand in the community for much needed health care and medical services, Cuyahoga Metropolitan Housing Authority (CMHA) formed a partnership with Care Alliance Health Center to offer primary care, dentistry, pediatric services and regular clinic hours.

"The primary goal of the partnership was to increase the health and well being of residents by integrating and tapping into the world class health services in the Cleveland area," said Tony Jeffries, Youth Services Coordinator at CMHA.

The benefits of the program have been remarkable. Most significantly, the services improve the general health and knowledge of residents of public housing and enhance their quality of life. The program has offered primary healthcare services for those residents who previously did not have access to primary care, dental services, pediatric services (immunization), pre-natal care, drug and alcohol treatment, health education, counseling and case management.

The presence of a Primary Care facility in the community has continued to dramatically increase the access residents have to quality health care services, allowing better tracking of health outcomes for specific groups and decreasing the fear of visiting physicians and hospitals. "Having a health care facility in the neighborhood has allowed us to secure other opportunities as well, such as a vehicle for youth to participate in camp and sporting activities," said Lisa Enoch, CSS Operations Manager at CMHA. "I appreciate the fact that we have a partner that is willing to provide a way for kids to have access to these vital programs."

The effort has exhibited an enormous reduction in low income population's tendency to use emergency rooms as a primary source of health care. This, in turn, created a much more affordable health experience for residents. The onsite facility eliminated transportation issues and educated the population on the importance of prevention. Regular screenings for HIV/AIDS and STD were administered, also resulting in the reduction of sexually transmitted diseases.

By having a Primary Care facility in the community, it increases the opportunity to host strategic health promotions. Many partnerships were developed as a result including: The Cleveland Health Museum, Healthy CMHA, and the Ohio Commission on Minority Health. In addition, several other grant driven initiatives were achieved such as educating low-income populations on smoking cessation classes, asthma prevention, and child obesity issues.

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QOLHS Diabetes Health Disparities Collaborative

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The third barrier was the lack of education on diabetes. In response, Quality of Life began to offer quarterly diabetes workshops and employed a community health nurse to educate patients on the disease.

The most difficult barrier to address was access to affordable specialty care. Quality of Life was fortunate to have a dental department at their main office that could provide dental services on a sliding scale fee, based on income, in an effort to decrease cost to the patient. A partnership with the Lyons Club and a few years ago we were able to partner with a local optometrist who offers his services at a discount rate to our patients. Foot care has been more difficult to address, but we are in communication with a local podiatrist who will see our patients and offer them a payment plan for outstanding fees. After addressing some of the major barriers, we began to collect data on all of these measures and report them to the internal Quality Management Committee so that we could determine if efforts were benefiting the patients' health outcomes. We also reported our findings were also reported to the National Health Disparity Reporting Network where progress was compared to other agencies who were also participating in the Diabetes Collaborative. Over time, we determined that the overall health of the diabetic patients has improved although the incidence of diabetes is still increasing. The goal now of the program is to target the younger population and teach prevention in hopes that one day the incidence of diabetes will decline.

For more information contact Carrie Lowe at carrie.lowe@qolhs.com ■

Addressing Diabetes Among Residents of Public Housing

By Nancy L. Rothman, EdD, RN Consultant/Director Public Health Management Corporation, Philadelphia, PA

To improve quality and reduce the cost of chronic illness care in the Commonwealth of Pennsylvania, the Governor created a Chronic Care Initiative for primary care practices focused upon pediatric asthma and adult diabetes. Primary care practices were invited to apply to be part of this pay for performance opportunity. The network of four nurse-managed health centers of Public Health Management Corporation (PHMC) applied and was accepted to address adult diabetes. Two of the four nurse-managed health centers of PHMC sit within and serve Philadelphia residents of public housing, Rising Sun Health Center in Hill Creek and PHMC Health Connection in Norris Apartments.

Diabetes is a chronic illness and a common diagnosis of adults living within public housing. The Chronic Care Initiative works within the six components of the Chronic Care Model to improve outcome measures for diabetes: 1) Self-Management placing patients in a central role in determining their care; 2) Decision Support using evidence-based or proven guidelines; 3) Delivery System Design clarifying the roles and tasks within the practice; 4) Clinical Information Systems that can track individual patients and populations; 5) Organization of Health Care focusing on creating an environment to allow improvements in patient outcomes; and 6) Community to improve health care through collaboration with other organizations serving the same populations.

Changes are being made in how we care for our diabetic patients using planned rapid cycles of change that are written as PDSAs (plan, do, study, act) and tested with a small number of patients before institutionalizing the change in one center or spreading it to our other network centers. All staff need to be involved and new roles may be assigned as part of the rapid cycle changes, e.g. medical assistants being trained to do monofilament foot testing. This dramatically improved access to foot testing, an important part of diabetic care. The goals for the program are based upon national standards, indicating very good care. Baseline measures were reported for June, 2008 from an electronic medical record and reported monthly. The outcome measures being followed include: blood pressure, cholesterol, hemoglobin A1C, dilated eye exam, tested or under treatment for nephropathy, asked about smoking and if smoking counseled to stop, on statin to reduce cholesterol, over 40 on an aspirin, 55-75 years of age on ACE/ARB to reduce blood pressure, foot exam, influenza vaccination, pneumonia vaccination and documented self-management goals.

Diabetic patients at the public housing sites also receive planned visits, where they and the staff are aware of their key numbers, including their blood pressure, hemoglobin A1C, cholesterol and are asked to set their own self-management goals supported by staff. Also, diabetic patients receive related health and nutrition education. To encourage patients to keep their follow-up appointments and attend diabetic education, $5.00 gift certificates are given for stores where patients can buy fresh produce.

Primary care practices involved in the Chronic Care Initiative have three years to meet the targeted goals for the outcome measures shared above. They are to be recognized by the National Committee for Quality Assurance (NCQA), for meeting at least level 1 standards for a medical home. We are working toward yearly and three year goals and writing and revising policies to meet the requirements of the NCQA and the Medical Home Model. Progress has been evident in all outcome measures. Successes in our public housing sites have been evident in establishment of self-management goals with patients, patients having foot exams, reduction in cholesterol, smokers counseled to quit and number of diabetic patients with flu shots.

Source: Wagner EH. Chronic disease management: What will it take to improve care for chronic illness? 1998;1(1):2-4.

For more information about PHMC, contact Nancy Rothman at rothman@temple.edu ■

Housing Authority Perspective

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"In a time where health care is so costly, and the demand for health care is so great, it is critical that partnerships like the one formed by CMHA and Care Alliance continue to exist for the purpose of ensuring that these essential services are made available to residents we serve," said Jeffery K. Patterson, Chief of Staff and Operations for CMHA.

For more information contact Cortney Kilbury at CMHA at kilburyc@cmha.net. ■

Whittier Street Diabetes Program

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Data Collection and Tracking. We regularly analyze five data reports: (1) the health outcome monthly and annual report, (2) provider team/individual provider panel outcome report, (3) a report created after a four months case management cycle, (4) no show data/survey- DNKA, and (5) data related to group sessions. All reports are compared to best practices and goals established in the Center's Strategic Plan.

For more information contact Dr. Mark Drews, Diabetes Provider Champion or Adeola Ogunghadero, Manager of Quality Initiatives at 617- 427-1000.■

Boston University School of Public Health Partnerships Help Residents of Public Housing Launch Health Programs

By Lisa Chedekel, Boston University School of Public Health, Boston, Massachusettes

As a longtime tenant of the Cathedral Housing Development in Boston's South End, Ruth Barkley knows that her fellow residents of public housing are more likely to suffer from ill health – including asthma, diabetes and hypertension – than other city residents.

She also knows that many residents land in the healthcare system ill-equipped, lacking information about issues ranging from choosing a doctor to buying prescription drugs. Until recently, Barkley, 77, who has lived at Cathedral since 1965, didn't think she could do much to empower her neighbors around issues of health. Now she knows differently.

The Cathedral tenants' association, which Barkley heads, is the first residents of public housing group to receive a health-promotion grant from the Partners in Health and Housing Prevention Research Center (PHH-PRC), based at Boston University's School of Public Health (BUSPH).

Barkley and another tenant leader, Joseph Jeans, spent weeks learning how to write a grant proposal and drafting plans for a series of health-education workshops they wanted to organize for Cathedral residents. Their work paid off: The Cathedral Tenants United Task Force secured a $3,000 grant from the PHH-PRC that it is now using to run workshops on elderly health, family health, addiction and other topics.

"When we started out with the grant training, I didn't know what we were getting into. I wasn't sure we could do it," said Barkley, a great-grandmother. "But by the final session, when we had designed a program that could be beneficial to all the age groups in our development, it was really exciting."

The training program, "Knowledge is Power," or KIP, was the brainchild of Doris Bunte, a former CEO of the Boston Housing Authority who chairs the PHH-PRC's Community Committee for Health Promotion. Bunte wanted to find ways to help residents of public housing help themselves, by teaching them how to apply for grants and tap community resources. She worked with BUSPH Environmental Health Professor Patricia Hynes to design the KIP program.

Bunte and Hynes designed a wide-ranging curriculum for the tenant leaders that covered "everything from the ethics of being responsible for a grant, to legal issues, to budgeting," Hynes said.

Barkley said the four, three-hour training sessions she attended were challenging, but she is proud that Cathedral made it through the process and secured a grant. The tenant task force designed the series of resident workshops with help from PHH-PRC staff members Tegan Evans, program manager for training and education, and Eugenia Smith, program coordinator for the Community Committee for Health Promotion."We wanted to do something that would be beneficial to all of our residents," Barkley said. "One of the things that bothers me is that whenever we have a program in our development it's usually just for youngsters or teens or for one particular age group. Too often, you educate the kids, but not the parents. We wanted to do a program that could go all the way from the elderly right down to the tots."

In October, the Cathedral task force sponsored the first series of health workshops, for older adults – sessions on prescription drugs, senior home-care options, household cleaning and home-care products, and community services, such as transportation. A second series of workshops is planned in March, focusing on family health. Smith, a resident of public housing who formerly was a resident health advocate at Cathedral, has been assisting Barkley's group in organizing the sessions. Barkley said she hopes the workshops will help to educate residents about health issues and community resources, so that they "know their options and aren't afraid to ask questions" of health-care providers. She said the program's larger value is simply in bringing residents together. "Too often in public housing, you become isolated to some degree – from each other and from the community outside," Barkley said. "This is a way of bringing folks together and trying to build partnerships with the community."

"Once they have a successful program going, the hope is they'll be poised to go to other institutions and form partnerships," Hynes said.

The PHH-PRC is one of 33 Prevention Research Centers nationwide that are funded by the Centers for Disease Control and Prevention (CDC). The center is a partnership among the BUSPH, the Boston Housing Authority, the Boston Public Health Commission and the Community Committee for Health Promotion. The mission of the center is to engage residents of public housing in community-centered research and education programs.

Barkley said she is proud that Cathedral, a 420-unit development that went through some "very bad years" of crime and violence, has regained a measure of stability in recent years, in a neighborhood that has experienced steady gentrification.

Clinicians' Corner
Spreading a Model of Diabetes Care at Zufall Health Center

By Anna M. Gard, FNP-BC, ACU and Rina Ramirez, MD, FPCN, Zufall Health Center

association of clinicians for the underserved

Information provided about diabetes is often too medically complex, lacking language, literacy and cultural sensitivity, and simply too difficult to understand for patients to participate in effective treatment plans. Language, literacy and cultural sensitivity are fundamental to achieving the goal of decreasing health disparities in diabetes care of public housing residents who suffer a larger proportion of prediabetes, diabetes, and diabetic complications than the general population. Zufall Health Center has developed a diabetes care model that utilizes the Chronic Care Model to address community specific needs through their health care organization, delivery system design, decision support, case management, and community resources.

Zufall Health Center (ZHC) has provided primary care services to low income and uninsured persons living in the Dover, New Jersey vicinity since 1990. The center was created as a "free clinic" by Dr. Robert Zufall and his wife when they recognized the need for primary medical care among Dover's immigrant population. In 2004, the center became an FQHC and since then, it has steadily grown in size and scope of services.

In March 2007, ZHC joined the Diabetes Collaborative and adopted the Chronic Illness Care Model and PI processes to provide continuity of care. As a result, the care given by the center has evolved from episodic, intermittent care to comprehensive, continuing primary care for our clients. The program improved its delivery design by facilitating access, assigning providers to patients, scheduling appointments, and expanding hours.

Patient education and involvement in their care has resulted in increased follow up visit and a rise in self-management goals. Providers were included in program changes, including testing out PDSAs, reviewing guidelines, and suggesting enhancements. As a result, ZHC's Medical Assistants, who are bilingual and members of the community, follow standing orders to perform interventions that assist in the medical evaluation and patient education. They obtain Hemoglobin A1c levels at predetermined intervals, review self-determined management goals with the patient, calculate BMIs, and introduce "The Plate Method" as an educational effort to reduce obesity. ZHC participates in the National Patient Safety and Pharmacy Services using a similar process and has been providing clinical pharmacy services to patients to improve their understanding of their medication and reduce adverse outcomes.

Group sessions are held on a monthly basis with a bilingual diabetes educator who reviews nutritional and dietary habits while being sensitive to the cultural and socioeconomic factors that affect food choices and lifestyles. She also reviews the disease process, assists clients to understand their condition, and helps with medication management.

Since the inception of the diabetes program, ZHC's patients' average hemoglobin A1c levels have dropped 0.5 points (from 8.3 to 7.6), the number of patients with HgA1c under control (was less than 9%) has risen by 13%, and the percent of patients who have received flu vaccines has increased by 22%.

The success of the program is mostly due to dedicated, community based staff, the implementation of the Chronic Illness Care model, partnerships with community organizations, and the trust relationship we have developed with our clients over the years.

This summer ZHC will open a health center site in Morristown and will provide care to residents of public housing. It is estimated that over 1,300 individuals are residing in public housing in Morristown.

Our approach to providing care to diabetic residents of public housing is to use the programs that have met with success in Dover, and making relevant modifications based on the particular needs identified by representatives from the public housing sector. By hiring Outreach Workers and Care Managers who are residents of public housing, the center will seek to foster a strong and trusting relationship with the clients.

Services such as dental care, pediatric and elder care, podiatry and access to affordable medications are part of ZHC's program and will be offered as part of a comprehensive care approach. As in our Dover site, interactions will be culturally sensitive, especially when addressing diet and language. We are establishing strong working relationships with community partners in Morristown, including hospitals, social agencies and local pharmacies, in order to replicate and enhance the successful program we have in Dover.

For more information contact Rina Ramirez at ramirez@zufallhealth.org ■

Resources:

National Diabetes Education Program at www.ndep.nih.gov

Institute for Healthcare Improvement Group Visit Starter Kit at www.ihi.org/IHI/Topics/ChronicConditions/Diabetes/Tools/GroupVisitStartKit

Three New Fact Sheets on Residents of Public Housing

There is hardly any statistical data about the health concerns of residents of public housing. Most reporting and research does not look specifically at residents, rather it groups them in with individuals of a low socio-economic status or the general population.

To address this problem and develop this body of knowledge, NCHPH has partnered with the CDC funded Partners in Health and Housing - Prevention Research Center, Boston, MA to produce three new fact sheets on the health status of residents living in Boston public housing. The data for these facts sheets were gathered in conjuction with the Boston Public Health Commission and Boston University School of Public Health over a period of several years. The results of these efforts are briefs on Cardiovascular Disease, Diabetes, and Mental Health/Substance Abuse in residents of public housing.

These fact sheets will provide valuable data to health centers that serve residents of public housing, and will allow health centers to better identify and address the health needs of this special population. The fact sheets can be accessed at http://www.healthinpublichousing.org/resources.html

NCHPH's New Self-Assessment and Technical Assistance Tool

The National Center for Health in Public Housing has developed a new Self-Assessment and Technical Assistance Tool. Developed in cooperation with Public Housing Primary Care Health Centers, the Tool allows them them to have a straightforward method of identifying the strengths and weakness in their programs. It examines five critical areas of health centers operations: Governance, Management and Operations, Strategic Planning, Quality Monitoring, and Fiscal Management.

The Tool is completely free of charge and obligations. The responses given in the self-assessment portion of the Tool are confidential, will not be shared with other parties. The Technical Assistance Library contains a variety of resources that can assist health centers with some of the most common issues they face in their work serving residents of public housing.

Questions or comments? Please contact David Bates at dbates@nambco.com

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