

PARTNERING WITH PUBLIC HOUSING AUTHORITIES TO INCREASE RESIDENT PARTICIPATION

A RESOURCE TOOL KIT FOR HEALTH CENTERS



National Center for
Health in Public Housing

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MANAGEMENT

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INTRODUCTION

The World Health Organization (WHO) defines health as “...a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.” For those who have had the experience of working in community health centers or in the field of public health, it is a well-known fact that the physical and social environment play a major role in the health of individuals and communities.

This document addresses the significant impact an individual’s social environment has on their health. Social environment includes housing, transportation, urban development, land use, industry and agriculture and results in exposures such as work-related stress, injury and violence. Public housing residents frequently live in social environments that expose them to one or more of these factors which significantly impact their health and their lives.

Public housing authorities (PHAs) wield considerable influence and control over the social environment in which public housing residents live. The local PHAs are also restricted by federal policies, programs and guidelines as well as funding resources available to them. They offer numerous services and programs to residents and understanding the complexities of these programs and the various regulations governing them, which can be confusing if not outright daunting. Many community health center staff have expressed the need to develop a better understanding of their PHA in order to enhance collaborative efforts. This tool kit provides information, resources and references to enable both residents and community health center staff to partner and collaborate more effectively with their local Housing Authority.

The **Health Services for Public Housing Residents** program was established in 1990 through an amendment of the Public Health Service Act to include the Disadvantaged Minority Health Improvement Act. This amendment established the program now known as the Public Housing Primary Care Program (PHPC).

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

Grantees funded under the Section 330(i) Public Housing Primary Care program are required to:

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

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

This practical guide provides information and resources for health center staff to partner and collaborate more effectively with their local housing authorities.

The National Center for Health in Public Housing (NCHPH) can provide additional training and technical assistance.

For more information regarding available training opportunities, please contact: Deborah Murphy at dmurphy@nambco.com.

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

Villie provided the leadership for Grace Hill to become one of the first recipients of the Stewart B. McKinney Health Care for the Homeless grant in 1987 as well as one of the first Public Housing Primary Care grant recipients in 1992. Under her leadership, Grace Hill has also received numerous awards and recognition for its' innovative, community based programs and services for special populations.

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

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MODULE I: GETTING TO KNOW RESIDENTS OF PUBLIC HOUSING AND HUD

RESIDENTS OF PUBLIC HOUSING

In order to develop an effective working relationship with a community, and to address its' needs successfully, it is important to have an in depth knowledge of the socio-demographic characteristics of that community. Numerous research studies indicate that public housing residents suffer from alarmingly high rates of many chronic conditions, higher than the general population.

a. Socio-Demographic Characteristics

Following are some characteristics of residents of public housing:

- 2 million residents live in public housing and 4.7 million live in Section 8 housing
- Approximately 842,000 (40%) residents are children under the age of 17 years
- Approximately 2.3 million (47%) Section 8 residents are children under the age of 17 years
- Nearly 330,000 (15%) are seniors over 62 years
- Approximately 400,000 (8%) of Section 8 residents are seniors age 62 yrs and above
- 33 percent of public housing and 35 percent of Section 8 households include a member who is disabled
- 37 percent of public housing and 32 percent of Section 8 households are female headed with children
- The average annual household income for PH residents was \$12,569 and for Section 8 residents it was \$8,869
- The federal poverty level was \$14,000 for a household of two and \$17,600 for a household of three in 2008
- Only 34 percent of PH residents and 25 percent of Section 8 residents listed their primary source of income as wages
- Most residents of public housing and Section 8 fall into HUD's "Very Low Income" category with an income of less than 50 percent of the national median

b. Housing Authority Demographics

The following table provides data on the cities with the 10 largest Housing Authorities in the country:

		PH Units	Section 8 Units
1	New York City Housing Authority	161,735	97,743
2	Puerto Rico Public Housing Administration	56,454	32,539
3	Chicago Housing Authority	28,282	48,252
4	Philadelphia Housing Authority	16,572	18,588
5	Housing Auth. Of Baltimore City	14,452	16,262
6	Boston Housing Authority	11,938	12,189
7	Cuyahoga Metropolitan Housing Authority	11,369	14,266
8	Miami-Dade Housing Authority	9,505	16,543
9	Atlanta Housing Authority	9,321	16,610
10	Newark Housing Authority	8,715	5,389

c. Social/Environmental Concerns

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

- Poor access to health care services, including lack of adequate transportation
- Poor access to other services, e.g. grocery stores, resulting in limited access to fresh fruits and vegetables
- Crime/gangs with resultant anxiety and fear for personal safety
- Poor neighborhood environment that is not conducive to walking or outside exercise
- Neighborhood blight resulting in social isolation
- Hazardous buildings, with corresponding problems of lead poisoning and mold/mildew
- Fragile family structure with a high incidence of broken families and single parent families
- Disability and a higher incidence of morbidity and mortality
- Overcrowding as a result of extended families living in the same house

- High rates of unemployment/poverty

d. Health Concerns of Public Housing Residents

According to a 2004 Urban Institute study in five HOPE VI developments:

- 47% adults are obese compared to 33% of black women nationally
- 37% have hypertension versus 21% of all black women
- 15% are diabetic versus 8% of all black women
- 22% have asthma versus 11% of all black women
- 41% reported being in fair or poor health – more than three times the rate reported nationally by all adults and about twice that of black women
- 54% of children had two or more behavior problems compared to 44% of poor children nationally

e. PHPC Grantee Data – 2007

There are currently 40 PHPC grantees serving over 130,000 residents.

Over 90% represent communities of color, including:

- 44% black
- 42% Hispanic/Latino
- 5% Asian/Hawaiian/Pacific Islander

Chronic Diseases accounted for a growing number of encounters in 2007, including:

- 34% increase in diabetes visits
- 35% increase in asthma visits
- 23% increase in hypertension visits

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

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HUD SUBSIDIZED HOUSING PROGRAMS

a. The Office of Public and Indian Housing:

The mission of the Office of Public and Indian Housing (PIH) is to ensure safe, decent and affordable housing; create opportunities for resident self-sufficiency and economic independence; and assure fiscal integrity by all program participants. The US Department of Housing and Urban Development (HUD) was created in 1965 as part of President Johnson's War on Poverty. However, low income housing programs were originally created as a result of the National Housing Act of 1934 and 1937. Today, PIH provides affordable housing to over 1.3 million households nationwide. These housing units are managed by over 3,300 local public housing authorities (PHA). HUD administers federal aid to local PHA's as well as furnishes technical and professional assistance in planning, developing and managing these developments.

Eligibility for public housing is limited to low-income families and individuals. The PHA determines eligibility based on: annual gross income; whether the individual is an elderly person or with a disability; US citizenship or eligible immigration status. Once an applicant is deemed 'eligible,' the HA will check references to ensure that the applicant is a good resident. PHA's use income limits developed by HUD. The lower limit is set at 50% of the median income for the country or metro area in which the individual lives.

The resident's rent is based on a formula, which is either 30% of the resident's monthly adjusted income or 10% of the monthly income, whichever is higher.

b. Public and Indian Housing (PIH) Programs and Services:

There are a wide range of programs administered and managed by the Office of PIH. A working knowledge of these will help PHPC grantees understand the resources currently available to their clients through HUD and their local PHAs, but also provide opportunities to initiate collaborations on some or all of them. The programs most relevant to the Public Housing Primary Care program include:

Resident Opportunities and Self Sufficiency (ROSS):

The ROSS program "works to promote the development of local strategies to coordinate the use of assistance under the public housing program with public and private resources, for supportive services and resident empowerment activities. These services should enable participating families to increase earned income, reduce or eliminate the need for welfare assistance, make progress towards achieving economic independence and housing self-sufficiency or, in the case of elderly or disabled residents, help improve living conditions and enable residents to age in place."

The ROSS program has been restructured and currently incorporates several older tenant services programs. ROSS provides funding to hire Service Coordinators to assess the needs of residents of conventional public housing or Indian housing and coordinate resources in the community to meet those needs.

Eligibility – ROSS grants may be made to four types of applicants:

- Public Housing Authorities (HAs)
- Tribes/tribally designated housing entities (TDHEs)
- Resident Associations (RAs) such as resident management corporations, resident councils, and intermediary resident organizations
- Nonprofit organizations supported by residents and/or HAs.

Family Self-Sufficiency – The ROSS program also funds the Family Self-Sufficiency (FSS) program. FSS is a HUD program that encourages communities to develop local strategies to help assisted families obtain employment that will lead to economic independence and self-sufficiency.

Only Housing Authorities are eligible for funding under this program. Through these funds, HA's are able to hire program coordinators to help link residents to resources available to them, including training programs and job placement services. Residents who wish to participate in FSS are required to enter into a contract with the HA agreeing to participate in and complete training and employment programs. This contract also outlines responsibilities of the

HA. The HA must establish goals for each participating family receiving welfare assistance, to help them become independent from welfare assistance and remain independent at least one year prior to the expiration of the contract. Residents may earn an escrow credit based on increased earned income during their period of participation, and may use it upon successful graduation from the program.

Elderly/Disabled Service Coordinator Program – This program was formerly under ROSS, but HUD currently provides funding to eligible HAs through the Public Housing Operating Fund. HAs can use these funds to hire Service Coordinators to obtain supportive services for the elderly and persons with disabilities to enable them to continue living independently in public housing and avoid more expensive assisted living alternatives.

HOPE VI – Initiated in 1993, HOPE VI has provided funding to rehabilitate and revitalize some of the most distressed public housing complexes in this country. Local HAs have had the flexibility to use these grants to address the housing and social service needs of their residents.

Housing Choice Vouchers – Formerly known as Section 8, these vouchers allow very low-income families, the elderly and disabled to choose and lease or purchase safe, decent and affordable privately owned rental housing.

Participants who receive a housing voucher are responsible for finding a suitable housing unit of their choice. The owner of the unit must agree to participate in the program, and the unit must meet minimum standards of health and safety as determined by the HA. A housing subsidy is paid to the landlord directly by the HA on behalf of the participating family. The participant only pays the difference between the actual rent charged by the landlord and the amount subsidized by the program.

This program is administered by the local HA who receive federal funds through HUD.

Eligibility is determined by the HA based on family income and size and is limited to US citizens and those with eligible immigrant status. Participants generally pay approximately 30% of their monthly adjusted income.

Moving to Work Demonstration (MTW) – MTW is a demonstration program that allows HAs to design and test ways to give incentives to families to become economically self-sufficient, achieve programmatic efficiencies, reduce costs and increase housing choice for low income households.

c. Application Process:

When funding becomes available to HUD through congressional appropriations, grant competitions are announced annually through HUD’s SuperNofa process. Information about how to apply and deadlines for applications can be obtained through: www.HUD.gov. Look under “funds available.”

Additional program information can also be obtained at: 1 (800) 955-2232.

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Involving the local housing authority and other key members of the community in program planning and implementation is vital to the successful implementation of the PHPC program. Healthy individuals and families are more likely to be self-sufficient and become contributing members of a healthy community. Decent, safe, sanitary and affordable housing contributes significantly to the health of the community. Several Community Health Centers (CHCs) have been successful at securing rent-free clinic space from their local HA (or paying a token \$1 per year). Unfortunately several CHCs are currently confronted by the possibility of having to start paying market rate rent on previously rent-free space. In addition the financial advantage of having rent-free space, there are other advantages to collaboration as well.

ADVANTAGES OF COLLABORATION

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

In addition to residents and PHA staff, some of the other key players in the community to engage as key collaborators include:

- City health department – in order to facilitate access to public health services including lead and mold remediation, immunizations, STD services and TB testing
- Community based organizations including social services, day care and mental health. Developing personal contacts with email and phone # helps ensure a speedier referral and linkage process for residents.
- Youth organizations including the YMCA; Boy Scouts and Girl Scouts and Boys and Girls Clubs. Frequently, these organizations are the only ones providing opportunities for young people to socialize and participate in safe, organized after-school activities in many inner-city neighborhoods and isolated communities.
- Faith-based organizations including store front churches and religious leaders in the community. These provide services ranging from soup kitchens and food pantries to day care and educational classes.
- Mass transit authority – mobility impairment or the absence of personal transportation results in social isolation for many residents. Maintaining a relationship with the local transit authority staff will provide opportunities for residents to have input when decisions concerning public transportation are made.
- Ethnic organizations and leaders - for access to Vietnamese, Bosnian and other ethnic groups
- Businesses – cultivating local businesses in order to provide employment opportunities for residents.
- Political groups including aldermen, political ward leaders - local politicians can be very influential in helping residents with environmental issues – from getting stop signs installed in order to make neighborhood streets safer to getting unsafe, abandoned buildings boarded up in order to reduce drug trafficking and loitering.
- Other community health centers

RECRUITING RESIDENTS AND GAINING COMMUNITY SUPPORT

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

- Identify Community Leaders** – Include church leaders, school principals, Resident management council presidents/chairs, agency CEO's, resident managers, and others with current or potential impact on the community. Include the parents/residents to whom other residents usually turn to for help, i.e. the ones looking out for everyone's children.
- Communicate Agency Goals and Program Mission** – Clearly communicate program goals, and share any new programs being implemented.

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

c. Ensure Buy-In – Seek resident input into the planning and delivery of services. Present ‘drafts’ of program ideas prior to finalizing. Program limitations need to be presented clearly, up front, in order to ensure that residents are aware of the parameters and don’t feel discouraged or angry if their ideas are not accepted or implemented.

d. Partner with the Housing Authority – CHC staff should work closely with their local housing authority staff. They should request permission to attend their staff meetings at which they can share information on their programs, suggest ways they can be of help and enlist the support and cooperation of the housing authority staff.

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

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

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

h. Floor Captains – In high rise buildings, CHC staff may want to set up a system for designating one or more responsible residents on each floor as ‘floor captains’. Floor Captains are generally responsible for distributing fliers door-to-door, referring residents to resources, and serve as onsite volunteers.

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

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

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

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EFFECTIVE TOOLS FOR COMMUNICATING WITH THE HOUSING AUTHORITY

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

- a. Solicit buy-in and support from the CEO of the Housing Authority.** Arrange a face-to face meeting with the Housing Authority Executive Director. Explain the PHPC program, its benefits and ‘sell’ the advantages of partnering. Use this opportunity to initiate discussion towards formalizing a Memorandum of Understanding (to include all or some of the following) for CHC staff to:
 - Attend PHA staff meetings to discuss the PHPC program with PHA staff
 - Attend resident council meetings held at their various housing complexes
 - Meet with resident council managers on a regular basis
 - Hold meetings with residents in community spaces on site
 - Post/distribute fliers and brochures regarding CHC events and activities on PHA property
 - Provide resident managers with pre-packaged “welcome” packets to distribute to all new tenants. Packets to be assembled by CHC staff and may include information on the CHC services and programs, useful health information, coupons, freebies such as magnets with CHC contact information.
- b. Attend PHA staff meetings regularly** – Provide program updates, offer to assist with outreach and recruitment
- c. Attend resident council meetings** – Ask to be on the agenda each month if possible. Provide health education tips, sessions. Recruit residents for future activities
- d. Provide tangible services** – TB screening, flu shots, blood pressure, diabetes and other screenings on site. These are always welcome and will help staff gain a foothold in the PHA community
- e. Say ‘thank you’** – often – Invite key PHA staff to a lunch meeting, invite them to CHC activities and functions
- f. Provide positive press** – feature PHA staff and activities in CHC newsletters, annual reports – send the CEO of the PHA copies of these.

BARRIERS TO COLLABORATION

Some of the best intentioned and well-planned collaborative efforts fail for various reasons. Some of these can be anticipated while others cannot:

- a. PHA CEO turnover** – Some PHAs have been known to have a frequent change in top management, including the position of CEO. This usually results in having to establish relationships with the new CEO all over again. The negative impact of this frequent turnover can be mitigated by a well drafted memorandum of understanding which specifically outlines the working relationship between the two entities and can continue to be implemented without disruption regardless of the turnover.
- b. PHA Staff turnover** – Frequent contacts between CHC and PHA staff will alert the CHC when key PHA staff have been replaced. A brief orientation of the new staff should be undertaken as soon as new staff are on board to ensure continuity of the relationship. CHC staff should prepare “orientation” packets to be given to new PHA staff. These can include information on CHC services, clinic and staff schedules, staff contact names and useful phone

numbers.

- c. **Space issues** – Some PH complexes do not have adequate meeting room facilities for CHC staff to hold health education or other activity sessions. PHPC staff may need to arrange for space as well as transportation.
- d. **HUD/PHA regulations/policies regarding confidentiality** – Because PHA's cannot provide names of their tenants for any CHC mailing lists, PHPC staff should negotiate other arrangements including providing the PHA with stamped mailers that the PHA can then address and mail.
- e. **Trust issues** – In some PH complexes, there may be conflict between the resident managers and the residents. It is critical for PHPC staff to maintain neutrality and not be seen as taking sides.

RESIDENT TRAINING AND INVOLVEMENT IN GOVERNANCE

Community health centers (CHCs) were first established in 1965. They were created by Congress to provide comprehensive primary care to high-risk patients in underserved communities. Community health centers are required to have a governing board composed of individuals, a majority of whom are being served by the center and who, as a group, represent the individuals being served. If patients from public housing represent only a small minority of the total patients served by a CHC, it is possible that the board would have just one or two PHPC consumers represented. In order to ensure that residents have a voice and participate in program planning and oversight, it is recommended that the CHC also establish a PHPC advisory committee.

The PHPC Advisory Committee should include representatives from resident councils, PHAs, local schools, community organizations and others impacting the lives of residents. This committee can serve as an excellent resource from which to select potential consumer board members for the CHC Board of Directors. Some of the issues to be addressed and steps involved in setting up an Advisory Committee include:

- Recruiting committee members – CHC clinicians and other staff are usually a good resource for referring patients who are articulate and care about the services provided. Self referrals are also welcome
- Comprehensive orientation – informed board members are usually effective board members. All board and committee members should receive a comprehensive orientation within a month of being elected.
- Members should be offered the opportunity to tour the CHC service sites.
- Efforts should be made to remove any barriers to participation at meetings, including provision of transportation, child care services, translators and any other resource to enhance consumer participation and attendance.
- Board and committee members should receive regular program updates, preferably from their respective program staff.

ESTABLISHING A MEMORANDUM OF UNDERSTANDING WITH A HOUSING AUTHORITY

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

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A meeting between the CEO of the CHC and the CEO of the Housing Authority is usually the first step for both agencies to come together and explore a mutually beneficial relationship. The CHC should come prepared to discuss the health care needs of residents and the programs and services it can offer to residents as well as the PHA staff. The CHC should bring handouts, including statistics on resident use of CHC services; resident health data; any unmet needs; as well as brochures describing health center services.

The CHC should also come prepared to suggest areas for collaboration – have specific “asks” outlined. Some typical areas for collaboration include;

- Provision of rent-free clinic space in a centrally located housing complex, usually two or more modified apartments at ground level
- Attendance at PHA staff meetings to discuss the PHPC program with PHA staff
- Attendance at resident council meetings held at their various housing complexes
- Meeting with resident council managers on a regular basis
- Holding meetings with residents in community spaces on site
- Posting/distribution of fliers and brochures regarding CHC events and activities on PHA property
- Providing resident managers with pre-packaged “welcome” packets to distribute to all new tenants. Packets to be assembled by CHC staff and may include information on the CHC services and programs, useful health information, coupons, ‘freebies’ such as magnets with CHC contact information.

If the PHA is unwilling/unable to enter into a formal MOU, the CHC should be prepared to suggest establishing a less formal collaboration. Either the CHC or the PHA can initiate this, on their letterhead., basically outlining the discussion that took place and the specifics of the collaboration agreed to by both parties.

MODULE III: COMMUNITY COLLABORATIONS

BEST PRACTICES/MODELS THAT WORK

The following are some examples of national models of collaboration highlighted at the National Heart Lung and Blood Institute’s (NHLBI) Education Strategy Development Workshop: Public Health in Public Housing – Improving Health, Changing Lives held May 2004:

- Housing Authority of the City of Paterson, NJ in collaboration with the Public Board of Health
- The Public Health Dept, Seattle, WA and the Seattle Housing Authority, resident community councils, CHC’s and the Seattle-King County Healthy Homes Project
- National Organization of African Americans in Housing (NOAAH), Council of Large Public Housing Agencies (CLAPHA), National Association of Housing Redevelopment Organizations (NAHRO), Public Housing Agency Director’s Association (PHADA)
- Massachusetts Union of Public Housing Tenants (MUPHT) in partnership with PHA managements throughout the state and Boston Healthy Start

This section will continue to be updated and expanded as additional ‘best practices’ around the country are identified.

APPENDICES

- A. Resource Directory
- B. Sample Memorandum of Understanding

MEMORANDUM OF UNDERSTANDING

BETWEEN

Name of Housing Authority

AND

Name of Health Center

FOR

PRIMARY HEALTH CARE

This Memorandum of Understanding shall describe and formalize the collaborate relationship between the (insert name of housing authority here) (hereinafter “(insert PHA name)”) and (insert name of community health center here) (hereinafter “(insert CHC name)”) in connection with a grant to (insert CHC name) from the U.S. Department of Health and Humans Services (HHS) for primary health care for residents of public housing.

WHEREAS, the (insert PHA name) and (insert CHC name) submitted a grant application to HHS in date for the Public Health Primary Care Open Competition, and;

WHEREAS, on date (insert CHC name) was notified of a grant award of \$(insert amount) for the full xxx years term of the grant and;

WHEREAS, \$(insert amount) of the full grant amount is allocated to the xx month term of this MOU, and;

WHEREAS, the (insert PHA name) and (insert CHC name) mutually agree to the following rights, duties, and obligations under this Memorandum of Understanding as described below:

Purpose of MOU: The entities named above join in this agreement with the intent of coordinating resources and providing services to increase the access of persons living in or approximate to specific public housing complexes in the City of (insert name) to primary health care resources, health education and referrals for care that cannot be provided on site.

Collaborators Statement of Mission: The above named collaborators share a commitment to supporting the efforts of families in public housing to realize self-sufficiency, an improved standard of living and a heightened quality of life. The collaborators will realize this commitment by providing these families unimpeded access to the resources that will allow them to improve and maintain their health, meet all basic needs, garner education and training and receive the guidance necessary to apply skills and experience in a manner that is socially productive and provides for fair remuneration.

Period of Agreement: This MOU shall be effective from (insert date) through (insert date) with the option to renew for three additional one year periods providing funding is available and both parties elect to exercise the option.

Collaborators’ Commitment of Resources: The resource commitments of (insert PHA name) and (insert CHC name) to the realization of this project are as follows:

(insert PHA name)

The (insert PHA name) shall:

1. Provide to the project one half-time Resident Initiatives Coordinator who shall serve as the liaison between the project's leadership staff as designated by the (insert CHC name) and that staff's housing counterparts in all departments and units that may prove relevant in conducting the business of the project.
2. Designate specific (insert PHA name) staff, where relevant to project operations, as contacts for (insert CHC name) project staff, and ensure ready access to those staff as a means of facilitating the timely development, implementation and expansion of the project. This is to include both project site-specific staff and administrative staff.
3. Make available to project staff at the housing complex sites (list sites) space sufficient to operate the Mobile Medical Unit and to provide other services (dental, mental health, health education) within the Learning Opportunity Centers/public areas through dedication of that space at times to be mutually agreed upon by (insert PHA name) and (insert CHC name) staff.
4. Make available to the project staff at the housing complex sites currently existing equipment (telephone, photocopier, fax machine, computer), where available, for the periodic use of project staff and/or facilitate placement of such equipment there as necessary when purchased by the project.
5. Facilitate the work of the project by supporting staff in gaining access to residents for purposes of conducting needs assessments, undertaking outreach, recruiting for the Outreach Worker/Case Manager positions and communicating with any resident-specific bodies, such as resident councils.
6. Provide (insert CHC name) with data pertinent to the documentation and evaluation of project activities undertaken by (insert PHA name) on behalf of this project, based upon a schedule to be mutually agreed upon by the relevant parties.

(insert CHC name)

The (insert CHC name) shall:

1. Provide funding to (insert PHA name) in the amount of \$(insert number) to cover the cost of one half-time Resident Initiatives Coordinator to serve as Housing Commission Liaison and funds to cover reasonable costs for office supplies, mileage, utilities, rent and telephone charges and/or indirect costs associated with the direct activities of the project for the (insert number)th month term of this MOU.
2. Provide a self-contained Mobile Medical Unit and three (3) staff persons including a Nurse Practitioner, Licensed Vocational Nurse, and an insured driver to provide primary health care services to residents at the public housing sites, weekly at (insert number) sites and twice monthly at (insert number) sites. (insert CHC name) staff shall coordinate any changes to the established schedule with designated (insert PHA name) staff and shall provide a current written schedule of services for the (insert CHC name)'s records.
3. Provide primary health care, dental services, prevention education, mental health and substance abuse related counseling, with related case management support.
4. Will assist with transportation to enable residents to access health services at other sites.
5. Establish a reporting relationship with that member or those members of the (insert PHA name) who will have responsibility for execution of xxHA activities in the context of the project. (insert CHC name) staff will establish a structure of communication with (insert PHA name) counterparts to meet the needs of (insert PHA name), including a schedule of meetings and/or telephone contacts, as desired.
6. Provide designated (insert PHA name) staff data pertaining to the project, its operations and outcomes, as generated in the course of project development and implementation or as otherwise specifically request in order to provide quantifiable progress toward project goals.
7. Provide for all equipment and supplies to be utilized at the project sites except where (insert PHA name) has given express authority that said equipment and supplies (e.g. telephone, fax machine, computer, photocopier) are to be available for the use of project staff.

8. Hire a Project Coordinator. Select and hire two Outreach Workers for the project who will work 32 hours per week, giving preference to public housing residents referred to (insert CHC name) by (insert PHA name) staff.
9. Fulfill all reporting requirements including collection, collation and analysis of all project data pertinent to project evaluation and the execution of reporting requirements.
10. Project Coordinator shall evaluate the efficacy of the collaborative arrangement described in the MOU. Project Coordinator shall consult with designated (insert PHA name) staff as necessary.

Confidentiality

The identity of participants is to remain confidential. The (insert PHA name) and the xxCHC assume responsibility for maintaining the confidentiality of individual participant records.

Nondiscrimination

The rights all will be respected without regard to color, creed, religion, sex, ethnicity, sexual orientation, nationality, legal status, health, or disability. All persons desiring to be served, and meeting the project's basic qualifications, but requesting project services, will enjoy access to project staff for purposes of referral to an appropriate entity.

(insert CHC name) Indemnifications

(insert CHC name) shall be responsible for all injuries to persons and for all damages to real or personal property of the (insert PHA name) or others, caused by or resulting from the negligence of itself, its employees, or its agents during the progress of or connected with the rendition of services hereunder. (insert CHC name) shall indemnify and hold harmless the (insert PHA name) and the City of city name, and all officers and employees of each agency from any and all liability, claims, and costs (including reasonable attorney's fees):

1. for damages to real or personal property, or personal injury to any third party resulting from the negligence of (insert CHC name), its employees or its agents; or
2. for any breach of any obligations, duties or covenants of (insert CHC name) under this MOU or transactions related to it.

(insert PHA name) Indemnification

(insert PHA name) shall indemnify (insert CHC name) from all injuries to persons and/or property which result from and proximately are caused by the sole negligence and/or willful misconduct of the (insert PHA name) in the performance or the failure to perform under the terms of this MOU, including liability arising out of the sole negligence and/or willful conduct of the employees, agents of the (insert PHA name), its officers and/or Commissioners, as referenced in paragraphs 1 and 2 below. This indemnity shall include only such liability, costs and damages which are proximately caused by such sole negligence and/or willful misconduct and which arise out of:

1. Damages to real and/or personal property, or personal injury to third parties resulting from such sole negligence and/or willful misconduct of (insert PHA name) and/or its employees and agents concerning the activities to be performed by the (insert PHA name) under the terms of the MOU; and
 2. For any breach of any obligations, covenants and/or duties of the xxHA under the terms of this MOU, arising from the sole negligence and/or willful misconduct of the (insert PHA name).
- Further, during the term of this Agreement, the (insert PHA name) shall maintain general liability coverages as it shall deem appropriate, which shall provide coverage for the sole negligence of the (insert PHA name).

Insurance Requirements

(insert CHC name) shall not commence work until all insurance required under this section has been obtained and approved

by the (insert PHA name). (insert CHC name) agrees to the following:

1. (insert CHC name) shall provide public liability and property damage insurance in the minimum amount of \$1,000,000 for injury or death of one or more persons and/or property damage arising out of a single accident or occurrence, insuring against all liability of the (insert PHA name), the City of (insert city name), (insert CHC name), its subcontractors and its authorized representatives, arising out of or in connection with (insert CHC name)'s performance of work under this MOU.
2. (insert CHC name) shall purchase and maintain in full force and effect worker's compensation insurance for contractors, subcontractors, employees and agents in form and amount acceptable to the (insert PHA name) during the full term of this MOU.
3. (insert CHC name) shall provide automobile liability insurance on owned and non-owned motor vehicles used in the performance of services described in this MOU, both on site or in connection therewith for a combined single limit for bodily injury and property damage of no less than \$500,000 per occurrence.
4. All insurance required to be purchased and maintained by (insert CHC name) shall name the (insert PHA name), the city name Housing Authority, and the City of (insert city name), as additional insured and shall contain cross-liability endorsements.
5. (insert CHC name) shall furnish to the (insert PHA name) Certificates of Insurance evidencing the insurance carried in compliance with this section. The Certificate shall contain a provision that at least 30 days prior written notice will be given to the (insert PHA name) in the event of cancellation or nonrenewal of the insurance.

Contact Persons

The contact person for (insert PHA name) shall be:

Contact Person, Title
Address
Phone Number

The contact person for (insert CHC name) shall be:

Contact Person, Title
Address
Phone Number

IN WITNESS WHEREOF, these tenets are agreed to by the following signatories:

(insert PHA name)

Typed Name
Title

Date

(insert CHC name)

Typed Name
Title

Date

Approved as to Form and Content:

By: _____

Date

Approver's names