

Cardiovascular Disease and Residents of Public Housing

Cardiovascular disease, including heart disease and stroke, continues to result in the deaths of millions of Americans each year, and causes high rates of suffering in millions more. These conditions are seen in greater frequency in vulnerable populations, including residents of public housing. The public housing setting provides solid opportunities for impacting the cardiovascular health lifestyles of residents by reaching them where they reside and an opportunity to make heart health education relevant, accessible, and convenient. In an effort to address the disparities in cardiovascular health of public housing residents and to improve the quality of life of this population, Public Housing Primary Care health centers have partnered with national organizations, such as the National Heart, Lung and Blood Institute (NHLBI) to infuse heart health knowledge and other strategies on cardiovascular disease (CVD), health promotion and disease prevention into these communities. This issue focuses on cardiovascular health interventions of Public Housing Primary Care health centers and also provides cardiovascular health resources.

Kokua Kalihi Valley's Healthy Heart, Healthy Family Demonstration Project

By Cynthia Sturdevant, Kokua Kalihi Valley Comprehensive Family Services Honolulu, HI

Kokua Kalihi Valley Comprehensive Family Services (KKV) has provided comprehensive health care and social services to the low-income Asian/Pacific Islander immigrant population of Kalihi Valley since 1972. In March 2008, KKV initiated a demonstration project entitled Healthy Heart, Healthy Family (HHHF) using a heart health education manual developed for Filipino communities by the National Heart, Lung and Blood Institute (NHLBI). Utilizing linguistically-competent community health workers to reduce

cultural barriers and improve care coordination, this project aims to increase access to preventive health care and promote active lifestyles for Filipino patients, including public housing residents, who have known risk factors for cardiovascular disease (CVD).

KKV serves four public housing communities that are comprised almost entirely of individuals of Asian/Pacific Island ancestry. Over 30% of KKV's patients are Filipino and, among these, 135 are known to have CVD, one of the leading causes of death

among Filipino Americans. The HHHF Project involves 98 participants ages 40-80, the majority of whom are female immigrants from the Northern Philippines who speak the dialect Ilocano as their primary language. At the beginning of the project, 78.6% of participants had high cholesterol, 76.5% had hypertension, 58% were overweight with a BMI > 25, 32.6% had diabetes and 36.7% of the participants have a known family history of cardiovascular disease.

The NHLBI's Healthy Heart, Healthy Family manual was used as a training resource to promote behavior modification, helping people build skills to make practical, lasting changes to fight heart disease and improve their health. KKV adapted the manual further to match the linguistic and cultural needs of HHHF Project participants, for example translating the "My Health Record" tool (which aids participants in tracking their progress on various clinical measures) into Ilocano. Three KKV staff attended a HRSA-NHLBI training on use and implementation of the manual, and they in turn trained eight additional KKV community health workers. The 98 participants recruited from KKV's patient pool were divided into six groups depending on their schedules and preferred locations, and the 11-week HHHF curriculum was delivered from July to September 2008 with an 87% graduation rate.

Groups met one day a week for two hours at a time, and at each meeting participants received healthy snacks includ-

INSIDE

WISEWOMAN -
Screening and Evaluation

Cardiovascular Health
Curriculum

A Model PHPC
Partnership

Call for Articles

Community Health
Workers

Cardiovascular Disease
and High Blood Pressure

Register Today - Annual
Conference

Clinicians Corner

Kokua Kalihi Valley's Healthy Heart, Healthy Family Demonstration Project

continued from page 1

ing nutritious versions of tinola, a Filipino chicken soup, and pancit, a noodle and vegetable dish made vegetarian to reduce the fat. Incentives varying from water bottles to T-shirts, following the program's emphasis on heart-healthy lifestyles, were given out at each meeting.

KKV offers a variety of programs that promote active lifestyles including weekly Health Maintenance exercise sessions for elders and organized community gardening opportunities at KKV's 100-acre Nature Preserve. Program graduates were encouraged to participate in heart-healthy activities through KKV or independently, by joining the gym or taking daily walks around the neighborhood. Through telephone calls, direct contact and home visits the trainers have kept in touch with the participants, providing continued support and empowerment. Further activities including family screenings, grocery tours and health fairs have been planned for 2009.

Participants' clinical and behavioral CVD risk factors were measured at baseline (June 2008) and 6 months (Dec. 2008), with 12-month measures scheduled for June 2009. Monitoring included measurements of blood pressure, cholesterol, triglycerides, blood glucose, weight, height and waist circumference, and Self Efficacy and Quality of Life surveys

to measure heart health knowledge and lifestyle adoption. Although data is pending analysis, KKV staff have observed significant changes among program participants, indicating that participants have been empowered to take control of their health. Graduates have demonstrated increased awareness of what they are eating by avoiding foods such as chicharon (deep fried pork skin) and reading the nutrition information on food packages.

Participation in heart-healthy activities has remained high, and there is now a weekly Filipina gardening group at the



Picture: Community Gardening

Kalihi Valley Nature Preserve. Set deep at the back of Kalihi Valley, the Preserve under KKV's care is becoming central to the Kalihi Valley community, providing boundless opportunities for culturally-appropriate active living programs including the Healthy Heart, Healthy Family Project.

For more information contact Cynthia Sturdevant at csturdevant@kkv.net ■

WISEWOMAN - Well-Integrated Screening and Evaluation for Women Across the Nation



The WISEWOMAN program is administered through the Center for Disease Control's (CDC) Division for Heart Disease and Stroke Prevention (DHDSP). The program provides low-income, underinsured or uninsured woman aged 40-64 years of age with chronic disease risk factor screening, lifestyle intervention, and referral services in an effort to prevent cardiovascular disease.

Why is WISEWOMAN Important?

- 80,700,000 American adults have one or more types of cardiovascular disease.
- Cardiovascular disease includes stroke, high blood pressure, congestive heart failure, heart defects, blood vessel hardening, and other circulatory system diseases.
- One in 3 female adults have cardiovascular disease.
- In 2004, cardiovascular disease caused a death a minute among females.
- In 2004, 460,000 female lives were lost due to cardiovascular disease.
- More female lives were lost due to cardiovascular disease than by cancer, chronic lower respiratory disease,

Alzheimer's disease, accidents, and diabetes combined.

- 49% of Black/African-American women have cardiovascular disease.
- 35% of non-Hispanic white women have cardiovascular disease.
- 34% of Mexican-American women have cardiovascular disease.

Source: Heart Disease & Stroke Statistics 2008 American Heart Assoc.

CDC funds 21 WISEWOMAN programs, which operate on the local level in states and tribal organizations. The program also offers diabetes testing. Women are not just tested and referred, but can also take advantage of lifestyle programs that target poor nutrition, physical inactivity, and smoking, such as healthy cooking classes, fitness competitions, or quit-smoking classes. The interventions may vary from program to program, but all are designed to promote lasting, healthy lifestyle changes.

For more information visit the WISEWOMAN website at: www.cdc.gov/wisewoman ■

Cardiovascular Health Curriculum: A Way to Educate Public Housing Communities about the Risk of Cardiovascular Disease

By Edward Donnell Ivy, MD, MPH, Medical Officer, National Heart, Lung, and Blood Institute, NIH

Despite advancements in modern medicine and an increase in knowledge about cardiovascular health, heart disease remains the number one cause of death and stroke continues to be the number three cause of death among all Americans. Heart disease is not only the leading cause of death for African Americans, Hispanics and American Indians, but these ethnic groups are also disproportionately affected by cardiovascular disease and its risk factors.¹ Cardiovascular disease risk factors, including physical inactivity, high blood pressure, cholesterol, overweight and obesity, diabetes and smoking continue to present challenges to good health for most of the U.S. population.

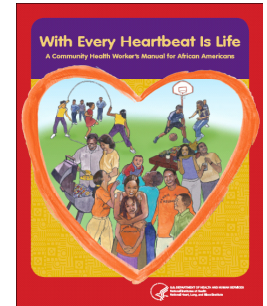
Residents of public housing are also disproportionately impacted by cardiovascular disease and its risk factors. The use of Community Health Workers as an effective strategy to address racial and ethnic disparities in health care is well documented.² Community health workers are members of the communities they serve, so they are in a better position to interact with hard-to-reach populations.

The National Heart, Lung, and Blood Institute (NHLBI) has developed tools to help communities address cardiovascular disease and its risk factors. These tools include a group of cardiovascular health curricula designed to be used by community health workers to educate community members about cardiovascular disease and its risk factors.

There are four core cardiovascular health curriculums intended to be used by trained community health workers and community health educators to teach community members and patients/families about heart healthy behaviors and to promote the adoption of healthier lifestyles. Each of the four curricula is tailored to a specific population: African American, *With Every Heartbeat Is Life*; Latino, *Su Corazon, Su Vida* (Your Heart, Your Life); American Indian/Alaska Native, *Honoring the Gift of Heart Health*; and Filipino, *Healthy Heart, Healthy Family*.

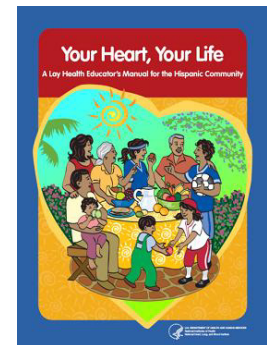
Each program is designed to be implemented using one of four possible strategies. These include train-the-trainer, where individuals from the community are trained to conduct the health promotion classes; health promotion classes without screening, in which trained individuals educate the community in a non-clinical setting; health promotion classes with screening, where classes are given in conjunction with medical testing services; and the lifestyle and clinical management strategy, where trained individuals are integrated into the service delivery process of the health center.

The core curriculum developed for the African American Population is the **With Every Heartbeat is Life** program. The program is presented as a manual with a comprehensive, culturally appropriate 12 session lesson plan which weaves together hands-on demonstrations for health educators, skill-building activities, handouts that can be copied, heart-healthy recipes for popular cultural dishes and inspirational quotes by African Americans. Community health workers can use this tool in community-based settings, including churches and worksites, to increase knowledge of heart disease risk factors and promote health behaviors.



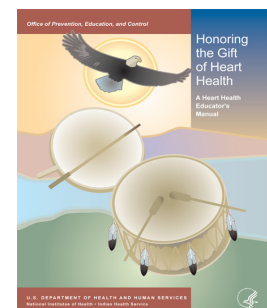
Your Heart, Your Life (Su Corazón, Su Vida)

This program is designed to help promotores teach an 11-lesson course on heart health education specifically created for the Latino community. Lessons provide information for understanding, skill building, self-assessment, and goal-setting for healthy lifestyle changes. The manual includes culturally appropriate teaching scripts, learning activities, and reproducible handouts. Interactive activities use telenovelas, photonovelas, role play, problem-solving, and discussion. Latino role models and family contexts appear throughout. This tool is available in Spanish and English.



Honoring the Gift of Heart Health

This user-friendly program for heart health educators, developed especially for American Indian/American Native communities. The manual provides the "how-to" for leading group education sessions. It offers "hands on" activities that help people build the skills they need to make simple, practical, and lasting changes to help them fight



continued on page 5

A Model of Partnership: Waco Housing Authority and the Heart of Texas Community Health Center

By Millet Hopping, Sr. Vice President/COO, Waco Housing Authority and Affiliates, Waco, TX

In partnering with the Heart of Texas Community Health Center (HOTCHC), Waco Housing Authority and affiliates hope to provide a more holistic approach to the overall physical and emotional health of our residents of public housing. Due to ever decreasing dollars and an economy that requires doing more for less, partnerships that provide increased standards in health care for low income families are always a priority. We, as social service providers, often see a tendency among low income families to delay going to the doctor or the dentist until they are in pain, not realizing the long term effects of ignoring preventative care.

The major role of HOTCHC is to find those most in need of health care and act as educators to promote better personal health in a one-on-one format in the comfort of the resident's home. They prescribe medications, home health care, as well as, make sure tenants have an understanding of their symptoms, and how important their medication is to their daily and long term health process. Home visits are the building blocks for this population to better manage their health care and work to stay healthy; rather than deal with a long term illness that will disrupt their path to self-sufficiency and independent living. This model of partnership epitomizes what can be achieved, not in terms of just numbers, but in terms of health, long term independent living and personal success.

Our residents have responded well to the one on one attention. While we are early in the partnership to determine true success, we expect to see healthier residents of public housing with fewer hospital stays due to an increased personal responsibility in their preventative care.

The Heart of Texas Community Health Center also provided interns at our Restoration Haven's onsite center. Restoration Haven, Inc. is located in a public housing unit, which facilitates outreach on health issues, as well as much needed social service components such as GEDs, parenting and employment.

The Heart of Texas Community Health Center (HOTCHC) has a 37-year history of providing health care services in its community. HOTCHC provides health services to three public housing sites located in Waco, TX.

HOTCHC provides an array of primary health care services including oral health, and mental health, as well as a specialty care (ob/gyn, pulmonary, diseases and critical care, psychiatry, orthodontics, etc.) and diagnostic (lab, x-ray, bone density, ultrasound, pulmonary function testing, etc.) services to residents of public housing.

For more information on A Model Partnership, contact Millet Hopping at mileth@wacopha.org ■

Call For Articles

NCHPH Quarterly Bulletin is published quarterly to feature updates on the health of residents of public housing, best practices of PHPC health centers, news about housing authorities' and housing organizations' efforts to promote resident health and self-sufficiency, funding opportunities and information on upcoming conferences and meetings.

Submissions should be approximately 800 words or less. Relevant pictures, illustrations and/or charts may be submitted with the articles. All material is subject to copy editing. Please include the author's full name, title, and contact information, including email, telephone and fax number. Information should be emailed to Monique Cuffee-Archibold at mcuffee@nambco.com.

We are currently looking for articles on health disparities of the public housing population. Also submit any stories you may have on a successful intervention that impacted the life of a resident of public housing.

For more copies of our Quarterly Information Bulletin please visit

www.healthandpublichousing.com ■

Community Health Workers In the Heart of the Community

By Lionel Marshall, Heart Disease, Strokes and You, St. Louis, MO

Lionel Marshall, a resident of Grace Hill Neighborhood Housing Community in St. Louis Missouri and a member of the public housing primary care clinical work group, knows the importance of providing health education to residents of public housing from his personal experience with cardiovascular disease. Mr. Marshall contracted rheumatic fever at age eleven causing significant cardiac valve damage necessitating mitral valve replacement surgery. A second valve replacement was necessary ten years later due to endocarditis during which he suffered a stroke.

Determined, Mr. Marshall worked hard at his physical rehabilitation while also accomplishing his goal of graduating from high school and college. Although he struggles with some physical disability, he has used his experience to reach out to other members in his community to educate them about the prevention and management of heart disease.

He completed the Train-the-Trainer program for community health educators to improve the cardiovascular health of families and the community sponsored by the Grace Hill Neighborhood Health Center. He has spoken to many stroke support groups and residential community centers about realistic management of living with heart disease. He talks about the challenges of changing the cultural diet and risks of smoking and drinking alcohol in excess.

As a health educator and a trusted and respected role model in his community, Mr. Marshall provides a vital service in promoting positive self-management behaviors among his peers. He serves as a bridge between patient community members and their health care providers by strengthening

his community's understanding and acceptance of medical care.

Mr. Marshall is an example of how community health workers (CHWs) can help the health care team meet the national Healthy People 2010 goals by conducting community level activities and interventions that promote health and prevent disease and disability. The recognition of their successes has led to recommendations that CHWs be included as members of health care teams to help eliminate racial and



ethnic disparities in health care. The CDC has developed The Community Health Worker's Heart Disease and Stroke Prevention Sourcebook as a training guide (http://www.cdc.gov/DHDSP/library/chw_sourcebook/pdfs/sourcebook).

For more information about Lionel Marshall please contact him at lionel@instruction.com ■

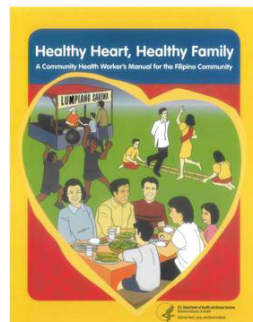
Cardiovascular Health Curriculum

continued from page 3

heart disease. This program is used to teach community groups ways to promote heart health for themselves and their families. This manual can also be used to train heart health educators or as basis for other community activities.

Healthy Heart, Healthy Family

Is a health education program that helps families in the Filipino community acquire life skills that foster heart health. This program aims to increase access to preventative health care and promote active lifestyles for Filipino patients, who have known risk factors for cardiovascular disease (CVD).



The manual is used to promote behavior modification, it includes scripts and training tips to guide community health workers. Each session is filled with issue-oriented interactive learning activities.

For more information on all four core curriculums please contact Dr. Edward Iry at inyed@nhlbi.nih.gov

Visit the National Heart, Lung, and Blood Institute online at www.nhlbi.nih.gov ■

1. Vital Statistics of the United States, NCHS
2. "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care," Institute of Medicine (2002)

Cardiovascular Disease and High Blood Pressure among Public Housing Residents in Atlanta: A Longitudinal Study

By Deirdre Oakley, Associate Professor and Erin Ruel, Associate Professor, Georgia State University

The Urban Health and Well-being Initiative (the Initiative) is an interdisciplinary group of Georgia State University faculty and graduate students documenting the impact of relocation on the health and overall well-being of public housing residents in Atlanta. In 2007, the Atlanta Housing Authority announced plans to demolish the remaining 10 family public housing communities as well as two senior high rises by 2010. Almost 10,000 residents will be affected. Qualified residents will be relocated with Housing Choice Vouchers (formerly Section 8) to private market housing.

Public housing is centrally located in Atlanta and in close proximity to needed health care services and the public transportation system. Health care services and public transportation are sparse in less central Atlanta locations. Thus, it is possible that relocation could negatively affect access to health care. To examine the impact relocation may have on the health and access to health care of residents we began a longitudinal study in March 2008. By July we had completed our pre-relocation survey of 387 residents across six public housing communities slated for demolition.

Our baseline findings concerning chronic health conditions, and cardiovascular-related conditions in particular, are as follows.

First, high blood pressure is pervasive. Three-quarters of the residents interviewed in the senior high rises reported having this condition. The prevalence in the public housing communities is lower but still high with just over forty percent of the residents reporting this condition. While only nine percent of family community residents reported having cardiovascular disease, almost a quarter of the residents in the senior high rises reported this condition.

Despite the prevalence of these conditions, residents at the family communities in particular were not always taking their medications. The number one complaint was that their insurance (mostly Medicaid and Medicare) only allowed for the purchase of generic brands and some of the residents we spoke with stated that the generics made them sick. Although we have no way to substantiate this, given what the residents told us, we believe that at some point their insurance allowed purchase of the name brand and when this was changed, residents may have perceived a difference in the drugs' effects.

Complete findings from this baseline survey can be found at:
http://urbanhealth.gsu.edu/files/gsu_public_housing_report1.pdf. ■

Register Today! Health Care for Residents of Public Housing Annual Conference



The Health Care for Residents of Public Housing annual conference will be held July 20-22, 2009 at the Fairmont Hotel in Washington, DC. The goal of the conference is to strengthen the capacity of health centers to meet the specialized primary care needs of residents of public housing. Conference participants will include health care professionals, staff of Primary Care Associations, HRSA and HUD officials, public housing officials, residents, researchers and

other key stakeholders. Participants will gain valuable knowledge to take back to their communities.

This is the only national conference with a focus on federally funded Public Housing Primary Care (PHPC) programs and other health centers that provide primary health care services to residents of public housing. The conference program provides participants the opportunity to customize their health care delivery experience from over five tracks and 25 workshop sessions. The plenary session speakers will be Dr. Marilyn Gaston, Co-Director of the Gaston and Porter Health Improvement Center and Dr. Eduardo Sanchez, Vice President and Chief Medical Officer of Blue Cross and Blue Shield of Texas. In the concurrent workshop sessions, health care providers will share effective practices, treatments, new technologies and policies to improve health outcomes among residents of public housing.

For more conference information and registration please visit
www.healthandpublichousing.com ■

Clinicians' Corner

By Anna M. Gard, MSN, FNP-BC, ACU and Tim D. Barker, MD, Medical Director, HOTCHC



Our vulnerable public housing communities have demonstrated greater morbidity and mortality from cardiovascular disease (CVD) disproportionate to the general population.^[1] The Jackson Heart Study, the largest single-site, prospective, epidemiologic investigation of CVD among African Americans, examines the reasons for CVD disparity and explores new approaches to reduce it.^[2] Social environment may play a greater role in the disparity between the numbers of African Americans living with hypertension compared to non-Hispanic whites with the disease, a disparity substantially reduced when comparing groups of African Americans and non-Hispanic whites living in similar social environments.^[3] A recent study published in the *Annals of Family Medicine* found that the lives of nearly 8,000 African Americans could be saved each year if their average blood pressure was lowered to the average level of Caucasians. This is the first study to calculate the lives lost due to racial disparities in hypertension control.^[4]

As clinicians serving residents of public housing, every day we see the majority of adult patients in our health centers have hypertension. They face many risk factors that contribute to and complicate CVD including smoking, obesity, high salt, high fat, low fiber diets, and physical inactivity. Managing CVD is a labor intensive endeavor for both the patient and the clinician. Most often patients require a multiple medication regimen; frequent monitoring of labs, blood pressure, and weight; lifestyle changes in diet, exercise, stress management, smoking cessation; and scheduling and adhering to medical office visits and diagnostic studies. With lives complicated by poverty, unemployment, violence, hunger, and loss, the priority of managing their CVD falls to the bottom or off of their list completely until symptoms scare them back into the health care system.

Tim Barker, M.D., the medical director of The Heart of Texas Community Health Center (HOTCHC) in Waco Texas, shares his approach to addressing the care of their 10,000 patients with CVD. As a participant in HRSA's CVD chronic care collaborative, they have created a model utilizing Community Health Corp (CHC) volunteers to help in the case management of their patients with CVD. "One of the greatest challenges to chronic care management in public housing communities is keeping patients engaged in their care. They are often lost to follow-up care when they do not return for medical visits or refill their prescriptions," he reports.

Last year, Dr. Barker attended the Institute for Healthcare Improvement annual conference and participated in a workshop on Appreciative Inquiry. Appreciative Inquiry is used as an approach to quality improvement and provides motivational tools for staff. Appreciative Inquiry seeks to

discover the unique qualities, gifts, and strengths of individuals essential to successful contributions and achievements.^[5] This method aims to examine what an organization does well and capitalizes upon that success.

While providing staff training on this method, he asked them to share positive examples of successful achievement. Dr. John Gill, a staff physician at HOTCHC, shared the case of an uninsured patient with complex poorly controlled hypertension, diabetes, and coronary artery disease. Despite intensive care from both the nurse practitioner and himself, this patient was not able to improve his disease control. Dr. Gill referred this patient to a CHC volunteer who also was a nutrition student at Baylor University. After three visits with the CHC volunteer for self management counseling, the patient made remarkable improvements in his disease control.

Recognizing the success of this example, Dr. Barker and his team developed a care delivery model that capitalized upon the strength of the CHC volunteer as an integral part of the health care team. Initially, they piloted a project in diabetes care where the CHC volunteers were provided with online training, a tool developed by Dr. Barker, to provide self management counseling to all diabetic patients. The CHC volunteers called all diabetic patients two days prior to their scheduled visit to remind them of their appointment and ask that they arrive early to meet with the CHC volunteer for self management counseling. This model is now being spread to the 10,000 CVD patients in their practice. Dr. Gill reports that this model "helps to engage the patient in education readiness with the consistency of a non-judgmental message provided by the CHC volunteer and re-emphasized by clinician."

Shirley Langston is a CHC volunteer who began her relationship with HOTCHC as an uninsured patient with newly discovered CVD. She opened Restoration Haven (www.restorationhaven.org), a public housing community advocacy organization that networks with other organizations to provide parenting support classes, tutoring, ministry, transportation, counseling, and outreach. Her patient experience has helped her in her outreach to other residents of public housing. She is able to demystify the health care system and encourage community residents to seek health care, adhere to medication regimens, and commit to self management goals that will contribute to their own self empowerment, "As a CVD patient myself, I am able to help change the mindset of the residents, improve their perception of the health center and clinicians, and engage them in taking responsibility for their health management."

continued on page 8

Clinician's Corner

continued from page 7

Examining care delivery design and incorporating CHC volunteers as patient educators, case managers, and self management counselors, Dr. Barker and the Heart of Texas Community Health Center staff are making inroads in reducing CV health disparities and lessening the burden of disease in their patient communities. In a recent published article from The Jackson Heart Study, data suggests that educational efforts have succeeded in increasing awareness levels and treatment of CVD in Southern African Americans^[6]. Public housing residents with CVD served by The Heart of Texas Community Health Centers are reaping the benefits of that success. ■

1. Manjarrez, C.A.; Popkin, S.J.; & Guernsey, Elizabeth; 2007. "Poor Health: Adding Insult to Injury for HOPE VI Families," Metropolitan Housing and Communities Center, Brief No. 5.
2. The Jackson Heart Study 2008 [online] available from <http://jhs.jsums.edu/jhsinfo/Home>. 26 January 2009.
3. Thorpe, R.J.; Brandon, D.T.; LaVeist, T.A.; 2008 "Social Context as an Explanation for Race Disparities in Hypertension. *Social Science & Medicine*, 67(10)s 1604-161.
4. Satcher, D.; "Examining Racial and Ethnic Disparities in Health and Hypertension Control," *Annals of Family Medicine*, 2008; 6:483-485.
5. Cooperrider, D.L.; Whitney, D.; 2005. *Appreciative Inquiry: A Positive Revolution of Change*. San Francisco. Berrett-Kohler Publishers, Inc.
6. Walker, R.; Andrew M.E., Keahey, W.J.; et al. 2008 "Prevalence, Awareness, Treatment, and Control of Hypertension in the Jackson Heart Study," *Hypertension*;51;650-656.

NCHPH Library and Resource Center

Designed to increase the ability of health centers to provide high-quality preventive and primary care services to residents of public housing, this online Library and Resource Center is a central access point for tools for and information on Public Housing Primary Care (PHPC) health centers, the PHPC program, demographics and health status of residents of public and assisted housing, and PHPC service models and best practices.

Available online: Fact sheets, monographs, links to Federal, state, and national organizations, research and reports, tools, Quarterly Information Bulletins, an annotated bibliography, and best practices presentations from the annual conference.

Visit the NCHPH Resource Center at:
<http://healthinpublichousing.org/resources.html>

National Center for Health in Public Housing

North American Management
2111 Wilson Boulevard, Suite 323
Arlington, Virginia 22201

The Quarterly Information Bulletin is prepared under a Cooperative Agreement with the Health Resources and Services Administration (HRSA). The contents of this publication are the views of the authors and do not necessarily represent the official views of HRSA or North American Management.

Please send your questions or comments to us at:
info@healthandpublichousing.org