

National Heart, Lung, and Blood Institute
Education Strategy Development Workshop

Public Health in Public Housing: Improving Health, Changing Lives

SUMMARY REPORT



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
National Institutes of Health
National Heart, Lung, and Blood Institute
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Contents

Acknowledgements	iv
Executive Summary	v
Day 1:	1
Introduction	2
Opening Session: NHLBI Remarks	3
Setting the Stage:	
An Overview of Public Housing and Public Health	4
Public Housing and Public Health:	
Public Housing Perspectives for Resident-Focused Programs	7
Making Public Health and Clinical Connections	
To Address Health Disparities: Clinicians' Perspectives	9
Public Health Programming in Public Housing:	
Presentations From the Field	16
Day 2:	29
“Dream Team” Breakout Sessions	30
Objectives	30
Pearls of Wisdom: Things To Consider	30
Preparation for the Breakout Sessions	31
Charge to the “Dream Team” Breakout Groups	31
“Dream Team” Scenarios and Frameworks Summary Findings	32
Adjournment	44
Appendices	45
A. Workshop Agenda	46
B. Workshop Objectives (Days 1 and 2)	50
C. Global Workshop Objectives	51
D. Participants List	52
E. Breakout Group Discussion Instructions	57
For More Information	inside back cover

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2004 (see Appendix A: Workshop Agenda, Appendix D: Participants List, and Appendix E: Breakout Group Discussion Instructions for a listing of names). Special thanks is given to Carol Payne, U.S. Department of Housing and Urban Development and Dr. Samuel B. Little, Washington, DC Housing Authority, for their contribution to the planning process.

Executive Summary

The National Heart, Lung, and Blood Institute (NHLBI) hosted the Education Strategy Development Workshop: Public Health in Public Housing—Improving Health, Changing Lives on May 5–6, 2004, at the Natcher Conference Center on the campus of the National Institutes of Health (NIH) in Bethesda, MD. The purpose of the Workshop was to hear from both public health and public housing professionals regarding public health strategies they have found to be effective in public housing communities. The Workshop focused on the (1) health conditions: asthma and cardiovascular disease (CVD) and (2) opportunities to improve the health of residents in public housing settings. On the first day of the Workshop, the guest speakers presented a picture of the public housing setting and shared their perspectives about best practices, lessons learned, and opportunities for reducing the prevalence of CVD and asthma in public housing. On the second day, participants applied the information shared on Day 1 and their collective experiences and knowledge to create scenarios and frameworks that could be used to plan future asthma control and cardiovascular health programs in public housing settings.

Day 1

Dr. Barbara Alving, Acting Director of the NHLBI, welcomed the participants and explained the purpose of the Workshop—to build on efforts to reach out to people living in public housing and help them take better care of themselves and their families.

Dr. Rob Fulwood, Senior Manager for Public Health Program Development of NHLBI's Office of Prevention, Education, and Control (OPEC) described the office's responsibilities for translating and disseminating scientific results to formats for the public, patients, and physicians. He also reviewed the Workshop's global objectives: to provide participants with a "portrait" of the public housing setting; to share perspec-

tives and identify opportunities to incorporate public health activities in new and/or existing resident services programs; to understand the importance of integrating clinical and public health strategies to address health disparities; to create innovative "best practice" approaches (scenarios) based on lessons learned from conducting community health programs in public housing and/or related settings; and to engage participants in facilitated exercises to stimulate creative ideas and interactive discussion.

Dr. Samuel Little from the Housing Authority of Baltimore City and Mr. Ron Ashford from the U.S. Department of Housing and Urban Development HOPE VI Community and Supportive Services in Washington, DC, provided an overview of public housing, describing the socioeconomic characteristics of public housing residents and the problems facing them—including health problems such as CVD, asthma, and obesity. There was discussion of the HOPE VI program, an effort of the U.S. Department of Housing and Urban Development (HUD) to transform public housing. It was suggested that HOPE VI needs to do more in the area of health. These remarks were followed by a series of panel presentations.

Panel 1. Public Housing and Health: Public Housing Perspectives for Resident-Focused Programs

Panel 1 focused on programs that would help transform residents' attitudes toward health and wellness. Carol Payne of the U.S. Department of Housing and Urban Development moderated this session. Panel members spoke from their experience in public housing addressing the topics of building partnerships, engaging public housing residents, and promoting programs in public housing. Irma Gorham (City of Paterson, NJ, Housing Authority); Dr. James Krieger (Seattle-King County Healthy Homes Project); Pamela Taylor (National Organization of African Americans

in Housing); Harry Karas and Martha Benton (Resident Advisory Board of the Housing Authority of Baltimore City and Hope Village in Baltimore); and Jack Cooper (Massachusetts Union of Public Housing Tenants, Dorchester, MA) were panelists. They described their organizations' programs, partnerships, target populations, and strategies.

The panel came to several conclusions:

- Residents are the experts; this expertise needs to be recognized.
- Policies are needed to address health disparities.
- Cultural sensitivity is important, especially when addressing diet and language in public health activities.
- HUD and the U.S. Department of Health and Human Services should join efforts. One way is to create a health line item in public housing operating budgets.
- Relationships are crucial to obtaining program funding; potential partners include housing authorities and faith- and community-based organizations.

Panel 2. Making Public Health and Clinical Connections To Address Health Disparities: Clinicians' Perspectives

Panel 2 included four clinicians who discussed how their organizations have implemented programs to address health disparities. Dr. Megan Sandel, from the Boston Medical Center, described asthma rates in Boston's public housing. She described how environmental asthma triggers in some public housing units were driving requests for transfer to public housing units free of these "triggers." A collaborative of several organizations and groups established a Public Housing Transfer Policy Workgroup to address environmental asthma triggers in public

housing to mitigate the rates of public housing transfer requests. Dr. Marielena Lara, representing Allies Against Asthma in Puerto Rico, described this community-centered coalition that has had early success in promoting asthma control in a housing project. Dr. James Krieger, representing Seattle and King County Public Health, described the Healthy Homes project in Seattle, which offers an in-home education program, as well as several other projects in Seattle that aim to improve clinical care. Dr. Henry Dethlefs, representing the Health Disparities Collaborative in Omaha, described a project in Omaha's One World Community Health Center that focuses on improving health outcomes in patients with chronic disease by changing provider practice behavior and systems and improving community relations.

Panel 3. Models To Promote Healthy Lifestyles in Public Housing

Panel 3 speakers described programs that have been successful in promoting healthy lifestyles in public housing. Dr. Jeanne Taylor, a health care consultant from Global Evaluation and Applied Research, and Anita Crawford, representing the Roxbury Comprehensive Community Health Center (RoxComp) at the Orchard Park Housing Development in Boston, described the RoxComp program. RoxComp was awarded a HUD grant to upgrade the center and worked with the tenant association and residents to determine health care services needs. Myron Bennett, representing Healthy-CMHA (Cuyahoga Metropolitan Housing Authority), described this community partnership that promotes health and wellness in 48 housing developments in Cleveland. This program has implemented a multicultural health promotion/wellness model, which focuses on increasing awareness, implementing health education and, lifestyle enhancement programs, and creating cultural change opportunities within the community to improve health. Staci Young, of the Medical College of

Wisconsin) described a community health advocate program in a housing development in Milwaukee. This program trains advocates to provide services and programs for residents in the areas of education, safety, and social activities. Ms. Carol Payne, representing the Baltimore Office of the U.S. Department of HUD, described the Healthy Hearts in Public Housing NHLBI-funded CVD Enhanced Dissemination and Utilization Center (EDUC) in Baltimore, a program that has helped to raise community awareness about CVD through training and hiring public housing residents as community health workers (CHWs).

Panel 4. Integrated Chronic Disease Models

Panel 4 speakers discussed programs that provide integrated chronic disease control. Henry Taylor, representing the University of Illinois at Chicago Mile Square Health Center, described how this Center provides quality health services to a diverse urban community by linking public housing residents to primary care and social services. Patricia Hynes, representing Boston University's School of Public Health, described Boston's Healthy Public Housing Initiative, which works to improve home environments for better respiratory health. The program trains residents at home to serve as community health advocates. They conduct surveys of housing and health conditions and collect environmental samples and data as well as educate community residents on asthma management strategies and integrated pest management (IPM). The YES WE CAN program in San Francisco was described by Dr. Mary Beth Love from San Francisco State University and Arthur Hill, a community health worker (CHW) in the YES WE CAN program. This coalition of 17 organizations has developed a medical/social model for chronic disease management in children that includes roles for the clinician, clinical care coordinator, and CHW. The Asthma Ambassador Project was described by Judith Taylor-Fishwick and Lilly Smith of the

Center for Pediatric Research, Eastern Virginia Medical School/Children's Hospital of the King's Daughters in Norfolk, VA. This project identifies and evaluates the needs of disadvantaged asthmatic children living in public housing in the Hampton Roads area of southeastern Virginia, using a case finding approach and lay health workers (Ambassadors) who provide outreach and education at the public housing community.

Day 2

Dr. Janice Bowie, of the Johns Hopkins University Bloomberg School of Public Health, facilitated the "Dream Team" Breakout Sessions. To begin, participants shared thoughts and conclusions about strategies and best practices for asthma and CVD programs discussed during Day 1. Then Dr. Bowie held a discussion on what program planners should consider in the areas of community partnership and involvement, implementation, and sustainability, and she provided questions to consider in program planning. Next, she asked the four breakout groups to identify effective strategies in prevention and treatment of asthma and CVD in public housing, and to consider global factors associated with community partnership and involvement, implementation, and sustainability. In the first hour, each group would develop two scenarios that identify and define a problem related to asthma or CVD in terms of issues, needs, and concerns; the population to be reached; the rationale for selecting the problem; and potential barriers and opportunities for resolution. The next hour would focus on constructing a framework/approach for solving at least one of the scenarios. The groups were asked to define specific objectives and strategies, key stakeholders, the materials/tools/resources that would be needed, and how outcomes would be tracked and measured. Other assignments were to determine the extent to which the project components form an integrated approach and to construct a "pictorial display" of the

approach with all the relevant elements to show connectivity.

*“Dream Team” Scenarios and Frameworks
Summary Findings*

Group I—CVD focused on multiethnic intergenerational families in public housing and the impact of CVD on them. The group’s scenario addressed residents’ problems and needs by developing an inclusive strategy that involves various segments of the target community to reduce CVD disparities in a high-risk population. The main opportunity to solve the problems discussed was to create links with power brokers in the community and with organizations such as social service agencies, churches, schools, and the public housing development residential association. Goals were to enhance awareness of CVD disparities, increase awareness of CVD morbidity and mortality among the target populations, and empower community residents in the target population. Approaches were to create a resident association and a health committee, hire and train a CHW to educate the community, hold community forums that involve residents, encourage residents to serve on the boards of community organizations, involve residents in the planning process, and provide them with incentives.

Group II—Asthma developed a scenario that incorporated the problem of asthma in public housing in two contexts: by each resident emergency asthma case and by the factors in public housing that trigger asthma symptoms in the resident population with asthma. The scenario involves 30 resident families, with 50 children, who were considering suing the Housing Authority and HUD for very detrimental conditions in their housing units. The goal was to address the environmental conditions associated with asthma: mold, insect infestation, dust, overcrowding, and lack of cleanliness. This scenario was an opportunity

to build community-based coalitions (among residents, the Housing Authority, local proactive groups, the local community, and government officials) that would focus on each individual asthma emergency case and the conditions in this public housing development that contribute to asthma. The solution to the problem involves a triaging process which employs environmental assessment and clinical evaluation.

Group III—CVD and Asthma viewed the problems of CVD and asthma in public housing as being interrelated since these chronic diseases have common factors that either contribute to or exacerbate these diseases. Participants created a fictitious scenario to describe how conditions in public housing may impact asthma. They described an old and overcrowded public housing building situated in a closed-in environment, isolated, and having poor-quality services, little transportation, and a culturally diverse population. They assessed that in this scenario CVD and asthma would be prevented or lessened by addressing disease risk factors, environmental and psychosocial factors, and barriers. The scenario provides an opportunity to build partnerships with the community and to utilize CHWs. Activities to address CVD and asthma include holding meetings, classes, and workshops; providing culturally appropriate health information; and ensuring transportation to access health services and stores that sell healthy food/products/medications. They recommended tools to support activities, including a Web-based clearinghouse with links to existing resources.

Group IV—CVD and Asthma felt that the program should target oppressed, intergenerational, multiethnic residents who are at higher risk for CVD and asthma. The roots of asthma and CVD start in youth and continue during one’s lifetime, and one is never too old to change health habits. The group concentrated on health education and nutrition and thus

CVD initially, because they surmised that nutrition is a link between poverty and poor health. They believed that increasing the availability of healthy food would be an important activity. They identified that the most effective strategy to address poor nutrition is to build a broad, community-based, governing body that would serve as a tool to turn agencies into allies and empower community residents. Empowerment, advocacy, and the creation of a governing body were described as key elements to addressing the health problem. Though this discussion focused on nutrition rather than asthma, the group believed that once community empowerment is achieved in the area of CVD, its benefits could transfer into activities to impact asthma as well.

Suggestions

During the course of the meeting, the following suggestions were made:

- Raising awareness about CVD and asthma could help change policies (e.g., for technical assistance for inspections, to mobilize resident groups to train other residents, and to teach families to adopt healthier lifestyles).

- Federal agencies such as the Environmental Protection Agency, the Department of Energy's National Laboratories, HUD and NIH need to come together around the issues of health and housing through their programs and grants.
- Building coalitions among stakeholders would lead to the greatest chance to address CVD and asthma. A suggestion was made to establish a Public Housing Disparities Collaborative which would be housed near clinics that have been associated with the Health Resources and Services Administration Health Disparities Collaboratives.

Conclusion

At the conclusion of the workshop, participants were informed that a Workshop summary report will be created, shared with participants, and used as a planning tool by NHLBI.

Day 1:

- Introduction
- Opening Session: NHLBI Remarks
- Setting the Stage: An Overview of Public Housing and Public Health
- Public Health Programming in Public Housing:
Presentations From the Field



Introduction

The National Heart, Lung, and Blood Institute (NHLBI) hosted the Education Strategy Development Workshop: Public Health in Public Housing—Improving Health, Changing Lives on May 5–6, 2004, at the Natcher Conference Center on the campus of the National Institutes of Health (NIH) in Bethesda, MD. The purpose of the Workshop was to have both public health and public housing professionals share intervention strategies they have found to be successful in engaging public housing residents in community-based activities for health and community development. The Workshop focused on ways to control asthma and improve the cardiovascular health of residents in public housing settings. On the first day of the Workshop, the guest speakers presented a picture of the public housing setting and shared their perspectives on best practices, lessons

learned, and opportunities for reducing the prevalence of CVD and asthma in public housing. On the second day, Workshop participants applied the information shared on Day 1 and their collective experiences and knowledge to create scenarios and frameworks for future asthma and CVD program planning in public housing.

Workshop participants were diverse both geographically and professionally. They included local, State, and Federal Government professionals; public housing and public health practitioners; and public housing resident advocates and leaders. Among the participants were health educators, public health program managers, community health workers, housing administrators/managers, physicians, social workers, and consultants. The following sections summarize the Workshop proceedings and contributions made by participants.

Opening Session: NHLBI Remarks

Dr. Barbara Alving, Acting Director, NHLBI

Dr. Alving welcomed the participants to the Workshop and shared that the activity was one of NHLBI's efforts to focus attention on the need to address health disparities of high-risk and minority populations living in public housing. Dr. Alving's introduction to public housing was as a medical student at Washington University School of Medicine in St. Louis, MO, where the students provided a nighttime clinic for the residents of Pruitt-Igo, one of the Nation's first public housing projects. She mentioned that medicine at that time was focused on the very sick patient, but today the hope is to prevent illness, which is one of the goals of the NHLBI's Office of Prevention, Education, and Control (OPEC). Dr. Alving stated the purpose of the Workshop was to build on efforts to reach out to people living in public housing to help them take better care of themselves and their families.

Dr. Rob Fulwood, Senior Manager for Public Health Program Development, NHLBI OPEC

Dr. Fulwood described OPEC's responsibilities for translating and disseminating scientific results into formats for the public, patients, and physicians. OPEC directs several national education programs, including the National High Blood Pressure Education Program, National Cholesterol Education Program, National Heart Attack Alert Program, National Asthma Education and Prevention Program, Obesity Education Initiative, Women's Heart Health Education Initiative, and Sleep Education Initiative. These programs share common tenets. They all have a strong science base, use education and communication strategies, and address the problem of underutilization of science-based information. The office works in partnerships, using a wide variety of

traditional and nontraditional approaches to get the information utilized.

The Institute has been challenged by Healthy People 2010, the Nation's health agenda, to work towards eliminating health disparities. To do this, it is supporting activities to reach high-risk populations who suffer disproportionately from chronic diseases. NHLBI's community health projects that fall under this effort include the EDUCs and the Minority Health Outreach and Education activities. The outreach process involves working in partnership with communities to develop and implement culturally and contextually appropriate activities that will have public health impact and improve both behavioral and clinical outcomes.

The Workshop's global objectives are to:

- Provide participants with a "picture" of the public housing setting; to share perspectives and identify opportunities to incorporate public health activities in new and/or existing resident services programs;
- Understand the importance of integrating clinical and public health strategies to address health disparities;
- Create innovative "best practice" approaches (scenarios) based on lessons learned from conducting community health programs in public housing and/or related settings; and to engage participants in facilitated exercises to stimulate creative ideas and interactive discussion.

The following sections summarize the Workshop proceedings and the contributions made by participants to better understand issues associated with implementation of public health interventions in public housing settings.

Setting the Stage: An Overview of Public Housing and Public Health

Public Housing and Health: Making the Connections at the National, State, and Local Levels

(SAMUEL LITTLE, PH.D., AND RON ASHFORD)

Public housing agencies must do four things well: (1) manage property, (2) redevelop obsolete housing, (3) perform administrative functions, and (4) provide core programs for residents. There are 3,200 public housing agencies nationwide, and 40 percent of those public housing structures are more than 40 years old. Most public housing residents have limited space and are isolated from core social and health services. One database indicates that there are more than 1 million occupied public housing units with 2.3 million household members who belong to intergenerational families. The majority of tenants are single-parent working families with children (See Box 1 for additional socioeconomic and demographic information on public housing.).

There is a national crisis in public housing that must be addressed—a “social cancer”

that needs prevention and intervention. Public housing residents must deal with issues of disenfranchisement related to drugs, poverty, chronic disease, disability, racism, blight, hazardous buildings, fragile family structures, crime, overcrowded units, and unemployment. Residents’ problems include health (e.g., obesity, hypertension, diabetes, cancer, CVD, HIV) and safety and security issues (e.g., crime, drugs) (See Figure 1 on page 5.). One group of housing residents identified their three most important concerns as economic conditions, health barriers, and safety and security.

The HOPE VI program is an effort of the U.S. Department of Housing and Urban Development (HUD) to transform public housing. HOPE VI was established in 1993 with a budget of \$5.6 billion to improve approximately 100,000 public housing units that were in poor condition. The program began with 196 grants, which were originally \$50 million each and are now reduced to \$20 million per grant. Housing authorities typically

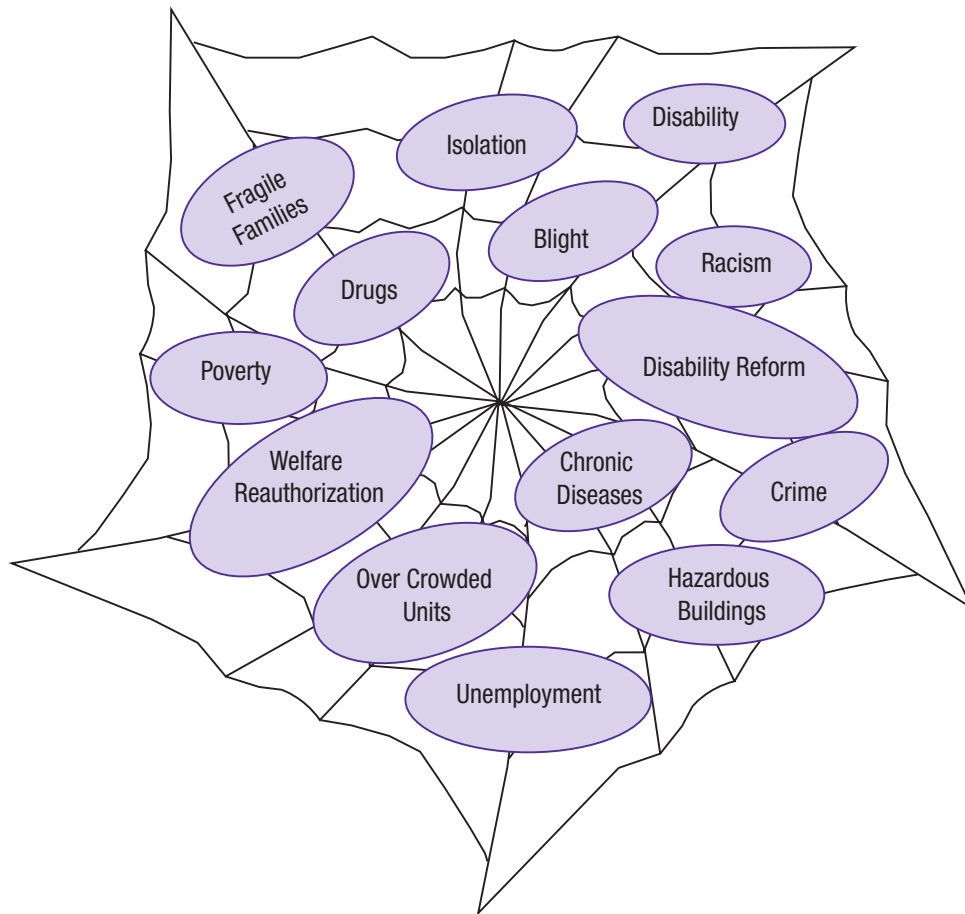
Box 1: Who Are Public Housing Residents?

- 41 percent are younger than age 18.
- 35 percent are 18–50; 8 percent are 51–61; 13 percent are 62–82; and 2 percent are older than age 83.
- 31 percent of the families have elderly members.
- 14 percent of families have members who are disabled.
- 52 percent of families have stayed in public housing 5 years or more.
- 50 percent of residents are white and 47 percent are African American.
- 90 percent of residents have annual incomes less than \$15,000, average annual income is \$10,473, and average monthly rent is \$237.
- 31 percent report wages as a source of income, and 71 percent receive public assistance.

use these grants to clear outdated, obsolete housing and build new housing. Depending on the community, the new housing may be a mixed-income community that includes public housing units, affordable housing (Section 8), and housing at the market rate. The goal of mixed-income housing is to improve the lives of public housing residents. For example, in Baltimore, many of the traditional hi-rise housing project buildings were demolished and replaced with new buildings and townhouses, but the lives of the people who live in them must also be rebuilt by addressing the human problems and concerns they face.

HOPE VI could do more in the area of health. As a construction program, only 10 percent of HOPE VI's funding is designated for community and supportive services. With the advent of the Temporary Assistance for Needy Families (TANF) program, the focus is economic self-sufficiency. Case management staff work with families to help them become economically solvent. The case management program has also begun to stress the need to identify health problems such as depression and to refer residents to participating clinics. An article on the "Moving to Work" program—a demonstration program developed by HUD to promote self-sufficiency

Figure 1: Web of Issues Impacting Public Housing Residents



among assisted families, achieve programmatic efficiency and reduce costs in public housing, and increase housing choice for low-income households—shows that when housing residents were relocated to new neighborhoods, they began to experience better health.

A new programmatic direction for resident programs in public housing should be based on an assessment of the problems resident families are faced with today. These programs

could include health resources and health intervention programs as a core set of services, efforts to transform the way residents think about health and wellness, expansion of partnerships to address health disparities, and new initiatives with more resources to address the root causes of disenfranchisement. Redevelopment without healthy people and families means an unhealthy community, an unhealthy city, and an unhealthy Nation.

Public Housing and Public Health: Public Housing Perspectives for Resident-Focused Programs

(MODERATED BY CAROL PAYNE, R.N., M.S.N.)

This panel was convened to discuss resident-focused programs that would help transform residents' attitudes toward health and wellness. Carol Payne asked the panelists to discuss how to build partnerships to start a health program in public housing and how to offer programs to meet the needs of residents. The panelists' responses provided insight into these topics.

Building Partnerships

Irma Gorham noted that the City of Paterson, NJ, Housing Authority started a number of health programs by contacting the Public Board of Health and then expanded to include local hospitals, universities, advocacy and faith-based groups, resident councils, community members, local businesses, and lenders. This consortium brought everyone to the table to address health concerns in the community.

Dr. James Kreiger said that key players are the groups represented at this meeting—public housing, public health, community leaders, etc. The Public Health Department in Seattle, WA, worked with the Seattle Housing Authority, the resident community council, community health centers, and the Seattle-King County Healthy Homes Project to identify children with asthma through the schools and then established neighborhood asthma committees.

Pamela Taylor said that all groups must partner for the same goal: to provide affordable, decent, and safe housing for public housing residents. One organization working toward this goal is the National Organization of African Americans in Housing (NOAAH), which was established in 1999 to provide affordable housing and to advocate for people of color. African Americans make up 12 percent of the U.S. population and 47 percent of public housing residents. As such, one-third of NOAAH's membership and directors is required to be public housing residents or represent resident organizations. At its national

conference each year, NOAAH honors a resident, a resident organization, a public housing organization or staff person, and an industry group. Other industry groups—the Council of Large Public Housing Agencies, National Association of Housing Redevelopment Organizations, and the Public Housing Agency Directors Association—have been excellent advocates for residents of public housing.

Jack Cooper described the Massachusetts Union of Public Housing Tenants (MUPHT), founded in 1969, as the first statewide agency of its kind and is responsible for resident advocacy and rights in 237 housing authorities in Massachusetts. MUPHT's executive board of public housing residents operates as a community partnership with Housing Authority management and 12 residents from housing projects in different parts of the State. Many of the housing authorities part of MUPHT do not have a formal relationship with health centers and hospitals, but some do, particularly in Boston. Some of the organizations partnering with Boston's public housing are the Boston Asthma Group and other agencies serving children in Boston.

Engaging Public Housing Residents

Dr. James Krieger said that public housing residents are partners in change, and the first step is to involve them because they know the issues. Working with residents, the health community brings its knowledge of what works from the clinical and public health realms. Multiple strategies are needed because each public housing community is unique. Health is determined not only by the actions of individuals but also by access to services and the social and physical environment in which they live. The Seattle public housing population represents great ethnic and linguistic diversity, including Whites, African Americans, Vietnamese and other Southeast Asians, and, more recently, persons from East Africa and the Soviet Union.

These multiple minicommunities often require simultaneous translation at community meetings, an important consideration in developing educational activities for these diverse public housing communities.

Mr. Harry Karas agreed that resident groups know best; they must be involved and encouraged to take responsibility. He stated that there is enough data to know what needs to be done, and that it is time to look at the results from surveys that have been done and to build on existing resources.

Programs in Public Housing

The participants mentioned several successful programs that were not labeled as “health” activities but raise awareness about health and diseases. For example, the Paterson Housing Authority offered a program to young people as an opportunity to audition for a talent show; another was offered as a “get-together chat” for women.

Mr. Karas described programs offered by Hope Village in Baltimore, MD. This nonprofit organization started with a \$40,000 budget and now has almost \$300,000 a year to provide cultural, education, and social programs for youths, including art, music, martial arts, and a summer camp. Seniors in the community benefit from diet and exercise programs. Living in healthy homes conclusively leads to better mental health and allows residents to take responsibility for their lives.

Mr. Cooper noted that 5 years ago, MUPHT ran a program (with funding from Boston Healthy Start) to address problems such as infant mortality and to bring services to the public housing community. The program provided training and held health celebrations and

other activities. Several resident board members have raised the need for programs to address domestic abuse and keeping families together.

Conclusions

Carol Payne summarized the following key points made by the panel discussants:

- All social issues converge at the point of health.
- Residents are the experts; their expertise needs to be recognized and utilized.
- The focus on behavior is important, but policies are needed to address health disparities.
- Issues such as diet choices and language need to be addressed in a culturally sensitive manner.
- HUD and the U.S. Department of Health and Human Services (DHHS) should join efforts, perhaps by combining budgets for health and housing, to lead to a health line item in public housing. These agencies have a common goal: healthy families who are self sufficient.
- Healthy families make healthy communities and cities. People cannot be healthy without housing that is safe, clean, and decent, and they cannot work if they are not healthy.
- Relationships are crucial to obtaining program funding. Potential partners include, but not limited to, housing authorities and faith- and community-based organizations (CBOs).

This session was a useful way to start the Workshop, since it touched on several topics that would be explored further during the following sessions.

Making Public Health and Clinical Connections To Address Health Disparities: Clinician’s Perspectives

(MODERATED BY SYLVIA FLACK, ED.D., M.S.N.)

Dr. Flack introduced the panel members and asked them to provide their perspectives as clinicians to help inform planning for programs in public housing. The panelists described several programs that address the needs of public housing residents in different settings: asthma patients in Boston public housing; a community-centered coalition to fight asthma in Puerto Rico; the Healthy Homes project in Seattle; and the Health Disparities Collaborative in Omaha.

Asthma and the Need for Transfer in Public Housing: Is There a Better Way?

(MEGAN SANDEL, M.D., M.P.H.)

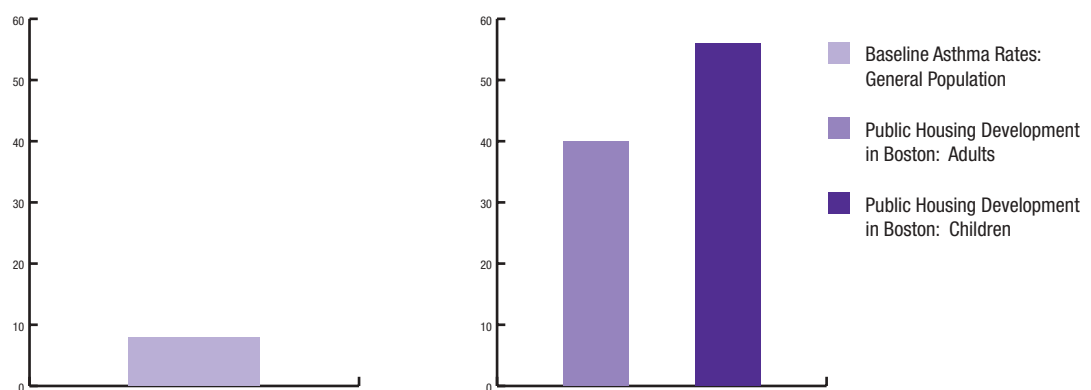
Asthma rates are higher in public housing residents. The baseline asthma rates are generally <10 percent in the general population, but a survey in a Boston public housing development showed rates of 40 percent in adults and 56 percent in children (See Figure 2.). The Urban Institute conducted a nationwide survey of five sites with 887 households waiting for the completion of HOPE VI housing renovations. Asthma was found in

1 in 5 children ages 6–14; 1 in 4 children ages 0–5, and 1 in 5 adults. These are two to three times the national rates.

Asthma severity is well connected with certain housing conditions, or “triggers” that are common in public housing. A report by the Institute of Medicine (IOM) titled “Clearing the Air: Asthma and Indoor Air Exposures” identified factors that contribute to or exacerbate asthma such as dust mites, mold, cockroaches, rats, mice, cats, dogs, and excessively cold air or dry heat.

A HOPE VI study in five housing developments found that 42 percent of residents reported water leaks in the past year, 30 percent reported their unit was cold, 25 percent had problems with visible mold or mildew, 16 percent reported problems with rodents or roaches, and more than half of the units reported at least two problems (e.g., peeling paint, pests, toilet leaks, radiator problems). In Boston, MA estimates of mice infestation were more than 70 percent, and mold rates varied from 5 to 30 percent.

Figure 2: Asthma in Public Housing



• Baseline asthma rates across the country under 10 percent¹

• 40 percent of adults and 56 percent of children surveyed reported asthma in a Boston Public Housing development²

Source: 1. Centers for Disease Control and Prevention. Forecasted state-specific estimates of self-reported asthma prevalence—United States, 1998. *MMWR* 1998;47(47):1022-5.

2. Brugge D, Rice P, Terry P, Howard L, Best J. Housing conditions and respiratory health in a Boston public housing community. *New Solutions* 2001;11(2):149-64.

Many residents with asthma want to move. Clinicians working with public housing residents often write letters requesting moves for residents with family members with asthma. The Boston Housing Authority receives almost 2,500 transfer requests a year (from a total of more than 11,000 households). The most common requests relate to asthma and requests for first-floor accommodations. The Public Housing Transfer Policy Workgroup was established to address this problem. This Workgroup is made up of a tenant advocacy organization (the Committee for Boston Public Housing), the Boston Housing Authority (BHA), Boston Medical Center, the Boston Public Health Commission, and tenant task forces at each development. The hypothesis is that most residents do not want to move; they want a better home. The Workgroup advocates for better maintenance practices by public housing development managers, better resident education about what they can do to keep their home healthy, and better medical documentation for severe cases of asthma that cannot wait for transfer, or where maintenance practices and resident education were not enough to remedy poor housing situations.

Within 64 housing developments in Boston, the project chose 8 that were part of the State-funded portfolio. This project trains development managers, maintenance supervisors, and maintenance

staff to do health-related maintenance. It also trains residents through the tenant task forces in evening sessions. Training consists of a slide show connecting asthma and housing conditions, a review of Boston Housing Authority protocols around mold and pests, and a review of resident work orders protocols and things residents can do themselves. Box 2 provides an example of how the partnerships established for this project help to address housing conditions triggers of asthma, as well as educate residents on how to better manage asthma. After 1 year, the project will look at work orders and transfer requests in eight developments.

Mutual suspicion between public housing management and residents is a problem. Potential neutral third parties could include visiting nurses, public health departments, community outreach workers, or special public health inspectors.

Allies Against Asthma in Puerto Rico (MARIELENA LARA, M.D., M.P.H.)

Community-centered coalitions are a possible solution to the asthma problem. One such coalition is the Allies Against Asthma (Alianza Contra el Asma) program in Puerto Rico, a coalition of the RAND Corporation, the University of Puerto Rico, and the Luis Llorens Torres Community Center. During the planning phase (2001–03), a trusting relationship

Box 2: An Example of How a Partnership Can Help

A resident whose child's asthma became worse reported mold in her apartment. A public health worker found a roof leak with resulting water damage in the kitchen, and observed that the resident boiled water often to cook meals and never opened a window. The manager replaced the water-damaged ceiling, and the resident got a window fan to flow steam out of the kitchen.

with the community was established. The intervention began in 2003, linking a quality improvement program with increased health insurance coverage and community health workers (CHWs) who provide outreach and education. The program includes local housing project leaders and organizations; Puerto Rico-wide organizations with commitment and expertise in asthma-related issues; a local health clinic, managed care company, and an insurance company; and university and research institutions. The fact that Puerto Rico has universal health insurance has helped the program.

The program's vision is to establish a model health service program in Puerto Rico to improve the quality of life for children with asthma and their families through community intervention strategies and interagency collaboration agreements. The program's goal is to do this in three steps: (1) develop a pilot model in the Luis Llorens Torres Housing Project within 4 years, (2) prepare this community to sustain services by itself after 3 years, and (3) develop strategies to disseminate the model in Puerto Rico and, potentially, to other Hispanic communities.

The Luis Llorens Torres Housing Project is the largest low-cost housing project in the Caribbean, with about 2,600 apartments in 140 buildings. It includes a local health clinic, sports complex, police station, three Head Start programs, and four schools. One-third of the households are headed by single mothers, and half of the residents have monthly incomes less than \$500. Initially, it is difficult for outsiders to access the housing community for health programming. Once accepted, however, the community members and public health planners form a partnership.

Alianza Contra Asma has had early success in promoting asthma control in a housing project. The community center coalition approach is a

promising one, with strengths and challenges. One strength is that the coalition approach promotes integration and synergism. For example, a local physician did not know about all the social services available but the community director did. Challenges include lack of awareness and apathy of some families; gaps in some community capacities; communication gaps about expectations and priorities; the length of time it takes to establish a program; a tendency to hold the coalition accountable; and power and role conflicts. Successful strategies include an adolescent troupe that has put on a play about asthma, which was very well received, the participation of an influential community leader as a key clinical staff coordinator in the program, and an agreement with a managed care company to provide increased insurance coverage.

The project has developed several community capacity outputs to address asthma and other health issues. A formal pre- and post-evaluation of the program will look at asthma prevalence, symptom control, environmental risk factors, and hospitalization and emergency department (ED) visits. There will also be qualitative and quantitative evaluation of the coalition structure.

Public Housing and Asthma: From Clinic to Community

(JAMES KRIEGER, M.D., M.P.H.,
AND CARMEN OLVERA)

A spectrum of interventions around asthma, housing, and public health exist in Seattle. These efforts include the Seattle-King County Healthy Homes Project funded by the National Institute for Environmental Health Science (NIEHS); the Better Homes for Asthma project, funded by HUD's Healthy Homes Office; Allies Against Asthma, funded by the Robert Wood Johnson Foundation; as well as other projects funded by the Centers for Disease Control and Prevention (CDC), the local health department, the Nesholm Family Foundation, and the Seattle Foundation. Asthma cannot be

managed only in the clinic—there must be a holistic approach that takes place in the home, community, and housing.

The Healthy Homes project offers an in-home education program. In a randomized controlled trial (RCT), CHWs make five to nine visits each year to persons in the high-intensity group and one visit to those in the low-intensity group. The CHWs make a home environment assessment and develop an action plan to improve the indoor environment. They also offer education, social support, and referral to resources; work on landlord-tenant communication; and provide liaison with the Housing Authority for transfer issues. Residents in the program are given trigger control resources, such as bedding covers and vacuum cleaners. Box 3 describes a case study of how the application of changes to the physical and social environment, together with behavior change, can make a difference in asthma management. The study found significant declines in the number of symptom days in children with asthma and improved quality of life in both the high- and low-intensity groups. However, only in the high-intensity group were there decreases in hospitalizations, ED visits, and unscheduled

clinic visits, as well as greater improvements in quality of life. The study also showed decreases in exposure measures as well as changes in resident behaviors and actions. Cost analysis indicated that savings in health care utilization were significant enough to justify the cost of the program.

Healthy Homes II is an RCT that will compare asthma education delivered by CHWs in home versus clinic-based education. Enrollment will be completed this month, and the families will be followed for 1 year.

Improving Clinical Care. Clinical care projects are being carried out with the King County Asthma Forum (a local asthma coalition) and Allies Against Asthma. These projects include a learning collaborative that brings clinicians and other staff together with experts to examine approaches to changing the system to provide more effective care. Other projects provide information support (data systems and registries) to track care, resources (such as training and machines to measure lung function), and technical assistance in how to set up system change in clinics.

Box 3: Case Study

A 15-year-old girl with asthma had been hospitalized twice and had had three ED visits. The girl was not using Flovent but was using Albuterol three times a day. A walk-through in her apartment showed mold in the kitchen and bathroom, a hole in a wall, and no fan. Better Homes for Asthma partnered with the landlord to remove the mold, repair the hole, and add a fan. The CHW worked with the teenager to explain the role of the controller medication. After these interventions, the girl increased her use of Flovent, had no further hospital or ED visits, and fewer missed school days. This is an example of how changes in the physical and social environment, together with behavior change, can make a difference.

Linking the Home With Clinics. Another effort uses CHWs to link home visit activities with clinics. Health care providers refer patients to CHWs who then send back home visit reports. A nurse works with the CHWs and relays information to the providers. The CHWs are trained in medical aspects of self-management as well as environmental aspects of asthma control.

Linking the Clinic and Environment. In a public housing project at Hyde Point, health care providers at the health clinic include environmental and exposure assessments in their patient intake histories, thus linking asthma with the home environment. Providers are trained to recommend simple steps to reduce exposure.

Making Existing Housing Healthier. Better Homes for Asthma is working to remediate 70 substandard homes and then compare the results with asthma education provided by the CHW. Because many of the homes are in public housing sites, this involves working with the local Housing Authority. The cost of remediation is \$3,000 per unit to repair and prevent water damage, remove mold, replace flooring, and improve ventilation. Injury prevention and dealing with lead contamination are other issues. Families have been enrolled in this study, and data will be available in about 18 months.

Building Healthy New Housing. As part of the Healthy Communities/Healthy Homes Project at the Hyde Point development, 1,600 units are being redeveloped with HOPE VI funding. This project uses the principles of sustainable building to create a “green” community that will make the homes energy-efficient and water-tight and use finishes without volatile toxic substances. A subset of this project will provide 35 “Breath Easy” units that will include special heating and ventilating systems to minimize

allergen exposure for people with asthma. The project will also provide CHW support to work on behavior issues. An evaluation with pre- and post-measures will look at the program’s effects on exposures and health outcomes. Lease agreements will require no smoking and no pets and recommended behaviors such as avoiding clutter.

Building Healthy New Communities. Also at Hyde Point, community resources provided by the King County Asthma Forum will set up neighborhood asthma committees to work on residents’ asthma-related concerns and provide onsite asthma education classes. A goal is to build community capacity and cohesion by establishing “action teams” made up of youth and adult residents to work on environmental projects. The physical environment at Hyde Point will include open space trails, easy access to public transit, spaces to promote social interaction, low-allergen landscaping, local markets, and community gardens. Pre- and post-evaluations will examine the effect of the project on global health measures as well as on social factors and community empowerment and cohesion. The study will include a subset of families with asthma.

Health Disparities Collaborative, Omaha, NE

(HENRY [HANS] DETHLEFS, M.D.)

The Health Disparities Collaborative is a project of the Health Resources and Services Administration (HRSA) Bureau of Primary Health Care. It focuses on improving health care in patients with chronic disease (diabetes, asthma, CVD, depression). One World Community Health Centers of Omaha, NE, participated in this program. The Health Disparities Collaborative is an effort directed at improving systems and community relationships, not just changing provider behavior. The chronic care model includes interactions

between informed, active patients and a prepared, proactive practice team to improve outcomes. The larger framework involves community resources and policies; a health care system that provides self-management support in addition to clinical care; delivery system design (e.g., getting clinic staff to check the feet of diabetics); decision support (e.g., practice guidelines); and clinical information systems that provide data to see if changes have an effect (See Figure 3 on page 15.).

One such system is the Patient Electronic Care System (PECS), a dynamic patient registry that includes key information from clinic visits. This information is used to drive improved care for chronic diseases—both for individual patients and for populations of patients. PECS provides aggregate data for selected health measures, which is then reported and tracked nationally to see whether the Health Disparities Collaboratives are improving care for their patients.

Improved outcomes require system change, including negotiating with the pharmacy to get low-cost drugs; training people to enter data in the electronic registry; training patients on medication self-management; opening a Saturday lab once a month to improve access;

generating a list of patients from the registry who need chart reviews and contacts; creating reminders that appear at the time of visit; and educating providers to change behavior. This infrastructure can be used for improvements in diabetes, depression, and other chronic diseases. Box 4 shows how the practical application of the Health Disparities Collaborative Model for controlling low-density lipoprotein (LDL) has lowered LDL in a diabetic patient population.

The project started with clinicians entering their own data. Later, the clinic received funding from grants to permit hiring a database manager and data entry person. Purchasers of health care and managed care organizations are a potential source of funding. Many clinicians who choose to work in public housing depend on grants.

The Health Disparities Collaborative has several implications for public housing. Changes in health care need to fit within the context of system change (the chronic care model). Process and outcome measures need to be tracked from the outset. Improvements should have a dual focus—on both individual patients and patient populations.

Box 4: Practical Application of the Health Disparities Collaborative Model for Control of LDL Cholesterol

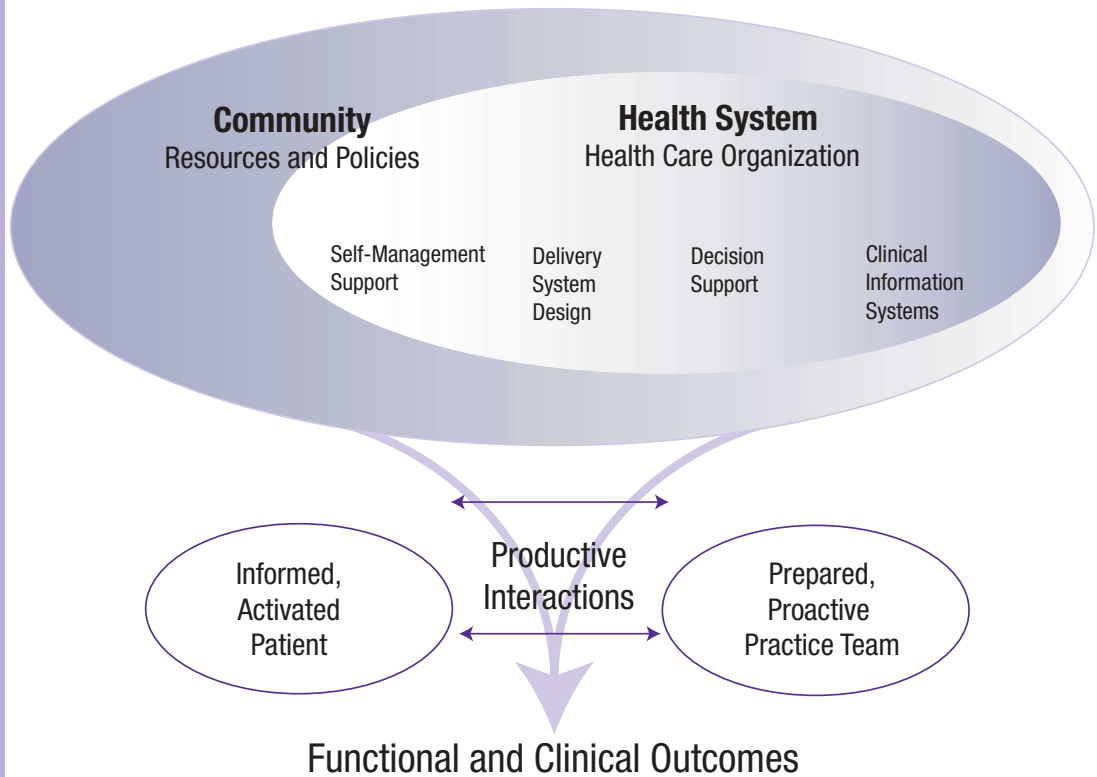
Population: Diabetic patients ages 40 and older

The application steps are to check patients' LDL cholesterol levels, teach the patients self-management and/or prescribe statins, and monitor data to assess improvement.

The Collaborative now has about 350 diabetic patients, with 74 percent now on statins.

After several years in this program, the patients' LDL cholesterol levels were lowered, which translates to fewer heart attacks.

Figure 3: Chronic Care Model



Discussion and Conclusion

This panel ended with a discussion about funding. Dr. Dethlefs said his project started with clinicians entering their own data. Later, grant funding permitted hiring a database manager and data entry person. Grants may also provide incentives for clinicians to work with public housing residents. It was noted that purchasers of health care and managed care organizations are a potential source of funding. Other topics

raised were the need for research to define culturally competent care, and a suggestion that patient advocates accompany residents on their doctor visits.

By describing several diverse public health programs in public housing, this panel helped to identify some important issues for further discussion.

Public Health Programming in Public Housing: Presentations From the Field

Dr. Bowie introduced the panelists, who included people working in public housing programming nationwide. Objectives of this session were to appreciate the multifaceted community outreach interventions that have been implemented in public housing settings; understand the role of CHWs in connecting medical and public health interventions in public housing settings; discuss “best practice” strategies for CVD and related risk factor interventions and for asthma management and control; appreciate the level of involvement of various stakeholders and partners; and understand aspects of community participatory intervention efforts.

Models To Promote Healthy Lifestyles in Public Housing

(MODERATED BY MARY LUNA HOLLEN, PH.D., R.D., L.D.)

Dr. Mary Luna Hollen introduced the panel and noted that she represents a lay health education project for Hispanics at the University of North Texas.

Health Care and Public Housing, Boston, MA (Jeanne Taylor, Ph.D., and Anita Crawford)

The Roxbury Comprehensive Community Health Center (RoxComp) in Boston was established in 1969 and offers a number of ancillary support services for the community. In 1991, RoxComp responded to a request for proposal (RFP) from HUD to provide health care services at public housing. RoxComp enlisted the Orchard Park Housing Development (OPHD) to participate in this project. The tenant association was attracted by the fact that HUD was involved because the development needed upgrading. The planning process included design of a survey to determine what services residents felt were needed and to help develop the project plan. Group meetings run by the tenant association were held.

RoxComp won the HUD grant and was ranked number 1 of 50 applicants. An article in *The Boston Globe* helped gather the support of other stakeholders to fund renovation of the site for a satellite center within the grounds of Orchard Park. HUD donated the building, and the tenant association helped design it and determine what services would be provided. Monthly Orchard Park meetings included both the tenant association and other residents who were not part of this association, all having a voice to determine health care service needs. The health center at Orchard Park provided a comprehensive list of medical and special services, including:

- primary care
- vision care
- health screenings
- case management
- mental health services
- substance abuse services
- Saturday office hours
- home visits for high-risk patients
- trainings for resident community health aides, and
- monthly health fairs

Operational challenges facing RoxComp at OPHD were similar to those at RoxComp’s main site (e.g., inappropriate walk-in visits, frequent requests for lost medications, resident conflicts in the waiting room). Orchard Park closed in 1997 for several reasons: the area had become a prime real estate area, tertiary hospitals began to seek ethnic patients as clients,

residents had choices of access to primary care services, and residents voted not to replace the health center. One reason residents voted not to replace the health center was the new welfare-to-work program, which created a need for daycare (the health center was replaced with a daycare facility). The entire family practice health care unit was moved to Roxbury's main facility, allowing residents to keep their health care providers. Major clinical health outcomes in October 1997 indicate that the model worked well. An example of one successful outcome from the clinic is that 95 percent of children 6 years of age or younger were up-to-date with immunizations based on a chart audit.

*HealthyCMHA, Cleveland, OH
(Myron Bennett, M.B.A., M.B.H.)*

HealthyCMHA is a community partnership promoting health and wellness at the Cuyahoga Metropolitan Housing Authority (CMHA) in Cleveland that includes 48 housing developments and more than 20,000 residents. HealthyCMHA was established because of the level of health disparities found in the low-income residents in nine of the housing developments located in Cleveland's central neighborhood. This area had the highest poverty rate in the city, with almost 95 percent of its children living below the poverty line. In addition, CVD is the leading cause of death in this area, and Cleveland has a high rate of risk factors, such as smoking, overweight, and sedentary lifestyles, which have proven resistant to intervention over the last 10 years. A survey found a higher number of businesses selling tobacco and alcohol near public housing areas, and many billboards market these products.

A survey of individuals living in the housing developments targeted by onsite primary care clinics found that while 88 percent of respondents were aware of the clinics, only 57 percent of adults and 37 percent of children used them. In addition, 22 percent of adults and 11 percent

of children had no usual source of health care. Many residents were not aware that health facilities had to accept them as patients regardless of their ability to pay. Also, there was no coordinated system for referring residents to health services or social services.

In 1997, CMHA leadership created the Resident Opportunities and Community Initiatives (ROCI) program to unite and coordinate resident services and join with new collaborators to set health goals. This led to HealthyCMHA, a multicultural health promotion delivery model with three partners: HealthSpace Cleveland (a health museum that provides health education), CMHA, and Case Western Reserve University Medical School. Initial funding was from the RWJF; cofunders were the Cleveland Foundation, Mount Sinai Health Care Foundation, Abington Foundation, Murphy Foundation, and Bruening Foundation.

The goals of the program are to motivate residents to fully utilize the many health services already available to them, coordinate wellness efforts within the community, and provide new programs and services as needed. HealthyCMHA targets 9 of the 48 housing projects in the central area. Of its 16,000 residents, 99 percent are African American; the average annual per capita income is \$2,371; 26 percent of residents receive TANF funds; 15 percent are employed; and 10 percent report no income. On average, there are 2.26 children per household; 94 percent have female head of households; and three out of four are single-parent homes.

HealthyCMHA implemented a corporate wellness strategy within the public housing community based on the U.S. Public Health Service's National Coordinating Committee on Worksite Health Promotion model, which was refined in British Petroleum America's multinational workforce.

The programs address four categories:

- **Awareness**—Increase health awareness, hold an intensive social marketing campaign, and foster collaborative relationships among existing health and social service providers.
- **Health Education**—Help people with healthy decisionmaking, provide screenings and health education classes (exercise/fitness, nutrition, stress management), hold an annual health fair, and sponsor field trips to the HealthSpace museum(no fee).
- **Lifestyle Enhancement**—Support behavior modification and long-term healthy lifestyle decisions; hold a “Heart Healthy Happy Hour” every Friday; sponsor a walking club known as “CMHA Walks”; and offer “Fit for Life” fitness classes, smoking cessation programs, and nutrition and cooking programs.
- **Culture Shift**—Promote a healthy culture (e.g., offer healthier foods at events), do planning and development for identified gaps in service, foster policy changes within CMHA and the health care infrastructure, and offer the HealthQuest Club that gives points and incentives for participation.

Funding for HealthyCMHA will end in July 2004. There is a need to transition from soft-to-hard money. It takes 4–5 years to build trust; without long-term funding, the program will end.

*Community Advocates in Milwaukee Public Housing, Milwaukee, WI
(Staci Young, M.S.)*

A community health advocate (CHA) program was established in the Highland Park housing development in Milwaukee, the most stigmatized of 13 housing developments in Milwaukee. CHA programs recruit and train community residents to advocate for and assist other community members regarding health and other community issues. CHAs improve the

accessibility, quality, and sustainability of health care services; empower communities to effect change; translate information for residents; and increase collaboration among families, community members, and health care providers in identifying and resolving problems.

Partners in the Milwaukee CHA program include the Center for Healthy Communities; Department of Family and Community Medicine; Medical College of Wisconsin (MCW); Service, Empowerment and Transformation (SET) Ministry, Inc. (which had an existing contract with the Housing Authority to provide nursing case management); the Highland Park Resident Organization and residents; the MCW Cancer Center; Froedtert Hospital; and Boys and Girls Clubs of Greater Milwaukee.

The Housing Authority and SET Ministry already had a HUD grant to increase social services around mental health and to provide core leaders in the housing development. Highland Park already had regular health discussion groups and presentations. Fliers were placed in the buildings to announce a possible advocate program; 11 residents (of 120) came to a meeting and 8 were recruited. To be an advocate, a resident had to have lived in the development for a minimum of 6 months.

The recruited advocates and the planning team defined eight advocate characteristics, including respect for confidentiality, personal and social level of maturity, and ability to be a team player. The planning process took about 4 months. Two community advocate training sessions were conducted (in 1999 and 2001). The trainings, offered in 1-hour sessions over 6 weeks in the summer, included presentations and small group discussions. The topics included effective communication, conflict resolution, health and wellness, community organizing, and leadership development. The topic of how to run effective meetings was added in the second training

session. All building residents were invited to the graduation ceremony and dinner, and half (60) of the residents attended. This was the beginning of something exciting, for this building had long been stigmatized.

To begin, the advocates developed a tenant safety patrol because safety was a major issue. A coffee club, weekly discussion group, and spirituality group helped to develop social networks in the building. The Housing Authority donated an exercise room and equipment. Other activities are an annual community health fair and health presentations by medical students every other month.

Program outcomes include increased numbers of residents participating in advocate activities. Advocates report an improvement in their interpersonal skills and increased awareness of important health issues in the community. Two community resource guides were developed—one specific for Highland Park and one for community resources for CVD, cancer, and diabetes.

The following are some of the lessons learned from the project:

- Reimbursement for advocates (vouchers for a local store) was found to interfere with the public assistance benefits of some of the advocates, so they decided to donate the vouchers to the program.
- Living and working together led to some problems. The roles of elected building officers and advocates had to be defined.
- Community stressors (e.g., the closing of a building) affected the program.
- HOPE VI construction activities to tear down old buildings and build new ones impacted activities.

The CHA program has no more grant funding and has continued to operate without it for a year. It has applied for new funding.

*Healthy Hearts in Public Housing,
Baltimore, MD*

(Carol Payne, R.N., M.S.N.)

Healthy Hearts in Public Housing was established in 2002 to address the needs of the 50,000 public housing residents in Baltimore, where 47 percent of deaths are caused by heart disease, stroke, and diabetes, and where more than 90 percent of the public housing community is African American. The program got its start in 2001 when a Strategy Development Workshop brought together housing leaders and residents as well as leaders from the broader community. This workshop helped identify the state of CVD and what a public housing program might look like. CHWs and residents asked that the project be a lasting one that provides comprehensive training and compensation. In a separate effort, there was a resident needs assessment for community-based outreach and education.

Healthy Hearts has four partners: the Housing Authority of Baltimore City (HABC), the Baltimore Office of HUD, Morgan State University's Public Health Program, and the Baltimore City Department of Parks and Recreation (which was already working with the NHLBI's Hearts N' Parks program). This partnership will raise the community's awareness about the prevalence of CVD among African Americans, promote cardiovascular health awareness through community-based education and prevention, build on existing programs and leadership, and test the CHW model by recruiting, training, and hiring a cadre of CHWs. The program expects to demonstrate that high-risk populations will engage in heart healthy lifestyles, that strategic partnerships can stimulate change, and that decisionmakers can

be persuaded to embrace policies that promote cardiovascular health.

The CHW model is central to the program. The Institute of Medicine report, “Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare” (2003), identified trained CHWs as a strategy to address health disparities. A flier was posted in public housing communities of Baltimore to recruit CHWs, and 20 of the 70 people who responded were selected. Training consisted of a competency-based, 9-week curriculum delivered by Baltimore City Community College (leading to three college credits). One part of the curriculum focused on personal skills building and team building. Another part focused on cardiovascular health promotion, including core CHW roles and functions, (from NHLBI’s “Your Heart, Your Life” manual), which was adapted for use in the African American community, and training in blood pressure measurement and CPR. In June 2003, the graduation of 18 CHWs was celebrated.

The program’s activities are all led by the CHWs, with support of the partnership (See Figure 4 on page 21.). These activities include an annual health fair, presentations on cardiovascular health throughout the year, special events, and radio broadcasts. Six Heart Healthy Clubs have been established, two each for youths, seniors, and families. The program paid for residents to participate in a 10-week weight management program brought onsite, and public housing residents in the program participated in a 5-mile Health Freedom Walk that took place recently along the trail of the Underground Railroad in Baltimore City.

To engage policymakers, the program held a Health Disparities Leadership Forum that was cosponsored by the Greater Baltimore Committee, which comprises the CEOs of major corporations in Baltimore City. One goal

was to create a call to action around CVD and diabetes and to gain support for the Healthy Hearts in Housing program.

Important lessons have been gleaned from the project and include:

- Challenges that include time, money, and infrastructure.
- Enablers that include community support, relationships and partnerships, and the ability to continue to revise the project plan.
- The tight bond that developed among CHWs and the sense of community that was established around project activities was an unexpected outcome. These two outcomes have resulted in the project serving as a facilitator of other programming in this public housing community.
- Community building through health promotion that offers significant potential for improving years and quality of life, as well providing jobs for community residents.

Conclusion

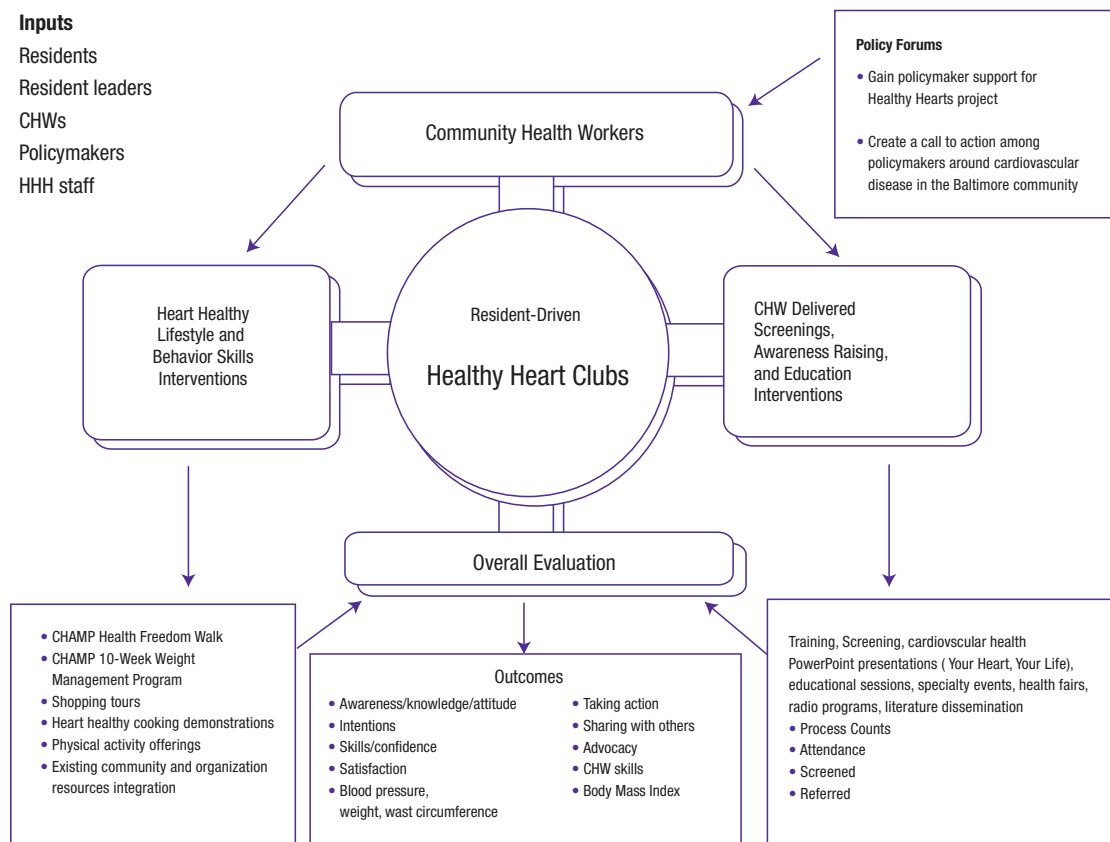
By describing several successful public housing programs, this panel provided practical and detailed information on developing and sustaining programs for the Workshop participants to consider.

Integrated Chronic Disease Models

(MODERATED BY KRISTEN WELKER-HOOD, SC.D., M.S.N.)

Dr. Kristen Welker-Hood introduced this panel, which would focus on integrated chronic disease models in Chicago, IL; Hampton Roads, VA; Boston, MA; and San Francisco, CA. She noted that the process of program development and implementation is important, but there must be evaluation to show effectiveness and to promote sustainability.

Figure 4: CWH Model: Healthy Hearts in Public Housing EDUC



*University of Illinois at Chicago (UIC)
Mile Square Health Center, Chicago, IL
(Henry Taylor, M.P.H.)*

The mission of the Mile Square Health Center is to provide holistic quality health care services to a diverse urban community with a continuing commitment to address the needs of the underserved. Goals are to link public housing residents to primary care and social services, serve as advocates for the residents, provide health education and outreach, collaborate

with other agencies in order to leverage resources, serve as a liaison between the academic environment at the University of Illinois at Chicago (UIC) and the community, and be viewed as the provider of choice for public housing residents. The hope is to develop stronger families and communities.

According to the City of Chicago’s Department of Public Health Epidemiology Report (2000), the communities served by Mile Square had

some of the worst socioeconomic and medical outcomes when compared with the other 77 communities throughout Chicago. Annual family income in public housing in 2000 was \$6,400, compared to \$34,800 for all Chicagoans. In the late 1990s, low-income residents were displaced by the Chicago Housing Authority's redevelopment program and were replaced by higher income residents. The redevelopment plan includes new housing, principally mixed-income buildings, and market rate and affordable (Section 8) housing.

Miles Square Health Center is a full component of the UIC Medical Center. It collaborates with 27 community and city organizations and has developed a Community Advisory Council. The Center hired community residents to serve as health educators and health advocates and developed an intensive 6-week training curriculum in the areas of asthma education, good work habits, and identifying community resources. The CHWs utilized skills they learned and deployed them in the community, making home visits and holding workshops. The program had a specific emphasis on linking males to health care, leading to the development of an African American Male Healthcare Initiative.

Some of the lessons from this project include:

- Staff can successfully link residents to needed medical and social services.
- The level of pride and accomplishments among staff, the level of trust among public housing residents, and the level of understanding of issues affecting residents can be increased.
- Staff can benefit from understanding the impact of violence in the community, the value of the relationship with the local advisory council, and the new ways to reach residents.

*The Asthma Ambassador Project,
Hampton Roads, VA
(Judith Taylor-Fishwick M.Sc., F.A.E.C.,
A.E.-C., and Lilly Smith)*

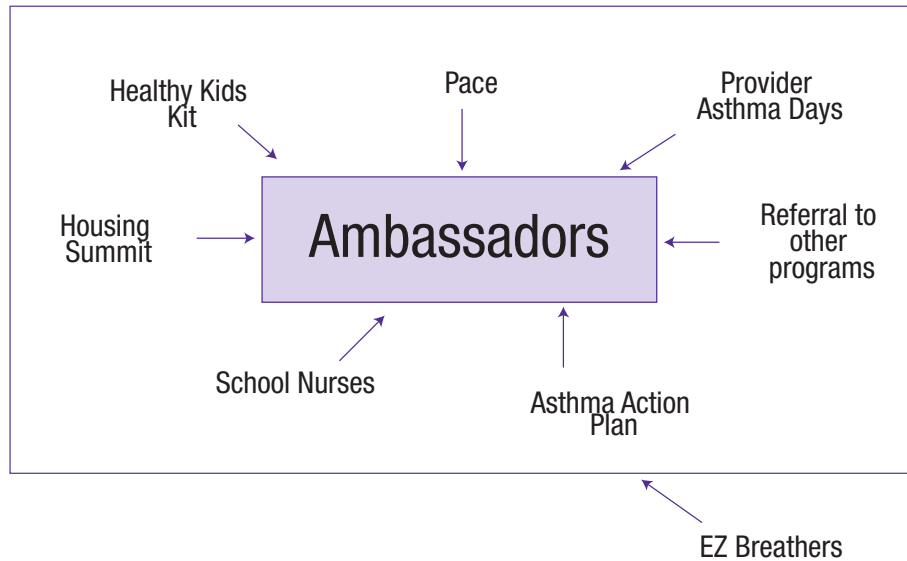
The Asthma Ambassador Project is a community-based intervention to evaluate the needs of disadvantaged, hard-to-reach children living in public housing in the Hampton Roads area of southeastern Virginia. The project uses a case finding approach to identify asthmatic children living in public housing and to assess health care utilization, quality of life, and self-management strategies. Lay health workers provide an outreach education program at the public housing community.

The "Report of the Health of Children in Hampton Roads" identified asthma as a problem in the pediatric population. A grant from the Robert Wood Johnson Foundation established the Ambassador Project. To target the intervention, an analysis of hospital and ED rates by ZIP Code found a high rate of asthma-related morbidity in housing projects.

A controlled trial included intervention and control groups, with 100 children in each group and case finding in targeted housing projects. The study looked at hospitalizations, ED visits, symptoms, medications, self-management behavior/self-efficacy, and quality of life.

The project development process began by holding community orientations. Ten local women living in targeted housing projects were interviewed and trained, and four were selected to work as asthma ambassadors. The Ambassador Project offers education and appropriate referrals, and also provides and assists families with applications for Family Access to Medical Insurance Security (FAMIS), a State-funded Medicaid insurance program. In a series of four home visits, educational topics are: (1) a basic understanding of asthma and asthma action plans, (2) a review of early

Figure 5: Linked Programs: Asthma Ambassador Project



warning signs and triggers, (3) medications and spacer use (the child must be in attendance), and (4) asthma management—asthma action plans and asthma diary.

Three ambassadors (one full-time, two part-time) cover five housing projects and a total of 100 clients. A nurse supervisor is responsible for clinical oversight of clients, and shadows at least two ambassador visits per month per ambassador. The Ambassador Project Coordinator is responsible for program oversight and management of ambassadors, making weekly visits to review cases and determine needs.

Program and educational resources include a sheet of family concerns and priorities, a checklist of family outcomes, a medical information release form, “A Parents Guide to Asthma,” low-literacy materials, a checklist of asthma triggers, and a list of questions and concerns for the doctor. Other resources include a spacer, a spacer

video (produced by Children’s Hospital of the King’s Daughters), an Allies Against Asthma bag, a T-shirt for the child, a Frisbee, magnet, bookmark, “Galaxy of Gifts” incentives (provided by a nonprofit organization), special events for families enrolled in the Ambassador project, and gift vouchers for completion of the survey.

The Ambassador Project is linked with other programs in the community (See Figure 5.). For example, the Physician Asthma Care and Education (PACE) program provides a two-part course to educate physicians on NHLBI guidelines, communication strategies with patients and reimbursement for patient education. The Healthy Kids Kit for Asthma targets faith-based groups by providing slides and training with ministers. A housing summit that was held in conjunction with the Housing Authority and housing residents led to changes in extermination contracts. School nurses attend Parent Teacher Association (PTA) meetings and provide asthma resources. The program works

with managed care organizations to allow visits by home nurses and avoid duplication of services. A standard asthma action plan gives school nurses the authority to call physicians. The program also collaborates with the EZ Breathers program in selected Head Start Centers.

Preliminary baseline data on 144 children aged 2–12 shows that 85 percent are on Medicaid, 53 percent are male, and 99 percent are African American. Fifty-six percent had at least one visit to the ED in the last 12 months, and 8 percent had more than five visits; 7 percent had one hospitalization; 83 percent did not have an asthma action plan; 33 percent were taking inhaled corticosteroids; 13 percent had taken oral steroids; and 18 percent were taking Singulair. Caregiver concerns were worries about their children's performance in normal daily activities (29 percent), about their children not being able to lead a normal life (30 percent), and about side effects of medications (36 percent).

The following are lessons learned from this project:

- Include plenty of advertisement before implementing the program (e.g., newsletter articles).
- Include community resource agencies (e.g., rental office managers).
- Use schools, churches, physicians' offices, and community health centers to promote the program.
- Provide community activities that are both educational and entertaining. Health fairs are not always the best venue to promote health-related programs.
- Ensure that programs are feasible, practical, and viewed as a priority by the target population.

Boston's Healthy Public Housing Initiative, Boston, MA

(Patricia Hynes, M.A., M.S.)

The Healthy Public Housing Initiative (HPHI) is funded by HUD, the Kellogg Foundation, and several local foundations. Partners include the Boston Housing Authority (BHA), Boston Public Health Commission, Boston University School of Public Health, Committee for Boston Public Housing, Inc., Franklin Hill Tenant Task Force, Inc., Harvard University School of Public Health, Peregrine Energy Group, Tufts University School of Medicine, Urban Habitat Initiatives, and West Broadway Tenant Task Force, Inc.

Five percent of the Boston population lives in public housing with an equivalent percent on the waiting list. People of color make up 78 percent of this population; 72 percent of the families have a female head of household; and the average annual income for a family of four is less than \$11,000. There are 68 housing developments with 15,000 units in Boston, many built in the 1940s. Current capital improvement needs exceed annual capital funding.

When the Behavioral Risk Factor Surveillance System (BRFSS) was administered in Boston, an additional question asked whether respondents live in public housing. The survey results indicated that BHA residents reported "fair or poor health" at three times the rate of other Boston residents. They also reported substantially higher rates of heart disease, hypertension, and diabetes, and three to five times the national rate of child and adult asthma.

The goals of the HPHI are to: (1) document baseline housing conditions and respiratory health status in Boston public housing; (2) improve home environments for better respiratory health and increase quality of life for residents of public housing; and (3) impact local, State, and national policy on housing

design, integrated pest management (IPM), and health care financing for asthma. HPHI activities include focus groups with residents, a survey of health in housing conditions, and interventions such as IPM. HPHI also examines the effect of interventions on health outcomes and focuses on analysis and policy. Residents are trained to serve as community health advocates (CHAs) who conduct cross-sectional surveys of housing and health conditions and collect environmental samples, temperature and humidity data, and asthma health data within the IPM. The CHAs include 10 women and 1 man. The HPHI project interventions include in-home asthma management training, access to peak flow meters, and maintaining an appropriate medication regimen. Environmental improvements include IPM, which involves sanitation, removal of cockroach residue, patching and caulking of holes, application of gels, and providing resident education. Followup will create job training for CHAs so that they can become IPM assistants. Project indoor monitoring results showed high NO₂ (nitrogen dioxide) concentrations in kitchens with gas stoves and a need for ventilation.

Data are collected for purposes of education, action, and social change, and the results are shared with community partners. The following are HPHI survey results in one development:

- 64 percent of housing units were affected by leaks, moisture, and mold (compared with 17–46 percent of regular housing). The mean apartment mold index score was related to symptoms of respiratory conditions.
- 48 percent of the units showed visible indications of cockroaches.
- 49 percent of respondents smoke.
- 26 percent of adults reported being diagnosed with asthma.

- 37 percent of asthmatics had a written asthma action plan; 27 percent had a peak flow meter; and 36 percent used long-term control medications (The most frequent reason for not using these medications was that the local pharmacy did not carry them.).
- About 80 percent of children were allergic to something, such as dust mites and cockroach antigens.

These results demonstrate the need for public health activities to address public housing conditions and resident awareness, diagnosis, risk factors, and behaviors surrounding asthma in public housing communities.

YES WE CAN: A Medical/Social Team Model To Scale Up Best Practices, San Francisco, CA (Mary Beth Love, Ph.D., M.P.H., and Arthur Hill)

YES WE CAN is a coalition of 17 organizations that, since 1997, has developed, demonstrated, evaluated, and codified a chronic medical/social model for chronic disease management in children. San Francisco State University/City College of San Francisco is the lead agency for this project. YES WE CAN is based on the fact that proper medical care and good family self-management can prevent the overwhelming majority of asthma episodes and hospitalizations. However, for low-income families, many social and economic factors complicate good asthma management.

YES WE CAN has been demonstrated in four settings in San Francisco and includes protocols that other clinics can implement. The YES WE CAN toolkit, funded by Kaiser Permanente and the California Endowment, includes three manuals: a Program Implementation Manual, a Community Health Worker Training and Resources Manual, and a Clinical Care Manager Training and Resource Manual. Best practices

were combined from Kaiser Permanente, the National Initiative for Children's Healthcare Quality, and the community health center movement.

YES WE CAN uses three methods: (1) risk stratification, data feedback loops, and close case management to focus on the small number of very sick children with asthma; (2) the community health team model in which CHWs engage in case finding and case management; and (3) the chronic care model and continuous quality improvement. Community-focused team-based care includes roles for the clinician, who diagnoses, prescribes, educates, and champions quality improvement; the clinical care coordinator, who coordinates the team, tracks clinical care, provides education, and leads case finding; the CHW, who coordinates social aspects of care, does environmental remediation, and reinforces health education; and the family, who carries out asthma treatment plans and reduces triggers (See Figure 6 on page 27.).

The five components of the YES WE CAN intervention at a clinic include detailed reorganization of clinical care to establish an asthma clinic; clinical care coordination by a registered

nurse; social care coordination by a CHW; risk stratification and computerized feedback loops to allow identification of children who make frequent ED visits; and team training, coaching, and championing. Box 5 outlines results of Yes We Can from the demonstration site at the Pediatric Asthma Clinic at San Francisco General Hospital.

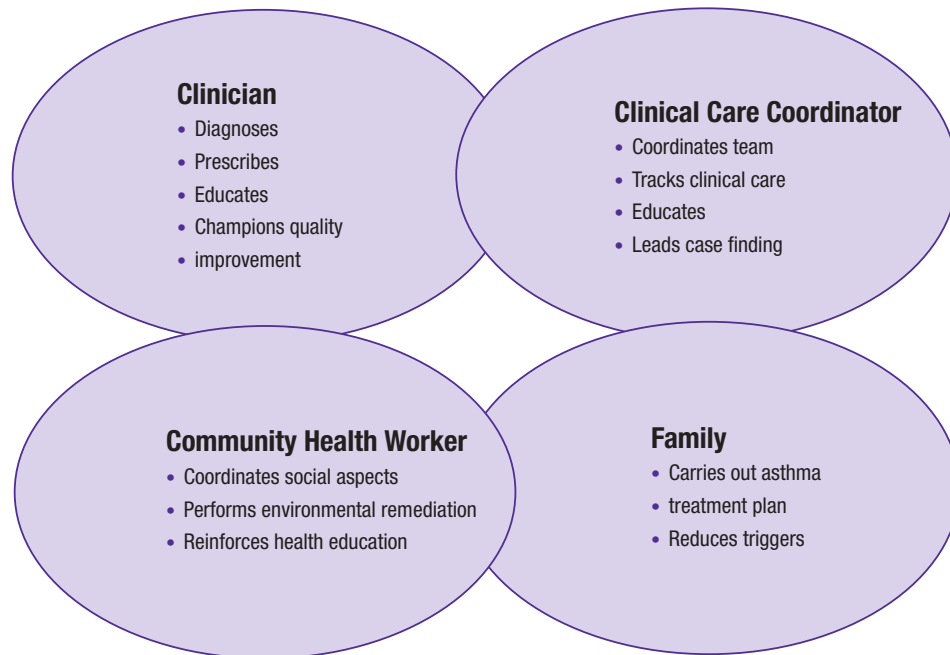
CHWs working in the YES WE CAN program act as liaisons. Referred by the primary care physician (PCP), the CHW meets the family and child in the hospital, and provides followup—making home visits, conducting environmental assessments, and providing further support for home self-management. In some public housing settings, deplorable conditions (mold, roaches, water leaks) undermine the family's management efforts and advocacy. The CHW then writes to the housing manager and advocates for a move and/or remediation, providing a letter signed by the PCP and the CHW. Response to this is often slow, and only a few families are moved. The next step is to send letters to the Public Housing Eligibility Office and to the city's Department of Building and Housing, as well as the Department of Public Health Environmental Health inspectors

Box 5: Results from the Demonstration Site at the Pediatric Asthma Clinic at San Francisco General Hospital*

- Use of written asthma care plans increased from 0 to 100 percent.
- Use of preventive medications increased from 39 to 83 percent.
- Symptom days dropped from 5.1 to 2.8 days per 2 weeks.
- Clinic capacity increased from 219 to 420 patients.
- ED visits dropped from 63 to 32 percent; and hospitalizations dropped from 21 to 4 percent.

* These results are from a series of evaluations; an RCT is currently underway.

Figure 6: Community-Focused, Team-Based Care: Roles



to conduct joint inspection of CHW-identified units posing a health risk to sick children. This approach leads to better results—systematic inspection of housing stock problems and environmental hazards and remediation within 30 days.

In addition, San Francisco State University and the City College of San Francisco host the Community Action To Fight Asthma (CAFA) State Coordinating Office. An initiative of the California Endowment, CAFA comprises 12 community-based coalitions across California, 4 regional centers, the State Coordinating Office, and technical assistance partners. San Francisco State University and the City College of San Francisco have served as leaders in CHW training and coordinated the Asthma

Management Project (AMP), which focuses on prevention and policy change to improve the air quality in public housing developments and the environment in which they exist. Several initiatives for improving clinical care in California are shutting down this summer because their funding is running out. There are efforts to get the California Legislature to provide funding from MediCal to allow the AMP to continue.

Conclusion

A common thread in these presentations is that asthma is not being adequately managed in public housing settings. Public housing conditions and patient care and self-management are factors. These programs are implementing strategies to address these areas.

Day 2:

- “Dream Team” Breakout Groups: Creating Public Health in Public Housing Scenarios and Building Public Health in Public Housing Programming Frameworks



“Dream Team” Breakout Sessions

Objectives

(DIANA SCHMIDT, M.P.H., COORDINATOR, NHLBI NATIONAL ASTHMA EDUCATION AND PREVENTION PROGRAM)

Ms. Schmidt listed the following objectives for this part of the meeting: (1) to agree on best practice approaches to address the prevention and control of CVD risk factors and asthma management and control and to appreciate the components of an effective community mobilization and its application to public housing; (2) to identify proven methods to promote the sustainability; (3) to develop scenarios that paint a picture of real public health problems; (4) to develop conceptual frameworks, using public health planning processes and best practice strategies; and (5) to present and discuss these scenarios and frameworks.

Pearls of Wisdom: Things to Consider Before “Dream Team” Breakout Group Discussions

(FACILITATED BY JANICE BOWIE, PH.D., M.P.H.)

This session began with an open discussion in which participants shared thoughts and conclusions about strategies and best practices for asthma and CVD programs discussed during Day 1. The purpose was to capture thoughts for further discussion during the “Dream Team” breakout sessions. Participants made the following comments:

- People who live in housing developments are residents, not “tenants.”
- No one knows public housing like the residents. They can tell you what, how, and why programming should be done.
- Resident-focused programs produce positive results. Things that worked well were educational interventions linked with entertainment and trainings linked with graduation ceremonies.
- CHW training can lead to employment opportunities.
- Health programs should be matched to the existing infrastructure of a housing development to enhance and sustain the programs. For example, a communication system through the resident association might be a way to get the word out.
- Onsite programs such as senior centers and daycare centers may offer unique opportunities.
- The roots of stress, depression, and obesity could be based on the experiences of residents’ parents and grandparents. Programs should deal with issues underlying CVD risk factors or asthma.
- Safety and security as well as mental health are issues that need to be considered. Many residents of public housing have witnessed homicides and knew the victims of violence.
- The community must have ownership of the program.
- Programs need to embrace diversity, and link the academic culture with that of the community.
- A connection must be made between housing, social programs, and health. Residents need to know what’s in it for them. We need to build capacity in communities and connect health with the social ills in the community.
- There are big gaps between health needs and health services. Collaboration with health agencies and organizations is key to sustaining and serving residents.
- More CHWs need to be trained. They are making a difference in people’s lives.

- It was surprising that the Salud para su Corazón program was not mentioned because it offers significant potential for improving years and quality of life, as well as providing economic opportunity for community residents.
- There needs to be clear definitions about what a community agency can and cannot do.
- HUD needs to work with DHHS to understand what is needed by a health program.
- Health has to be part of housing developments—part of the way they do business. HUD needs to work collaboratively with HHS, perhaps by blending funds, for partnership at the highest level.
- We need the NIH guidelines to help make prevention work. This could, for example, help HUD enforce policies regarding inspections.

Preparation for the Breakout Sessions

Dr. Bowie prepared the participants for contributing to the breakout discussion by stimulating thought on what program planners should consider in the areas of community partnership and involvement, implementation, and sustainability. A summary of her presentation follows.

In projects that involve partnerships, program planners should understand who the partners are and what they can contribute. There should be clear expectations about their level of participation, communicated verbally and in writing.

Implementation requires adequate resources and trained staff, and compatibility between the mission and the vision of the partnering organizations. Program planners should identify goals and objectives for their program and anticipate potential barriers such as intended

and unintended consequences. Timeframes and financial costs should be reasonable; programs should be good stewards of money and time.

Both institutionalization and sustainability focus on the capacity to survive beyond the initial program period, and both require early and consistent planning. Program planners should not seek to sustain or institutionalize things that are not working because this can jeopardize community trust. Sustainability is measured by the ability to maintain improvements in health status achieved through an initial program, continuous monitoring, organizational capacity to continue program activities, and measures of capacity building in the recipient community.

Questions to consider in program planning include the following:

- What is the nature of your initiative? Is it compatible with the mission and vision of the organizations that might be involved?
- Can you articulate and write your goals and objectives? Can you measure them?
- How is your initiative structured and governed? Who are the partners? How is the project run? Does everyone have input?
- What kind of publicity is needed? Is there a program champion?
- Is there sufficient staffing and budget? Is the staff trained?
- Do you have a plan to address obstacles that may be encountered?
- If you had the resources, staff, and funding, what kinds of initiatives would you develop?

Charge to the “Dream Team” Breakout Groups

The breakout groups were asked to reflect on the previous day’s discussion and to identify effective strategies in prevention and treatment of asthma and CVD in public housing. They were instructed to consider global factors associated with community partnership and involvement, implementation, and sustainability.

Dr. Bowie explained the goals of the breakout sessions as follows. In the first hour, the groups would develop two scenarios that identify and define a problem related to asthma or CVD in terms of issues, needs, and concerns; the population to be reached; the rationale for selecting the problem; and potential barriers and opportunities. The next hour would focus on constructing a framework/approach for solving at least one of the scenarios. The groups were asked to define specific objectives and strategies to address them; key stakeholders; the materials/tools/resources that would be needed; and how outcomes would be tracked and measured. Other assignments were to determine the extent to which the project components form an integrated approach and to construct a “pictorial display” of the approach with all the relevant elements to show connectivity.

“Dream Team” Scenarios and Frameworks Summary Findings

Group I—CVD

*Gregory Harris, M.A.S.S., facilitator
and reporter*

Creating Public Health Scenarios

The problem. The group listed a number of problems faced by housing residents, including poor nutrition, limited opportunities for physical fitness, childhood obesity, and sleep disorders and sleep deprivation. This population has needs in the areas of conflict resolution, problem solving, stress management, and motivation. In addition, there are needs for health literacy and health education that target

families, knowledge about how to access resources, cultural competency, service delivery, and professional education for physicians.

Scenario. The group’s scenario focused on multiethnic intergenerational public housing families and the impact of CVD on them. The rationale was that health disparities, including disparities in rates of disabilities, death, and chronic illness, include a likelihood of having multiple risk factors for CVD, and that a multiethnic intergenerational approach is appropriate in public housing.

Rationale. The program must be a total, inclusive system to reduce CVD disparities in a high-risk population.

Target populations. The group identified the target population as public housing residents. The program should have a strong emphasis on families, with an intergenerational approach to appeal to all residents. Children should not be overlooked as they can have a positive impact on their families, and mentoring could occur in the schools.

Barriers. Barriers include the lack of several things—money, interest, access to health care, community resources, community readiness, cultural competence, and linkages in the community. Other barriers include negative perceptions of the community and how residents view themselves, low health literacy, denial of problems, competing life priorities, and the U.S. cultural climate for housing projects (e.g., liquor stores, billboards promoting negative health behaviors in public housing communities).

Opportunities. The main opportunity to solve the problem is to create links with power brokers in the community and with organizations such as social service agencies, churches, schools, and the residential association. There needs to be a champion in the community who is respected and could serve as a CHW. Residents

should be empowered to take an active role in addressing the problems.

Constructing Public Health Frameworks

Objectives. The objectives of the framework are to: (1) enhance awareness of CVD disparities in public housing, (2) increase awareness of CVD morbidity and mortality among the target populations, and (3) empower community residents in the target population. A main goal is to address the broader needs of the people in the community instead of solely the diseases that they have.

Approaches/strategies/components/activities. The group identified several mechanisms to empower residents of the community to take an active role in solving the problems outlined in the scenario. First, it recommended the creation of a resident association and a health committee. Other mechanisms are to hire and train a CHW to educate the community, hold resident-based community forums, encourage residents to serve on the boards of community organizations, involve residents in the planning process, and provide residents with incentives. Other approaches are to educate health care providers about disparities that exist among public housing residents, provide overall coordination of care, conduct a needs assessment, and provide data management. Another strategy is to change the image of the community by beautifying it and making it safe. Suggestions were to create a green space, have youth paint murals, enlist law enforcement agencies to help maintain a safe environment in which people could walk and exercise, and ask community members to participate in a neighborhood watch. The community could also hold community events, develop family-strengthening activities, and hold special functions for men.

Components for this project include setting benchmarks, paying attention to “lessons learned,” and collecting qualitative data through personal interviews and surveys to help gather information for better planning in the future.

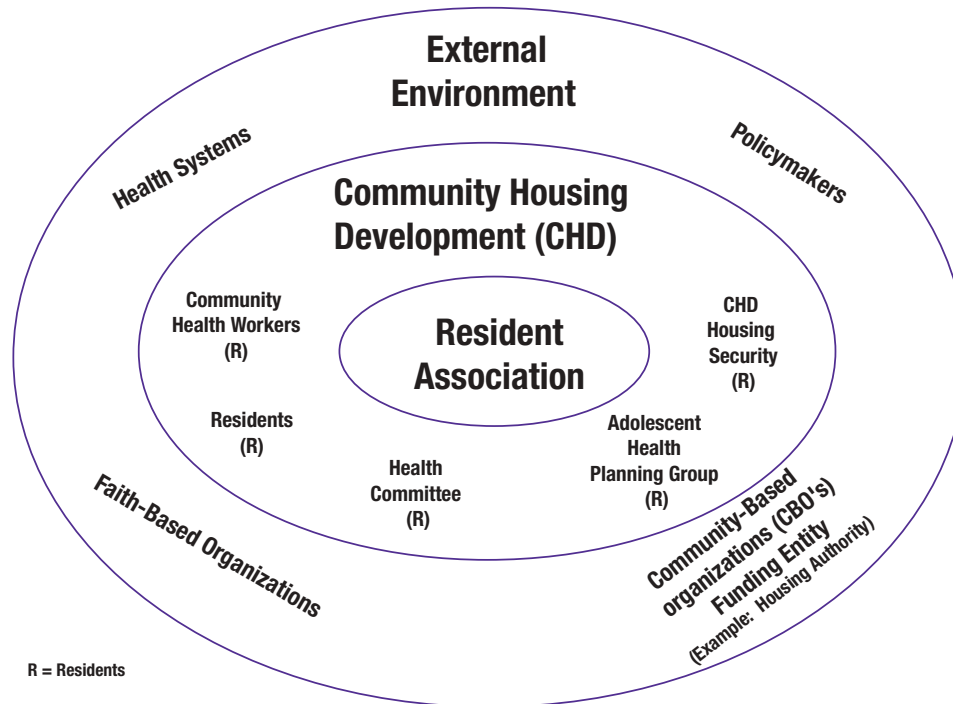
Key stakeholders. The following stakeholders were identified: residents, health care providers (who need to be educated about the needs in housing communities), local schools, city officials, policymakers, law enforcement, local businesses, funding entities, and community- and faith-based organizations within the community.

Tools and materials needed. Tools needed to support the framework include trained, well-paid, and qualified staff; staff development; continuing education and training; education and training materials with curricula appropriate to the target population; a database and management system; linkage to major health care providers in the immediate area; a place for conducting programs and holding meetings on the public housing site; public service announcements (PSAs) and a marketing strategy; and transportation and child care.

Measures to track progress and outcomes. One basic measure is to track residents’ attendance at education sessions by developing or using a database management system. Participant knowledge before and after the educational session(s) would be evaluated by pre- and post-tests. The program would also track individual health status. Qualitative data would be available from personal interviews, focus groups, and a survey of residents’ satisfaction with the program. The group recommended evaluating the coalition development process as well. Monthly collaboration meetings would be held to determine the status of the program.

Sustainability. An integrative model that involves participants strategically in the whole process would help create sustainability. The program would empower residents by teaching them to be responsible for themselves and to seek funding. Community residents must take

Pictorial Display 1: Group I—CVD



ownership in order to continue this project. Also of great importance is the need to market strategies and to ensure sustainability by seeking other sources of funding, such as integration of CBO funding support and residual income through managed care organizations.

Pictorial Display 1: The pictorial display graphically outlines this group's public health framework to address CVD in public housing.

Audience Comments

There was a recommendation to hold workshops to train residents on how to apply for grants. NIH should consider putting CBOs and residents on review panels that make recommendations on funding because their perspectives are valuable. Program planners can educate funders when responding to grant proposals, providing evidence that these kinds of programs work and touch peoples' lives.

Conclusion

The group felt that it is crucial to partner and collaborate with other organizations. The group also agreed on outcomes to be achieved in 3 years, including having an established health committee and the needed services to implement activities in place and operational.

Group II—Asthma

Pat Hynes, M.A., M.S., facilitator;
Marielena Lara, M.D., M.P.H., reporter

Creating Public Health Scenarios

The problem. The following scenario developed by this group incorporates the problem of asthma in public housing in two contexts: as an individual's crisis case of acute asthma and as a systemwide crisis in public housing, which contributes to asthma.

Scenario. The scenario involves 30 resident families, with 50 children, living in a housing development. These families are considering suing the Housing Authority and HUD for very detrimental conditions in their housing units. Many of the children have asthma; five have been hospitalized more than twice in the last year, and one is currently in the intensive care unit. The families have requested transfers, but they were denied by the Housing Authority. HUD has certified their units as livable. The families have Medicaid, but their clinic is distant and provides poor service, and they cannot get the medication and equipment from their pharmacy. The typical family head is a mother in her twenties who participates in the TANF program and has difficulty supervising her children. The Housing Authority recently requested a grant from HUD to clean and improve the units. The group has heard of an asthma coalition in the city. The residents' organization has contacted legal services and has threatened to sue the Housing Authority under the Americans With Disabilities Act and to sue HUD for health and safety failure. The goal is to solve the issues of the 30 families.

Rationale. The rationale for choosing this scenario was to address the environmental conditions associated with asthma: mold, insect infestation, dust, overcrowding, and lack of cleanliness.

Target populations. The target populations include residents (parents, youth, senior adults), the Housing Authority management, local elected officials, and the surrounding local community.

Barriers. The group listed barriers to solving the individual's case of asthma and systemwide problems: lack of funds and resources, no community health workers or clinic onsite; not enough housing units to make all the transfers requested; young, uneducated parents; no group or individuals willing to take ownership of the

problem; resident housekeeping problems; unsupervised children; and overcrowded living conditions in homes.

Opportunities. The group saw the scenario as an opportunity to build community-based coalitions (among residents, the Housing Authority, local proactive groups, the local community, and government officials) that would focus on the individual's acute asthma crisis case and the systemwide crisis in public housing that contributes to asthma.

Constructing Public Health Frameworks

Objectives. The group listed numerous specific objectives: building coalitions, helping residents obtain proper medical care, alerting the Housing Authority to the asthma crisis and asthma triggers, enabling the Housing Authority to make needed and beneficial changes to the physical environment, and training and educating residents in best housekeeping techniques.

Approaches/strategies/components/activities to address the objectives. The group's strategies/approaches/components aimed for empowerment of management and control of asthma:

- Action Against Asthma could provide educational programs to help people change their habits.
- Residents could be trained in housekeeping techniques and asthma triggers.
- A Resident Task Force could conduct a survey of residents to raise consciousness and decide on next steps.
- The Resident Organization could apply for grants for training and building improvement.
- The Resident Organization could alert local elected officials, file lawsuits, or alert the media (possible consequences should be considered first).

- The Resident Organization and the Housing Authority could form a partnership to address the problem together.
- Private building companies could provide training on construction, painting, and maintenance.
- The Department of Energy (DOE) could be applied to for amelioration of problems caused by overinsulation.
- Improved units could be created for temporary use in crisis.
- Resident and local youths could get involved as volunteers.
- The Community Room onsite could be used for educational and after-school programs.
- Resident Service Coordinators could provide outreach to many residents.

The group's pictorial display (page 37) illustrates an integrated approach. The child/family/resident organization is at the center. Indicators of an asthma crisis include requests for transfer, inspections, public health surveillance, and lead to environmental assessment and clinical evaluation. The Housing Authority, HUD, DOE, private industry, other interested local groups, the local clinic, the Health Resources and Services Administration, and Medicaid have roles in these activities. Their involvement leads to remediation/repair, education/training, and medical treatment. The community-centered coalition will work for both short- and long-term solutions (e.g., funding, tools, outreach, training, assessment, job opportunities, and capacity building).

Group II's solution to the problem involves a process of triage utilizing environmental assessment and clinical evaluation to evaluate the families. A child comes into triage in three ways

by: request for transfer; Housing Authority inspection that finds serious environmental hazards (e.g., mold, cockroaches); and public health surveillance that tracks who needs triage. Triage consists of both an environmental and clinical evaluation. It examines what is in the household that could trigger asthma, the level of the family's knowledge about asthma, and barriers that have been experienced by the family (e.g., getting medication). The triage process could determine who has the highest need for remediation. The group generally felt that an immediate solution (within 21 days) is needed or the lawsuit (described above in the scenario) would go forward.

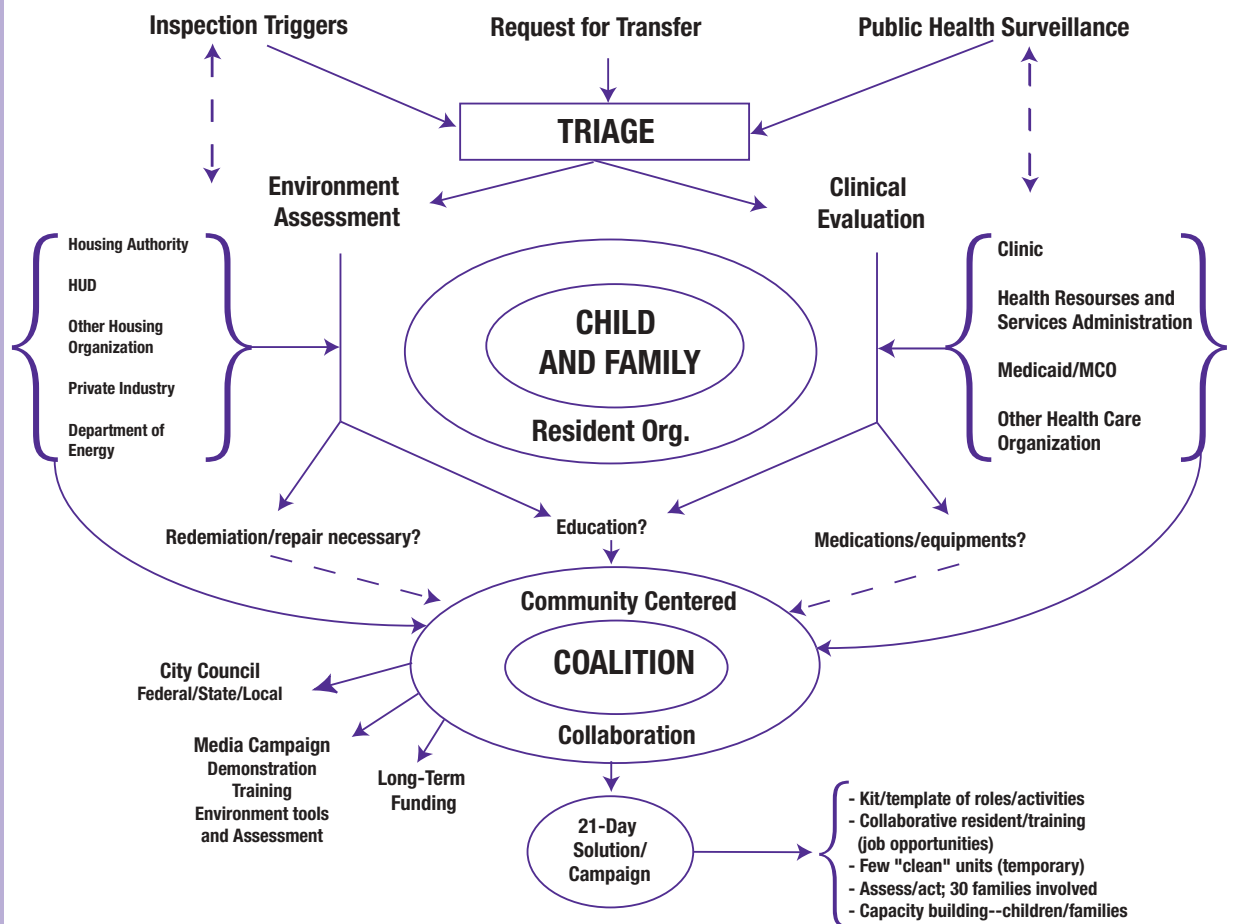
Key stakeholders. Key stakeholders in this framework include elected officials, residents, and the local community. Residents could be empowered to work proactively by conducting surveys, getting training, applying for grants, and encouraging youths to participate in the process.

Tools and materials needed. Tools and materials needed include funds and resources for capital improvements and maintenance, technical assistance to address mold and infestation conditions, trained staff, and training materials.

Measures to track progress. Progress and outcomes could be assessed with health data on changes in number of asthma cases and surveys of target populations and participants.

Sustainability. Continued sustainability depends on capacity-building activities for families and children at the same time that technical assistance is provided. It would also require long-term funding, continued resident training and participation, demonstration projects, continued access to environmental improvement tools and assessment, the development of scientific tools for assessment and remediation, collaboration building, and thinking "outside the box."

Pictorial Display 2: Group II—Asthma



The collaborative could provide a number of possible solutions. It could produce a kit or template that would detail what each party can do to help the families, and it could provide resident training and job opportunities in environmental assessment and remediation and health. The collaborative could clean two to three units within the housing development and make them available for short-term transfer of the sickest children. A media campaign could help get the attention of Federal, State, and local government representatives.

Pictorial Display 2: The pictorial display graphically outlines this group’s public health framework to address asthma in public housing.

Audience Comments

Participants made the following comments:

- Many individuals and groups can make contributions to improve the asthma context of the target community. This would make it easier to deal with urgencies and emergencies because asthma problems often occur in crisis mode.

- Raising consciousness about asthma could help change policies. For example, HUD should provide technical assistance to housing authorities for inspections. Other policies could mobilize resident groups to train other residents and teach families to adopt healthier lifestyles.
- Federal agencies such as the Environmental Protection Agency, DOE's National Laboratories, and NIH need to come together around the issues of health and housing through their programs and grants.

Conclusion

The group felt that building coalitions among stakeholders would lead to the greatest chance that the asthma crisis situation would be addressed.

Group III—CVD and Asthma

Hans Detblef, M.D., facilitator; Mary Luna Hollen, Ph.D., R.D., L.D., reporter

Creating Public Health Scenarios

The problem. Group III viewed the problems of CVD and asthma in public housing as being interrelated since these chronic diseases stem from or are exacerbated by risk factors for disease such as smoking, physical inactivity, poor nutrition, and not taking medications, as well as environmental factors such as lack of health information (in general and at appropriate literacy level) and lack of access to services. Other factors contributing to the problem are psychosocial issues such as lack of empowerment and self-sufficiency, isolation, violence, fear, anxiety/depression, as well as the many barriers discussed in the barrier section to follow.

The scenario. The scenario involves culturally diverse public housing residents living in an old building in a closed-in, crowded, and isolated setting with poor-quality services and little transportation.

Rationale. The rationale for the scenario is that CVD and asthma would be prevented or lessened by addressing disease risk factors, environmental and psychosocial factors, and barriers.

Target populations. Potential target populations include public housing residents; the Housing Authority; clinical institutions and service providers such as CHWs, clinicians, mental health professionals, and social workers; faith-based institutions; schools; local businesses; law enforcement; local and State elected officials; and public policy experts.

Barriers. Barriers include lack of funds and resources, difficulties sustaining programs, poor housing (overcrowding, old buildings, safety concerns), isolation/lack of transportation and access to larger community, kids lacking opportunities, poor nutrition, physical inactivity, inadequate medical care and lack of access to medications, lack of neighborhood stores with healthy food/products, lack of access to tools to manage disease, health illiteracy (Information is often presented at too high a level for the residents.), mental health issues (stress, fear, or distrust of the system), and cultural barriers/issues that may prevent immigrant communities from seeking treatment and managing care.

Opportunities. The group saw the scenario as an opportunity for residents to define their priorities and to take small, ongoing steps to solve the problem. The scenario provides an opportunity to build partnerships with the community and to utilize CHWs.

Constructing Public Health Frameworks

Objectives. While the primary goal is to reduce the morbidity of CVD and asthma, the group also discussed other objectives: (1) create activities, programs, and an environment that would emphasize self-determination and empowerment and allow residents to define and set their

priorities; (2) build capacity with involvement from the residents, community providers, and other partners; and (3) empower the residents to obtain proper medical care, information, and to manage their diseases.

Approaches/strategies/components/activities.

In order to achieve the goals and objectives, the group outlined an approach that would involve mobilizing support from the community and from partners, obtaining resources and tools, and planning and implementing activities for the target population and key stakeholders. This “logic model” approach comprises four major components: inputs, activities, outputs, and outcomes.

Strategies include collaborative efforts of community organizers, health workers, partners, and other leaders who would mobilize resources and support, as well as plan and manage the activities. Space for meetings and activities would be located in family resource centers. Building resources or contractors would repair buildings. Communication channels would be developed to engage/empower residents to shape programs and participate in decisionmaking through town meetings and summits. Culturally appropriate classes and workshops would be held to increase residents’ health knowledge and skills. The program would work with the community and stakeholders to ensure that public housing residents have transportation to access health services and stores that sell healthy food/products/medications. Efforts to improve the physical environment would include remediating substandard housing, creating or adapting existing space for social events, walks and walking groups, and holding a resident cleanup. Other activities would provide referrals to social and mental health services, provide learning opportunities for youth through leadership development, hold meetings with policymakers

and other stakeholders to facilitate change, coordinate or piggyback activities and health messages with programs or agencies, and provide ongoing support and training to core staff.

Outcomes. Outcomes include a combination of health and social factors, such as better self-management skills and behaviors that result in improved knowledge and use of services, increased quality of medical care, better nutrition, increased physical activity, and decreased tobacco use. Other results could be improved housing; decreased morbidity and mortality from CVD and asthma; increased empowerment; decreased violence, fear, and isolation; decreased anxiety and depression; better mental health and self-sufficiency; increased community leadership, networking, and involvement; and increased involvement of housing and elected officials.

Key stakeholders. The target population discussed above would also serve as the key stakeholders.

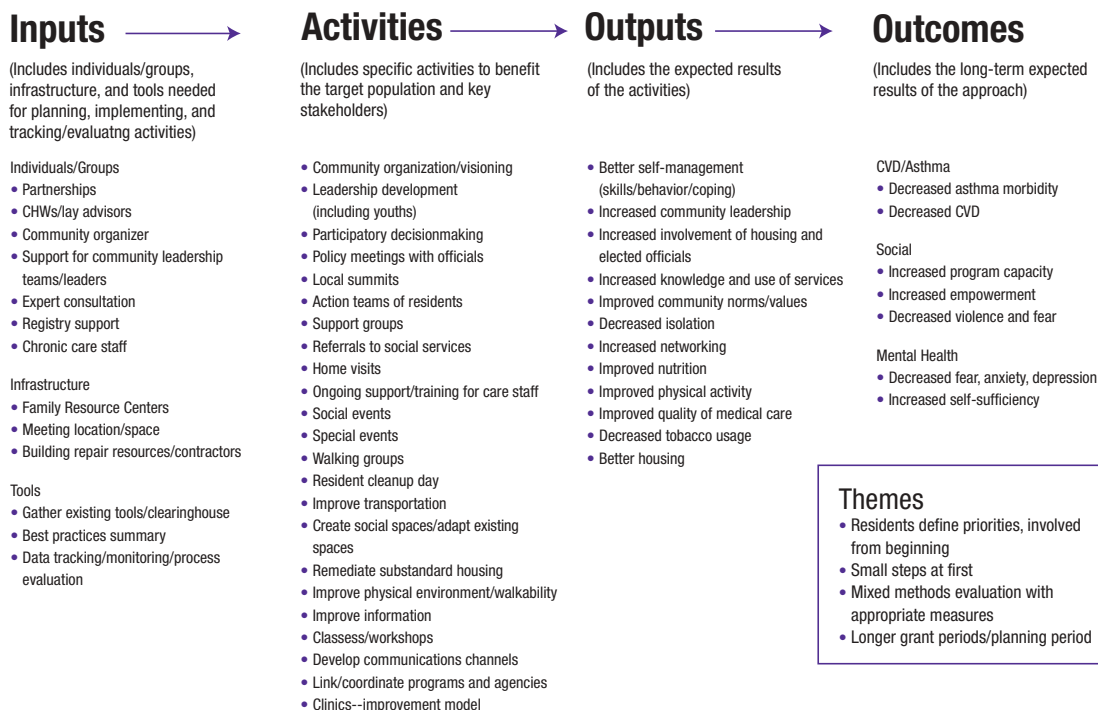
Tools and materials needed. New or existing tools would be used to help plan and track activities. Tools include a Web-based clearinghouse with links to existing resources and tools that would support public health—public housing intervention efforts. The group thought it would be important to include tools for housing administrators with additional information on capacity building.

Measures to track progress and outcomes. Measures might include interviews or testimonials of the target audience, newspaper articles generated, focus group research, and pre- and post-test data. The group indicated that continued sustainability depended on capacity building, long-term funding (>3 years), ongoing support and training for core staff, and use of appropriate measures to track success.

Pictorial Display 3: Group III—CVD and Asthma

Logic Model

In order to achieve the goals and objectives, the group outlined an approach (comprised of four major components: inputs, activities, outputs, and outcomes) that would involve mobilizing support from the community and from partners, obtaining resources and tools, and planning and implementing activities for the target population and key stakeholders.



Pictorial Display 3. The pictorial display graphically outlines this group's public health framework to address CVD and asthma in public housing.

Audience Comment

A participant described a suggested model which would apply the Health Disparities Collaboratives model to public housing. Health Disparities Collaboratives use NHLBI guidelines and best practices, bring community health centers together, and empower change, some of which is incorporated in best practices. These Collaboratives started as a pilot group of

5 clinics to improve diabetes care and there are now 500 clinics. A Health in Housing Disparities Collaborative could select five housing developments near clinics that have been associated with Health Disparities Collaboratives. This effort would build a team of representatives from the local Resident Council, the Public Housing Authority, local health practitioners, and other key stakeholders. These people could come together to brainstorm hard and soft outcomes and increase the number of community activities and ways to measure improvement, including health outcomes.

Conclusion

The group identified several themes: (1) Take small steps; this is a slow, ongoing process. (2) Residents must define priorities and should be involved at all phases. (3) Grants should include qualitative studies as well as RCTs. (4) A longer funding period (5–10 years) is needed. (5) Public authorities need to have buy-in.

Group IV—CVD and Asthma *Megan Sandel, M.D., M.P.H.,* *facilitator and reporter*

Creating Public Health Scenarios

The problem. Group IV began by brainstorming in the areas of two specific problems: health education (nutrition, medications) and inactivity. The group listed a number of problems faced by housing residents: lack of compliance with medications, inactivity, safety issues, outdoor air pollution, indoor problems (mold, pests), community identity, lack of health-specific education, lack of proper nutrition, lack of supermarkets, depression/hopelessness, and obesity. Larger problems are poor health literacy, a flawed health care system that leads to poor quality of care, and the negative effects of industry and business.

Scenario. The scenario involves a housing project population with the problems listed above. These oppressed, intergenerational, multiethnic residents are at higher risk for CVD and asthma. Their nutrition is poor, and they do not regularly engage in physical activity. The solution is empowerment, advocacy, and the creation of a governing body. A program focus on health education could address nutrition, obesity, the role of supermarkets in nutritional health behaviors, compliance with medications, and improving interactions in health care settings. A program focus on physical inactivity could address community identity, social support for depression, indoor activity to make oneself and one's home healthy,

and outdoor air quality as a factor that limits activity. The program should impact public housing residents, the health care community (e.g., doctors, nurses, social workers), policymakers (including HUD, Congress, the local Housing Authority), the food industry, and the faith-based community.

Rationale. This group's rationale served to define the roots of the problem and solutions. The group assessed that the roots of asthma and CVD start in youth and continue during one's lifetime, and that health behavior change can take place at any age or stage of life. Furthermore, they stated that empowerment through community organizing and advocacy is the only way to achieve this change.

Target populations. The group listed the following potential target populations: public housing residents; males; disabled persons; linguistic/cultural groups such as Latinos; and an intergenerational group including young mothers/fathers, children, and seniors. With further discussion, the group decided also to target systems, such as the Housing Authority; policymakers at the local, State, and Federal levels; the health care system (clinics, hospitals, health insurers, managed care, and pharmaceutical industry); and businesses such as the food industry and companies that produce environmental pollution.

Barriers. Barriers include lack of: time, money (soft-to-hard money), interest, grants for community work, and community involvement.

Opportunities. The main opportunity identified by the group is to build a broad, community-based governing body that would serve as a tool to turn agencies into allies and empower community residents. This governing body could be an advisory council or coalition, with equal representation from all segments of the community and community-based groups.

Constructing Public Health Frameworks

Objectives. The group first identified a key initial objective—to define how nutrition is related to CVD, diabetes, and obesity. Other objectives are to increase knowledge of healthy foods in a culturally sensitive way, teach residents how to prepare healthy foods in a timely manner, and increase the availability and affordability of healthy foods.

Stakeholders. The stakeholders include public housing residents and other community residents; policymakers such as the health commissioner and representatives from local, State, and Federal governments, including the local Housing Authority; health care providers; and representatives from the pharmaceutical industry, police department, schools, and the fast food industry.

Approaches/strategies/components/activities to address the objectives. The broader goal of the intervention is to create a community governing body that would give residents a voice in addressing the problem. This multisector/multiracial/multicultural community organization would be defined by a geographic area and would include members from the groups mentioned above as stakeholders, thereby bringing together a diverse and inclusive group of people to collaboratively work towards addressing the problem. Once the governing body is established, the program could focus on health-related goals.

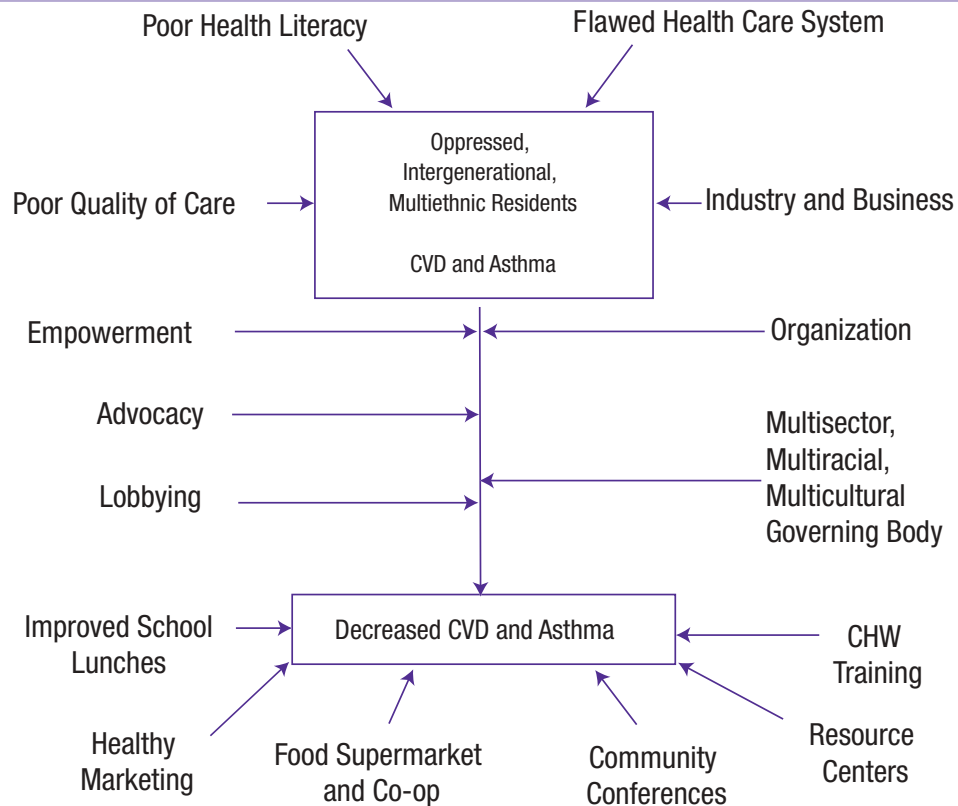
The group decided to concentrate on health education and nutrition, as well as environmental change to increase the availability of healthy food. It was noted that the programming needs are great, but resources are limited, and that the program must be realistic about what can be done. By focusing on a single factor (nutrition) and achieving success in this area first, opportunities for addressing other areas, such as physical inactivity, can follow. The program's nutrition activities have the following goals:

- Increase residents' knowledge of healthy foods and healthy eating in a culturally sensitive and appropriate way. This would impact CVD, diabetes, and obesity.
- Increase knowledge of food availability and affordability, preparation time, and safety. Hold train-the-trainer programs to teach residents about nutrition/obesity, healthy foods, and food preparation. Training could lead to employment opportunities as CHWs.
- Increase knowledge about healthy food and nutrition by holding cooking seminars (e.g., at community centers with food preparation facilities), sponsoring trips to supermarkets, and holding special activities at clubs for children and mature adults.
- Provide nutrition education programs in schools.
- Engage residents in health discussions by holding community forums, meetings, and health fairs. Conduct community building, organizing and empowerment activities. Mobilize residents in effective advocacy activities.
- Lobby for the establishment of supermarkets, food cooperatives, and farmers' markets in the community and for changes in school lunches and fast food choices.
- Lobby for the provision of social services in public housing, expanding the Resident Opportunities and Self Sufficiency (ROSS) grant program, and integrating nutrition with the social sciences.

Measures to track progress and outcomes.

Success would be measured by tangible nutrition-related results, and include nutrition education classes conducted in homes, holding CHW train-the-trainer nutrition programs,

Pictorial Display 4: Group IV—CVD and Asthma



and creating employment opportunities for trained nutrition CHWs. Other desired results would be holding conferences at health fairs, holding community meetings, establishing clubs for adults and youths, creating resource centers for healthy food preparation, establishing a food cooperative, involving supermarkets, and changing school lunches and fast food choices. Evaluation could be accomplished by measuring the number of people served, health care benefits in the community, and reductions in CVD rates (as determined by surveys of community residents and review of health data). Other outcomes are increases in knowledge about nutrition and the availability and affordability of healthy foods.

Pictorial Display 4. The pictorial display graphically outlines this group’s public health framework to address CVD and asthma in public housing.

Conclusion

Poverty, poor health and nutritional status are linked. The group believed that they could target the nutrition component of this link to impact the health of public housing residents. They described that the roots of poor nutritional status are lifelong, and that organized community empowerment is the only way to change the environment to address barriers to residents accessing healthy food and improving their nutritional status. Though this discussion focused on

nutrition rather than asthma, the community empowerment aspect of their strategy, once accomplished, could be used to address other health indicators, including asthma and other CVD risk factors.

Adjournment

Dr. Fulwood thanked Dr. Bowie for her work as facilitator and also thanked the NHLBI planning team and all the participants, speakers, moderators, facilitators, and residents for their contributions. He said that a workshop summary report will be used as a planning tool by the NHLBI.

Appendices

- A: Workshop Agenda
- B: Workshop Objectives (Days 1 and 2)
- C: Global Workshop Objectives
- D: Participant List
- E: Breakout Group Discussion Instructions



Appendix A

Workshop Agenda

Day 1: Wednesday, May 5, 2004

Opening Session

8:00 a.m.

Registration

8:30 a.m.

Welcome

- Dr. Barbara Alving, Acting Director, NHLBI, Bethesda, MD
- Dr. Gregory Morosco, Associate Director for Prevention, Education and Control, NHLBI, Bethesda, MD

Workshop Overview

Dr. Robinson Fulwood, Senior Manager for Public Health Program Development, NHLBI, Bethesda, MD

9:00 a.m.

Get Ready! Icebreaker

Lenee Simon, Community Health Specialist, NHLBI, Bethesda, MD

Setting the Stage: An Overview of Public Housing and Public Health

9:10 a.m.

Opening Address: Public Housing and Health:
Making the Connections at the National, State, and Local Level

Moderator: Dr. Samuel B. Little, Associate Deputy Director,
Office of Resident Services, Housing Authority of Baltimore City,
Baltimore, MD

Speakers

- Dr. Samuel B. Little, Associate Deputy Director, Office of Resident Services, Housing Authority of Baltimore City, Baltimore, MD
- Ron Ashford, Director, Hope VI Community and Support Services, U.S. Department of HUD, Washington, DC

9:35 a.m.

Panel Discussion: Public Housing and Health: Public Housing
Industry Perspectives for Resident-Focused Programs

Moderator: Carol B. Payne, Operations Specialist, Baltimore Field
Office, U.S. Department of HUD, Baltimore, MD

Panelists

- Jack Cooper, Executive Director, Mass Union of Public Housing Tenants, Dorchester, MA
- Pamela Taylor, National Office Director, National Organization of African Americans in Housing, Washington, DC
- Irma Gorham, Executive Director, City of Paterson Housing Authority, Paterson, NJ
- Denise Sharify, Community Health Program Manager, Neighborhood House, Seattle, WA

- Dr. James Krieger, Chief, Epidemiology, Planning, and Evaluation, Public Health—Seattle and King County; Project Director, Allies Against Asthma, Seattle, WA
- Mr. Harry Karas, Executive Director, HOPE Village, Baltimore, MD

Questions & Answers

10:30 a.m. Physical Activity Break

10:45 a.m. Panel Presentations: Making Public Health and Clinical Connections To Address Health Disparities: Clinicians Perspectives

Moderator: Dr. Sylvia Flack, Dean, The School of Health Sciences, Winston-Salem State University, Winston, Salem, NC

Speakers

- Dr. Megan Sandel, Assistant Professor of Pediatrics, Boston Medical Center, Boston, MA
- Dr. Marielena Lara, Project Director, Allies Against Asthma in Puerto Rico: RAND Corporation, Santa Monica, CA
- Dr. James Krieger, Chief, Epidemiology, Planning and Evaluation, Public Health—Seattle and King County; Project Director, Allies Against Asthma, Seattle, WA
- Dr. Hans Dethlefs, CVD Faculty with HRSA Health Disparities Collaborative; Family Practitioner, One World Community Health Center, Omaha, NE

Questions & Answers

12:00 p.m. Lunch (On Your Own)

Public Health Programming in Public Housing— Presentations From the Field

Facilitator: Janice Bowie, M.P.H., Ph.D., Assistant Professor, The Johns Hopkins Bloomberg School of Public Health, Baltimore, MD

1:00 p.m. Panel Presentations: Models To Promote Healthy Lifestyles in Public Housing

Moderator: Dr. Mary Luna Hollen, Research Assistant Professor, University of North Texas School of Public Health, Forth Worth, TX

Speakers

- Dr. Jeanne Taylor, Consultant, Global Evaluation and Applied Research, Los Angeles, CA; and Ms. Anita Crawford, Chief Executive Officer, Roxbury Comprehensive Community Health Center, Inc., Roxbury, MA
- Myron Bennett, Program Director, HealthyCMHA (Cuyahoga Metropolitan Housing Authority), Cleveland, OH
- Staci Young, Community and Student Coordinator, Medical College of Wisconsin, Milwaukee, WI
- Carol B. Payne, Co-PI, Healthy Hearts in Public Housing, Baltimore, MD

Questions & Answers

2:50 p.m.

Physical Activity Break

3:05 p.m.

Panel Presentations: Integrated Chronic Disease Care Models

Moderator: Kristen Welker-Hood, Assistant Professor, University of Texas Medical Branch, League City, TX

- Henry Taylor, Executive Director, Mile Square Health Center, Chicago, IL
- Judith Taylor-Fishwick, Program Manager; and Ms. Lilly Smith, Ambassador Program Coordinator—Allies Against Asthma, Norfolk, VA
- Patricia Hynes, Professor of Environmental Health, Boston University School of Public Health, Boston, MA
- Dr. Mary Beth Love, Chair, Health Education Department, San Francisco State University, Co-PI; and Mr. Arthur Hill, Community Health Worker—Community Health Works/Yes We Can, San Francisco, CA

Questions & Answers

4:40 p.m.

Facilitated Activity—Dr. Janice Bowie

4:55 p.m.

Day 1 Wrap-up

5:00 p.m.

Adjourn

Day 2: Thursday, May 6, 2004

8:00 a.m.	Registration	
8:30 a.m.	Day 2 Objectives	NHLBI
8:40 a.m.	“Pearls” of Wisdom: Things To Consider Before “Dream Teams” Breakout Group Discussions	Dr. Janice Bowie
9:15 a.m.	Charge to “Dream Teams” Breakout Groups: Creating Public Health in Public Housing Scenarios and Building Public Health in Public Housing Programming Frameworks	
9:30 a.m.	Breakout Group Discussions Group I Group II Group III Group IV	Creating Public Health in Public Housing Scenarios
10:30 a.m.	Physical Activity Break	
10:45 a.m.	Continue Breakout Group Discussions	Building Public Health in Public Housing Programming Frameworks
11:45 a.m.	Reports and Facilitated Discussion Group I Group II Group III Group IV	
12:45 p.m.	Summary and Next Steps	Dr. Bowie Dr. Fulwood
1:00 p.m.	Adjourn	

Appendix B

Workshop Objectives (Days 1 and 2)

Day 1

Morning Sessions' Objectives

By the end of the morning sessions, participants will be able to:

- Understand the historical, structural, and demographic characteristics of public housing.
- Appreciate needs and opportunities for making public health connections within public housing settings.
- Understand how resident-based programs in public housing are uniquely positioned to integrate public health interventions.
- Value the role of resident leaders as champions for community action.
- Recognize the role of physicians (clinicians) in linking public health interventions to public housing to address health disparity.

Afternoon Sessions' Objectives

By the end of the afternoon sessions, participants will be able to:

- Appreciate the multifaceted community outreach interventions that have been implemented in public housing settings on a broad range of chronic disease issues.
- Understand the specific role of community health workers and their roles in connecting medical and public health interventions in public housing settings.
- Discuss specific “best practice” strategies/approaches for CVD and related risk factor interventions.
- Discuss specific “best practice” strategies/approaches for asthma management and control.
- Appreciate the level of involvement of various stakeholders and partners.
- Understand aspects of community participatory intervention efforts.

Day 2

By the end of day 2, participants will be able to:

- Agree on best practice approaches to address the prevention and control of CVD risk factors and asthma management and control.
- Appreciate components of effective community mobilization and its application to public housing settings.
- Understand proven methods to promote sustainability.
- Develop scenarios that “paint” a picture of public health problems that need to be addressed in public housing settings.
- Develop conceptual frameworks using public health planning processes and “best practice” strategies to address the problems described in scenarios.
- Present and discuss scenarios and frameworks to address (1) asthma, (2) CVD risk factor, and (3) both CVD risk factors and asthma.

Appendix C

Global Workshop Objectives

- Provide participants with a “picture” of the public housing setting and a rationale for establishing partnerships between public housing and public health.
- Share perspectives and identify opportunities to incorporate public health activities in new and/or existing resident services programs in public housing.
- Understand the importance of integrating clinical and public health strategies to address health disparities in public housing.
- Create innovative, “best practice” approaches based on lessons learned from conducting community health programs in public housing and/or related settings.
- Engage participants in facilitated exercises to stimulate creative ideas and interactive discussion.

Appendix D

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Appendix E

Breakout Group Discussion Instructions

Overview

1. Decide who will record and report out.
2. Review instructions.
3. Brainstorm on issues.
4. Write scenarios.
5. Take break.
6. Brainstorm on framework elements.
7. Construct framework.
8. Report out.

Breakout Groups

Group I (Red): CVD—Facilitator: Mr. Gregory Harris

Group II (Green): Asthma—Facilitator: Ms. Patricia Hynes

Group III (Yellow): CVD and Asthma—Facilitator: Dr. Hans Dethlefs

Group IV (Blue): CVD and Asthma—Facilitator: Dr. Megan Sandel

Expectations

Part I: Creating Public Health Scenarios—9:30 a.m.–10:30 a.m.

- Create two public health-public housing scenarios in narrative, descriptive form. Address the following elements and try to be as comprehensive as possible:
 - The problem—define the problem, issue, or needs and concern as clearly as possible
 - Target population—describe the target population
 - Rationale/Impact—describe the rationale for selecting this problem/issue; cite current negative impact or burden and expected positive benefits if problem is solved
 - Barriers—specify possible barriers to solving the problem
 - Opportunities—speculate on possible opportunities to solve the problem

Break—10:30 a.m.–10:45 a.m.

Part II: Constructing Public Health Frameworks—10:45 a.m.–11:45 a.m.

- Construct a framework/approach to solve the problem/issue for at least ONE of the two scenarios.
 - **Assignment 1:** Drawing upon the most “effective strategies/approaches” shared over the two days, discuss a framework to address the problem
 - Describe the specific objectives.
 - Determine the specific approach/strategy to address each objective.
 - List and define the specific components (constructs) of the approach.
 - Who are the key stakeholders (housing authority administration, residents, etc.)? What are their roles?
 - How can residents be “empowered” to take an active role in solving the problem?
 - What activities/interventions would be implemented under each component?
 - What types of tools, materials, etc. would be needed to support your interventions?
 - What measures would you use to track progress?
 - How would you measure specific outcomes to determine overall success?

- **Assignment 2:** To what extent do your project components (elements) form an “integrated” approach?
- **Assignment 3:** Construct (draw) a “pictorial display” of your approach with all the relevant elements to show connectivity.

Part III: Reconvening and Reporting Out – 11:45 a.m. – 12:45 a.m.

All breakout groups will return to room F1/F2.

Each group will have 15 minutes to report out on both their created scenario and their framework. Directly followed by the report, Dr. Janice Bowie will conduct a brief facilitated discussion on the group report.

Breakout Group Participants

Group I	Group II	Group III	Group IV
Facilitator and Reporter: Gregory Harris	Facilitator: Patricia Hynes Reporter: Kristen Welker-Hood	Facilitator: Hans Dethlefs Reporter: Mary Luna Hollen	Facilitator and Reporter: Megan Sandel
Michael Ahmadi Teresa Andrews David Chen Janet de Jesus Andy Goodman Laverne Green Uriel Johnson Aleisha Langhorne Dennis Mcrae Carol Payne Sue Rogus Carmen Samuel-Hodge Annette Wilson Staci Young	Jack Cooper Gloria Cousar Irma Gorham Marielena Lara Carmen Olvera Diana Schmidt Julie Tu	Matilde Alvarado Jeanette Guyton-Krishnan Arthur Hill Jim Krieger Samuel Little Helena Mishoe Denise Sharify Lenee Simon Lilly Smith Terri Williams	Martha Benton Yvonne Bronner Sylvia Flack Suzanne Gaynor Jennifer Joyner Mary Beth Love Jeanne Taylor Judith Taylor-Fishwick Zoilo Torres Evelyn Walker Reyma Woodford

For More Information

The NHLBI Health Information Center is a service of the National Heart, Lung, and Blood Institute (NHLBI) of the National Institutes of Health. The NHLBI Health Information Center provides information to health professionals, patients, and the public about the treatment, diagnosis, and prevention of heart, lung, and blood diseases and sleep disorders.

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