

# Health and Wellness Programs for Public Housing Primary Care



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June 2008

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**National Center for Health Care for Residents of Public Housing**

North American Management

2111 Wilson Boulevard, Suite 323, Arlington, VA 22201

Phone: (703) 812-8822 ♦ Fax (703) 812-8822

Website: <http://www.healthandpublichousing.org>

## ACKNOWLEDGEMENTS

### Principal Author

Victoria Howard-Robinson, MA  
Institute for Community Strategies  
Arlington, Virginia

### Advisory Committee on Health and Wellness Programs for Public Housing Primary Care

Villie M. Appoo, MA, MSW  
Grace Hill Neighborhood Health Centers Inc.  
St. Louis, Missouri

Wayne Rowe, MBA  
Quality of Life Health Services, Inc.  
Gasden, Alabama

Stephen Bailey, PA  
La Casa-Quigg Newton Clinic  
Denver, Colorado

Sue Schlotterbeck, MS, RD  
Sara Goldberg, CCE  
Great Brook Valley Health Center  
Worcester, Massachusetts

Salvador Balcorta, MSSW, LMSW  
Centro de Salud Familia La Fe, Inc.  
El Paso, Texas

Marie Segares, MPH  
South Bronx Health Center  
for Children and Families  
Montefiore Medical Center  
New York, New York

Alison Dubois, MPH  
Hudson River Health Care, Inc.  
Peekskill, New York

Henry Taylor, MPA  
Mile Square Health Center  
Chicago, Illinois

Jacqueline M. Jackson, MSW  
North American Management  
Arlington, Virginia

David Vincent, MSW  
North American Management  
Arlington, Virginia

Kathleen Perez-Hureau  
NeighborCare Health  
Seattle, Washington

Karen Williams, MPH  
West End Medical Centers  
Atlanta, Georgia

Elizabeth Ramos, PhD  
San Ysidro Health Center  
San Diego, California

The staff of Public Housing Primary Care centers are givers – givers of health services, givers of health education and of empowering lives. We thank the above listed colleagues for their contribution to this project and for demonstrating the unyielding commitment of all PHPC providers as givers of care.

### Editorial Review

Robert Burns, MPA  
North American Management  
Arlington, VA

### Graphics

David Bates  
North American Management  
Arlington, VA

## TERMS AND ACRONYMS

AAP	American Academy of Pediatrics
ADHD	Attention-Deficit Hyperactivity Disorder
BPHC	Bureau of Primary Health Care
CAI	Childhood Asthma Initiative
CHEC	Community Health Education Coordinator
GBVHC	Great Brook Valley Health Center
HHS	U.S. Department of Health and Human Services
HRHC	Hudson River Health Care, Inc.
HRSA	Health Resources and Services Administration
HUD	U.S Department of Housing and Urban Development
LCQN	La Casa-Quigg Newton Clinic
NHLBI	National Heart, Lung and Blood Institute
NYC	New York City
OB/GYN	Obstetrics and Gynecology
PHPC	Public Housing Primary Care
QOLHS	Quality of Life Health Services, Inc.
SBHCCF	South Bronx Health Center for Children and Families
S-CHIP	State Children's Health Insurance Program
SMG	Self-Management Goal
SYHC	San Ysidro Health Center
UDS	Uniform Data System
WIC	Woman, Infants and Children Program
WISE	Wellness Information for Senior Empowerment

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## EXECUTIVE SUMMARY

### **IN NEIGHBORHOODS WHERE GETTING BY IS CHALLENGING, Public Housing Primary Care (PHPC) health centers are providing residents with opportunities to get ahead.**

These clinics have improved access to timely, high-quality health care in public housing and nearby neighborhoods; engaged these disadvantaged communities in improving health; and opened doors for residents to launch careers in growing employment sectors. Over time, these essential services aim to reduce health disparities, particularly in infant mortality, childhood obesity, asthma, cardiovascular disease, cancer, substance abuse and depression.

PHPC is a federally funded program administered through the Bureau of Primary Health Care in the Health Resources and Services Administration, U.S. Department of Health and Human Services. The cornerstone of the PHPC program is a legislative requirement that grantee projects must be located on the premises of public housing or at locations immediately accessible to residents of public housing.

Formed in 1990 under the amended Public Health Service Act to include the Disadvantaged Minority Health Improvement Act, PHPC was legislated under Section 340A to establish health services for residents of public housing. In 1996, the Health Centers Consolidation Act replaced Section 340A of the Public Health Service Act and consolidated the Health Care for the Homeless, Migrant Health Centers and Public Housing Primary Care Programs under Section 330 of the Consolidation Act, Public Law 104-299. This legislation reauthorized the health center programs as: 330(e) all health centers; 330(g) Migrant Health Centers; 330(h) Health Care for the Homeless; and 330(i) Public Housing Primary Care.

In 1991, the Health Resources and Services Administration (HRSA) initially funded seven PHPC programs.

- Ella Austin Health Center (now known as CommuniCare Health Centers) in San Antonio, Texas
- Family Practice and Counseling Network, Resources for Human Development in Philadelphia, Pennsylvania

- Grace Hill Neighborhood Health Centers in St. Louis, Missouri
- Great Brook Valley Health Center in Worcester, Massachusetts
- Primary Care Health Services in Pittsburgh, Pennsylvania
- The Clinic at Altgeld (now known as TCA Health, Inc.) in Chicago, Illinois
- West End Medical Center in Atlanta, Georgia

Today, the Bureau of Primary Health Care provides PHPC funding to 41 community health centers located in 19 states. The PHPC program sites include urban, rural, mobile, on-site and clinical settings. These programs provide high-quality, comprehensive, case-managed, and family-based preventive and primary health care services to approximately 129,280 residents, with 500,000 encounters at approximately 155 public housing service delivery sites.

The funding allows a PHPC grantee to establish a community health center within a public housing facility or near a public housing community. This effort represents a close partnership between the community health center and the local public housing authority, in essence doubling the effort. PHPC health centers work in collaboration with public housing authorities to assess the needs of residents, meet with resident councils and conduct on-site outreach to the residents. Housing authorities also offer further assistance to PHPC programs through participating in other funding opportunities that will support resident health programming and services.

**PHPC MISSION**

*The mission of the PHPC program is to improve access to health care for residents living in public housing communities, including family housing, elderly housing, Hope VI, Section 8 units and transitional housing. It is through providing primary health care, health promotion and disease prevention activities that the PHPC health centers improve the overall health, self-sufficiency and well-being of residents.*

Each PHPC project provides comprehensive primary health care services, which often include internal medicine, pediatrics, OB/GYN care, preventive and restorative dental care, health education, outreach, laboratory services and case management. Many PHPC health centers also provide behavioral health services, pharmacy, x-ray, optometry and podiatry, along with nutritional services through the Women, Infants and Children (WIC) program. By focusing on an integrated approach, PHPC health centers deliver high quality care to the target population. PHPC health centers serve as the hub of the community because they provide health education, primary care, support services, health promotion and prevention programs, and innovative initiatives to address chronic disease; in addition, they train and employ residents and provide a place for health-oriented events.

To provide an overview of the PHPC program, this monograph includes profiles of PHPC sites, patients, providers, quality initiatives and service models. It describes new approaches developed to meet the growing challenges and unique needs of the public housing population.

The first section of this monograph, *PHPC Users and Caregivers*, describes characteristics of current patient-based health statistics and concerns. The second section, *Distinctive Service Models and Approaches*, reviews several health programs and support services currently conducted at sites. This section outlines the benefits of different program designs and offers standards on successful service delivery. The third section, *PHPC Innovations*, describes three case studies of successful innovations developed by PHPC health centers to address the needs of their target population. The monograph will explore innovations in access, outreach and service delivery through the lens of the *Multidisciplinary Approach to Asthma in the Primary Care Setting* program at South Bronx Health Center for Children and Families, Montefiore Medical Center in New York City, New York; *Healthy Steps: Mobile Medical Services Providing Access to Care* at San Ysidro Health Center in San Diego, California; The Child and Adolescent Wellness Center at Centro de Salud Familia La Fe, El Paso, Texas; and *Community Health Education Coordinators: Keeping Community in Community Health Care* program at NeighborCare Health in Seattle, Washington.

The final section, *On the Horizon*, discusses PHPC challenges and opportunities. This section reviews growing health issues facing target populations, escalating costs for delivery of care, linkages and partnerships required to provide types of support services needed for comprehensive care, and the need for fundraising as a means for PHPC health centers to continue their ability to deliver care to public housing residents.

## 1. PHPC USERS AND CAREGIVERS

The Public Housing Primary Care (PHPC) program reaches out to the poorest and most vulnerable of Americans. Most patients are people of color who have no health insurance or are Medicare, Medicaid or dual recipients and many suffer from chronic diseases that are often complicated by multiple diagnoses. Almost half of all patients speak a language other than English, making their care that much more difficult. Each year the Health Services and Resources Administration (HRSA), through the Uniform Data System (UDS), collects statistics from health centers. UDS data track a variety of information – including patient demographics, services provided, staffing and utilization rates – to help evaluate and monitor health centers’ performance and report performance trends.

<b>PHPC PROGRAM OVERVIEW</b>	
PHPC Health Centers.....	41
States.....	19
Residents Served.....	129,280

  

<b>RESIDENT CHARACTERISTICS</b>	
Annual Income > 100 Percent Below Poverty Line.....	94%
Without Private Health Insurance or Uninsured.....	95%
People of Color.....	91%

Source: 2006 Uniform Data System

In 2006, UDS reported that more than 129,280 public housing residents received direct primary care services from PHPC health centers, and an even greater number of residents received support, enabling and outreach services. These patients had low incomes, with 84 percent having an annual income of at least 150 percent below the poverty line and 94 percent having an annual income of at least 100 percent below the poverty line. More than 95 percent of PHPC users were uninsured or were Medicare, Medicaid, or dual recipients. Of that number, 3 percent of PHPC patients had coverage through the State Children’s Health Insurance Program (S-CHIP). Only 5 percent had commercial

insurance. According to the U.S. Census, 33 percent of the country’s population are people of color.<sup>1</sup> In contrast, for patients at PHPC health centers, 91 percent were people of color. A closer look at the demographic characteristics reveals that 44 percent of the patients were Black/African American, 41 percent were Hispanic/Latino, 5 percent were identified as Asian/Pacific Islander and 9 percent were identified as Caucasian. Sixty-five percent of PHPC patients were women.

These statistics do not capture the number of languages served by PHPC health centers. Since most sites serve new immigrants and other non-English speaking populations, PHPC health centers must

be able to provide care to a patient population which speaks three or more languages. Forty-three percent of PHPC patients were served in a language other than English. For instance, the multicultural staff at Great Brook Valley Heath Center (GBVHC) in Worcester, Massachusetts, speaks 29 languages and comes from 36 countries. Seventy-eight percent of GBVHC staff are bilingual, 17 percent of which are trilingual.

The majority of PHPC patients, 52 percent, were adults between the ages of 20-64. Children, ages 0-19, represented 43 percent of the patient base. In the last three years (2004-2006), there has been a 50 percent increase in the number of patients less than one year old. Currently, only 12 percent are adults age 65 and older, and yet this number is increasing as the American population ages. A more detailed profile of elderly public housing residents indicates that they are most frequently single, low-income, African American females who have social connections but lack adequate support if they become less independent. According to the survey results in the *Service Delivery Systems to Help Older Public Housing Residents* study, although most respondents are functional, most have chronic conditions and appear to have significant mental health issues, including depression, that are not being treated. Most of the respondents have mouth pain, and an alarming 81 percent had not seen a dentist in the past year.<sup>2</sup>

Thanks to location, effort and quality care, PHPC health centers recorded 500,000 encounters in 2006. The most frequent encounters were vaccinations and health supervision visits for infants and children ages 0-11, followed by hypertension, diabetes, contraceptive management, and oral health exams. Chronic diseases account for a growing number of encounters, with a 34 percent increase in the number of diabetes visits, a 35 percent increase in the number of asthma visits, a 23 percent increase in the number of hypertension visits and a 250 percent increase in the number of patients with the primary diagnosis of depression within the past three years. Further, in the last two years there has been a 33 percent increase in alcohol-related disorder encounters and a 92 percent increase in drug abuse encounters.

The 41 PHPC sites throughout the country have a combined workforce of more than 10,000 caregivers; this estimate includes physicians, other clinicians, health center staff and volunteers, and partners. Physicians provided care for the majority (61 percent) of PHPC patients, mid-level providers provided care for 33 percent, nurse practitioners for 22 percent, physician assistants for 8 percent and certified nurse mid-wives for 3 percent. Nurses provided the remaining 6 percent of patient visits.

It is crucial to note that PHPC caregivers reflect the diversity of their patient populations. These individuals have earned the trust of their patients by providing excellent care while treating every patient with respect and dignity. Their talents cover a wide range of specialties to serve a

complicated population. The staff includes physicians who are leaders in their fields, nurse practitioners, interpreters, social workers, nutritionists, outreach and community health workers, domestic violence counselors, behavioral health specialists, medical assistants, HIV counselors, administrators, and committed support staff. Many are members of the community they serve, and many are bilingual, so they understand the cultural nuances of their patients. All are committed to providing exceptional care to residents of public housing.

It is through considering every component of the patient's health in assessment, prevention and treatment that the PHPC staff maximize quality care. Since a large number of public housing residents have dual or even triple diagnoses, physicians and caregivers at PHPC facilities provide a coordinated approach to care. This coordinated approach involves integrated care provided by multidisciplinary teams. Case managers, community health workers, physicians and medical staff work together to ensure patient access and compliance, leading to more beneficial health outcomes for patients. Residents of public housing communities receive comprehensive health care through numerous services coordinated along an integrated continuum of care. Whether care is delivered at a patient care facility or directly on-site at residential buildings, services are provided in a manner that encourages and engages patients' active participation in improving and maintaining their own health. This includes a strong emphasis on health promotion and education, preventive services and ready access to care.

## 2. DISTINCTIVE SERVICE MODELS AND APPROACHES

It takes extraordinary creativity, effort, collaboration and persistence to engage an often reluctant population. PHPC health centers are the care providers for more than 100,000 urban and rural men, women, adolescents and children, many of whom suffer from chronic, life-threatening conditions. Many of them are underemployed and poorly educated and also cope with language, social and economic barriers. Nearly all of them are minorities who suffer from disproportionately high rates of diabetes, depression, heart disease and cancer. Environmental conditions often exacerbate negative health conditions. Yet, they are unaccustomed to actively managing their health care issues.

In the 17 years of providing access to, and following up on the delivery of, quality care to residents of public housing, PHPC health centers have developed unparalleled expertise in addressing the health concerns of this target population. At the core are distinct PHPC attributes that are common to all PHPC programming.

- Culturally competent care
- Integrated continuum of care
- Access to care
- Outreach, patient engagement, health promotion and education
- Use of community health workers

These PHPC service models produce exemplary care that vastly improves the health and well-being of PHPC patients. The following are examples of innovative programming that not only provide quality care, but also deliver quality results.

### **Wellness Information for Senior Empowerment Hudson River Health Care, Inc. in Peekskill, New York**

Hudson River Health Care, Inc., (HRHC) engages seniors in social interaction, health education, primary care and supportive services through a program they have developed entitled Wellness Information for Senior Empowerment (WISE). WISE not only draws seniors to weekly sessions at public housing communities, but also schedules monthly community education events for them at local senior centers, public housing communities, senior housing units, community centers, local

churches, nutrition sites and other venues where seniors live and congregate. To achieve its goals, WISE offers three components.

- Targeted outreach links seniors to HRHC’s primary care services and community education events.
- Community education days offer a social outlet for health information, on-site presentations on senior-related health issues, nutrition forums, and blood pressure and glucose screenings. The events also provide access to a network of support and health education resources and create opportunities for seniors to share their concerns and interact with others. This serves to reduce depression, a common problem among the elderly.
- The senior-directed diabetes collaborative begins by identifying seniors with diabetes through a screening process and then linking these patients to the peer-oriented senior-directed diabetes collaborative.

The results within a 12-month period have been phenomenal. The WISE program has reached 1,121 seniors, attaining 112 percent of its goal. A total of 352 seniors have been linked to HRHC’s preventive and primary care – 117 percent of the goal. Ninety-one seniors that were identified as having diabetes through screening have been linked to HRHC’s senior-directed diabetes collaborative, achieving 100 percent of the goal. Five of the 91 seniors identified as having diabetes have brought their Hemoglobin A1c (<sup>Hb</sup>A1c) levels down one point.

### **Foot Care for Diabetic Seniors West End Medical Centers in Atlanta, Georgia**

West End Medical Centers, a PHPC health center, has developed an exceptional approach to addressing the needs of their diabetic seniors through a unique partnership with a local shoe company, Morehouse College, a local podiatrist and a pharmacy school. Twice a year, the shoe company sends a representative to the senior housing site to meet with diabetic patients and provide each patient with diabetic shoes supplied by the company free of charge. In addition, West End contracts with a local podiatrist to visit the senior community every other month to teach residents proper foot care. Seniors also receive home visits from the Morehouse students. These one-on-one visits are conducted bi-monthly and allow students to review and explain



West End Medical Centers Herdon Homes PHPC Site

Photo: West End Medical Centers

medications/routines to the seniors who request this assistance. West End also has a social worker convene monthly forums to offer seniors the opportunity to identify and discuss health topics of interest.

### **Child and Adolescent Wellness Center Centro de Salud Familiar La Fe, Inc. in El Paso, Texas**

Centro de Salud Familiar La Fe, Inc. has developed an innovative approach that builds upon La Fe's 41-year history, experience and current initiatives to address the needs of underserved children and youth that live near the U.S./Mexico border. The Child and Adolescent Wellness Center creates a comprehensive model of health promotion and disease prevention that addresses all aspects of well-being and is appropriate for the targeted service population by combining the rich cultural heritage of the Mexican-American family with new technology and health care practices.

The Child and Adolescent Wellness Center model consists of the three interconnected components. The first component is a pediatric health center that offers specialized primary and preventive health care through traditional services, such as immunizations, medical and dental care and appropriate health promotion programs.

The second component is the cultural activities of the Cultural and Technology Center. This important non-traditional component is what makes this model innovative and attracts youth and families to early preventive services. The center provides intergenerational programs in art, dance, music and theater for area children. Through the cultural component, children have the opportunity to develop their talents and interactively learn about their heritage, cultural traditions and values.

The third component is technology programs of the Cultural and Technology Center that both promote access to health information resources and also develops skills so youth and families can break the cycle of poverty through future opportunities. This high tech component provides access to the newest telecommunications and computer resources needed to teach youngsters about their health through the use of computer games, the Internet, interactive software and the latest audio/video hardware and materials. In South El Paso, students at area schools have limited access to hands-on computer use, with ratios of up to 100 students per computer being common. At the same time, severe poverty and literacy barriers make home computer access unattainable. By linking the latest technology with young people, La Fe's Technology Center is improving their future opportunities for gainful employment and higher learning and simultaneously exposing them to health information needed to make beneficial life choices.

## **Comprehensive Breastfeeding Support Program Great Brook Valley Health Center in Worcester, Massachusetts**

Great Brook Valley Health Center (GBVHC) increased breastfeeding in women who received prenatal care to 95 percent – a dramatic rise from 1980, when GBVHC’s breastfeeding rate was only 16 percent. In real numbers, that is 16 women breastfeeding their babies in 1980 compared to 269 women in 2006. This incredible achievement is the result of a highly successful breastfeeding support program that GBVHC instituted in 1994 to address low breastfeeding rates among new mothers. As a result of hiring and training bilingual breastfeeding specialists, the rate of breastfeeding among women receiving prenatal care at GBVHC grew significantly that year alone, to 45 percent. The 2006 rate of 95 percent far exceeds the *Healthy People 2010* goal of 75 percent.

According to *KidsHealth.org*, “[T]he American Academy of Pediatrics (AAP) joins other organizations such as the American Medical Association (AMA), the American Dietetic Association (ADA), and the World Health Organization (WHO) in recommending breastfeeding as the best for babies. Specifically, the AAP says babies should be breastfed exclusively for the first 6 months and that breastfeeding should continue until 12 months (and beyond) if both the mother and baby are willing.” Some of the recognized benefits of breastfeeding are as follows.



- Helps reduce occurrences of infection
- Provides an ease of digestion
- Serves as a cost-effective means of nutrition
- Helps to prevent childhood and adult obesity
- Enhances the mother-infant bond

The breastfeeding support program is successful because it is comprehensive and has become the standard of care for clients. GBVHC’s staff provides support and encouragement at many points of contact. These include: 1) prenatal counseling on breastfeeding provided by WIC program staff, health center nutritionists, perinatal case managers, nurses, childbirth educators and medical providers; 2) hospital visits at delivery by the breastfeeding specialist; and 3) follow-up home visits and/or telephone calls by the breastfeeding specialist. Breastfeeding specialists discuss with families the benefits of breastfeeding exclusively and provide education about the proper length of time to breastfeed; positioning techniques; the proper diet for the mother; the risks of drugs, alcohol and smoking; ways to aid latch-on; growth spurts; returning to school or work; engorgement care; infant

stool and urine patterns; and breast care. GBVHC is now working on increased tracking and follow-up in order to improve the program with the goal of reaching the AAP guidelines of mothers who breastfed exclusively for six months and continue to breastfeed for at least a year.

## **ProCare**

### **Quality of Life Health Services, Inc. in Gadsden, Alabama**

Quality of Life Health Services (QOLHS) has consistently collaborated with the Greater Gadsden Housing Authority to improve access to health care for residents of public housing. Primary care sites are in two locations designed to serve residents of seven housing developments and persons living within a one-mile radius of these developments. Their service model, called ProCare, focuses on family health care



Photo: Quality of Life Health Services, Inc.  
**ProCare Medical Center**

through education, counseling, preventive care and promotion of healthy living practices. Transportation is provided as a part of ProCare services, and an outreach component is located in three housing developments. The ProCare site features a full-time physician and a family nurse practitioner. The physician has hospital privileges, and 24/7 coverage is available through an on-call rotation system with other QOLHS network providers. Services not available on-site are accessed through a system of linkages that have been established to ensure continuity of care.

The following is a quote from Angelic Murphy, a resident who is served by ProCare:

*“Dr. Quilon and the staff here are some very compassionate people. They try to make me feel as comfortable as possible. If it is urgent and they can’t reach you, they will go to your house if you live close to the office. They are very kind and have good, loving hearts. I can truly say that I am comfortable here as a patient.”*

## **Raising the Bar (Diabetes Collaborative)**

### **La Casa-Quigg Newton Clinic in Denver, Colorado**

La Casa-Quigg Newton Clinic (LCQN) is one of many PHPC health centers that have registered impressive results as a Diabetes Collaborative participant. Nationally, each PHPC grantee participates in one of the Health Disparities Collaborative developed by HRSA to improve the health care provided to all people and to eliminate health disparities. Eighty-eight community health centers participate in the Health Disparities Collaborative program, with individual health center

leadership selecting the staff team to work on a collaborative. The current collaboratives are in diabetes, asthma, depression, cardiovascular disease, HIV and cancer. The collaboratives are designed to bring community health center teams together under the guidance of national experts to use the (Chronic) Care Model as a way to generate rapid improvements in care with a strong focus on disease management.

In an effort to achieve self-management goals for its diabetic patients, LCQN implemented a self-management improvement program called Raising the Bar. The diabetes team and the staff designed it to make LCQN the first to reach the HRSA goal of 70 percent of its diabetic patients having a documented self-management goal (SMG).

At the time the project started in January 2006, 26 percent of LCQN patients with diabetes had a documented SMG. This was the second highest in the Diabetes Collaborative, but well below the HRSA goal. The initiative was started with a series of meetings bringing together clerical, nursing and provider staffs to design a plan to improve the SMG rate for LCQN's 1,000 diabetes patients. The decided-upon process involved the entire LCQN team, starting with registration clerks who identify target patients at the time of registration and assist them in developing an SMG; then, providers review SMGs with patients. Specific teams of clerks, nurses and providers were linked with specific patients. These teams meet regularly to monitor patient progress and to suggest and make process enhancements to encourage patient compliance at the time of the visit. Within six months, through a consistent practice of team involvement in patient care, LCQN met and actually exceeded the national HRSA goal by achieving 82.4 percent of diabetes patients establishing documented SMGs.

### 3. PHPC INNOVATIONS

PHPC health centers work vigorously every day to deliver excellence in clinical treatment, achieve the highest possible level of performance, improve outcomes for patients and continuously adapt to the changing needs of the community. The following case studies are examples of PHPC innovations in chronic care treatment, access, increased usage and service delivery. This section will explore the *Multidisciplinary Approach to Asthma in the Primary Care Setting* program at South Bronx Health Center for Children and Families, Montefiore Medical Center in New York City; *Healthy Steps: Mobile Medical Services Providing Access to Care* at San Ysidro Health Center in San Diego, California; and *Keeping Community in Community Health Care* program at Puget Sound Neighborhood Health Centers in Seattle, Washington. These innovations are presented with these categories: need, design approach, program description, team, patient involvement, collaborations, significant results, lessons learned and modifications, among others.

#### **PHPC Innovation I: Multidisciplinary Approach to Asthma in the Primary Care Setting South Bronx Health Center for Children and Families, Montefiore Medical Center in New York City, New York**

##### ***Need***

Asthma prevalence rates in children in the South Bronx are 20-30 percent – among the highest in New York City (NYC).<sup>4</sup> Additionally, many South Bronx neighborhoods have the highest hospitalization rates for children with asthma in NYC. Based on the 2006 UDS data, the South Bronx Health Center for Children and Families (SBHCCF) had an overall asthma rate of 20 percent across all ages and 27 percent in the pediatric population (0-19 years of age).

##### ***Design Approach***

The Childhood Asthma Initiative (CAI) was developed to address the burden of illness seen in the population served by the SBHCCF. CAI is a multidisciplinary approach that focuses on clinical care and patient and community education. Pediatricians, nurses, health educators, psychosocial staff and public health specialists make up a diverse team that addresses the multifaceted needs of the asthmatic patient and their families. Comprehensive asthma care for children follows the National Heart, Lung and Blood Institute (NHLBI) guidelines within the medical home model.

To improve care and enhance standardization of documentation by providers, an asthma toolbox was created and incorporated into the medical record forms. Chart reviews provide regular feedback to the clinicians with documentation of the severity of classification and the appropriate use of controller medications. On-site access to mental health services, allergy testing and asthma education allow for “one-stop shopping,” greatly enhancing care.

### ***Program Description***

The asthma toolbox, based on NHLBI guidelines, is printed on all medical chart forms utilized by clinicians at various types of patient visits (well-child, follow-up, walk-in and acute/urgent asthma visits). The toolbox facilitates standardized questions, care management and clinician documentation. Following the medical home model, providers are also encouraged to utilize on-site referrals



South Bronx Health Center for Children and Families

for mental health services, allergy testing and asthma education as indicated. Referral support is also available for off-site referrals, such as pulmonology or spirometry.

### ***Team***

Multidisciplinary teams are essential to this project. The clinical staff and health educator collaborate with the clinical and administrative co-directors of CAI. Additionally, an evaluation and research team assisted in developing outcome measures and assuring quality improvement. The SBHCCF medical and program directors work closely with the CAI team to ensure smooth integration of activities in the busy primary care setting.

### ***Patient Involvement***

Through routine pediatric health care visits, asthmatics are regularly screened for severity level, exercise limitations, tobacco exposure, school or work absence, emergency room and hospital visits. The asthma toolbox also helps to support and standardize clinician management in appropriate controller use, referrals and follow-up care.

### ***Collaborations***

CAI is supported through the Children’s Health Fund and, in part, by a grant from the Picower Foundation. The asthma toolbox was developed and revised by the CAI team with clinicians’ input from the South Bronx Health Center for Children and Families. The CAI team participates with the

South Bronx Asthma Partnership, a coalition of South Bronx community-based organizations. The CAI team also participates in the Children's Hospital at Montefiore's Asthma Working Group.

Additionally, the CAI team has worked with the Children's Health Fund to develop a bilingual comprehensive teaching guide that is used in clinical sessions and given to the patients to keep as a reference. The CAI team reaches out to the community beyond the clinic through participation at various local workshops and conferences. Their asthma guide and materials are available at no cost by downloading documents from the Children's Health Fund website.

### ***Significant Results***

Chart reviews are done semiannually, and providers are given feedback about their clinical care. At the chart review in September 2007, 84 percent of pediatric patients had a documented asthma severity recorded using the asthma toolbox, and 96 percent of persistent asthmatics were on controller medications.

### ***Lessons Learned***

As determined in a prior chart review at SBHCCF, documentation of severity level quickly went from 16 percent prior to implementation of the asthma toolbox (in 2006) to 58 percent afterwards. The most recent chart review demonstrated that documentation of asthma severity level had reached 84 percent. The asthma toolbox is currently incorporated into only the pediatric medical chart forms. Because of its success, the plan is to incorporate it into the adult medical chart forms.

### ***Modifications***

Recently, a working group met to streamline the toolbox to make it more efficient and compatible with the 2007 revisions in the NHLBI guidelines. When these modifications have been integrated into the permanent forms, a training session is planned to review use of the revised toolbox to ensure understanding and compliance. The CAI is now developing an intensive asthma clinic in 2008 for SBHCCF. This will allow asthmatic patients to receive multidisciplinary services such as allergy testing, health education, and meetings with mental health clinicians, social service staff and legal services (e.g., for assistance with housing problems) during a one-day session.

The toolbox is based on NHLBI's National Asthma Education and Prevention Program guidelines, *Expert Panel Report: Guidelines for the Diagnosis and Management of Asthma, Update 2002*, and is currently undergoing modifications to be compatible with the revised 2007 edition.

### ***Quality Initiatives***

Semiannual chart reviews are conducted, and provider feedback and training sessions are scheduled as needed. Development of the toolbox for use in the adult population is underway, with training to be scheduled upon initiation.

## **PHPC Innovation II: Mobile Medical Services Providing Access to Care Healthy Steps, San Ysidro Health Center in San Diego, California**

### ***Need***

It is currently estimated that there are 110,000 low-income residents living in the South San Diego region. In 2006, San Ysidro Health Center (SYHC) and other safety-net providers in the area served a total of 21,904 uninsured patients, which represents only 20 percent of the low-income and/or uninsured population. This clearly illustrates the high level of unmet need for primary care services in the area.

The South San Diego region encompasses the following communities: San Ysidro, Chula Vista, National City and Imperial Beach. The international border between Mexico and California marks the southern boundary of SYHC's service area, much of which has been designated as a medically underserved and low-income area. These areas are populated by at-risk, vulnerable populations experiencing significant problems accessing health care services.

SYHC provides services to more than 10 public housing locations in the South San Diego region. Residents have reported that they encounter barriers to care such as: 1) lack of transportation; 2) lack of health/dental insurance; 3) difficulty finding a doctor; 4) cost; 5) language; and 6) time conflicts with work schedule. SYHC Healthy Steps program addresses these barriers by providing medical services at public housing locations with the use of medical mobile units. Additionally, transportation services are provided to residents for follow-up care at one of SYHC's fixed clinic locations.

### ***Design Approach***

SYHC's Healthy Steps program delivers a continuum of preventive and primary care services to public housing residents. SYHC's service delivery model consist of four integrated service components: 1) outreach and assessment; 2) referrals and access; 3) treatment; and 4) follow-up activities.

### ***Program Description***

The Healthy Steps program provides accessible, comprehensive primary health care and supportive services in order to improve the overall health and well-being of South San Diego region residents and to eliminate health disparities. The Healthy Steps program provides a variety of health care services to children and adults of all ages. Transportation services are available for all appointments to any San Ysidro Health Center location at no cost to the participant. Preventive health screenings include primary health care; vision, hearing and dental screenings; immunizations; tuberculosis skin tests; women's services (pregnancy tests and referrals to prenatal care services); and follow-up care services, including assistance with scheduling follow-up appointments.

### **Team**

The Healthy Steps program provides a comprehensive continuum of health care services by providing health care services through two mobile medical units, offering adult medicine, pediatric medicine, health education and other support services. Medical mobile units consist of two physician assistants, three medical assistants, two medical mobile unit drivers, one team leader, one medical clerk, one dispatcher/receptionist, two shuttle drivers, two health educators and one program manager.



San Ysidro Health Center Mobile Medical Unit

### **Patient Involvement**

The Healthy Steps program conducts health education classes that develop parents' skills in keeping their children healthy and offers anger management classes to all public housing residents. Through these classes some parents and participants have become volunteers to help with child care activities. These parents and participants have become the program's most successful form of outreach because they inform neighbors about the services received.

### **Collaborations**

The Healthy Steps program partners with three community collaboratives, five local school districts and other community agencies. The program works closely with SYHC dental department for all dental referrals; their HIV department, which provides HIV testing at public housing locations; and their salsa program that offers glucose and cholesterol testing. The Healthy Steps program also works closely with the SYHC's WIC program.

### **Significant Results**

Many more public housing residents are accessing health care services due to the Healthy Steps program. Approximately 900 to 1,020 PHPC patients are served on-site in their community by the Healthy Steps program. In addition, approximately 1,200 patients are transported to SYHC's fixed-site clinics, nearly all of whom would not be able to access health care services if it were not for the free transportation. Many of the transported patients are receiving types of dental services that are not provided on the mobile units. In the last three years, more than 6,159 encounters with public housing residents have occurred.

### **Lessons Learned**

One lesson learned by providing access to care via medical mobile units in public housing sites is that due to the convenience of being on-site, many patients do not make the extra effort to transfer to

a fixed site for their medical home, preferring instead to be seen close to home. This shows the significant level of trust that the providers have gained as they go into neighborhoods wanting to help with health care issues.

### ***Modifications***

In many cases, when a child's provider gave a referral for dental, medical or specialty care, the parents did not understand the urgency to obtain the referred care. A patient advocate assisted the patient or parent with scheduling an appointment and arranging transportation. In order to help address the dental needs of the children, the SYHC dental department travels on a quarterly basis with the mobile medical units providing dental screenings and fluoride varnish to age-appropriate children. Also, depending on the needs of the housing community, late hours were added to the monthly schedule. This allows the working residents to take advantage of the services offered.

### **PHPC Innovation III: Community Health Education Coordinators, Keeping Community in Community Health Care NeighborCare Health (Formerly Puget Sound Neighborhood Health Centers) in Seattle, Washington**

#### ***Need***

The pressure to maximize the number of encounters is common to all PHPC health centers. There are activities at the health centers and in other community sites to increase patient participation and improve their care and education. Community health education coordinators (CHECs) create a bridge between NeighborCare Health clinics and the community.

#### ***Design Approach***

In the past, PHPC funding was used to provide services in two very low-income communities where NeighborCare had medical clinics on-site. Due to changes in public housing in Seattle, this model no longer met the needs of their most vulnerable patients. HUD's Hope VI program changed those two communities into mixed-income communities so that serving low-income public housing patients became more challenging. When the second Hope VI project neared completion, NeighborCare decided to update the health promotion strategy to target the biggest challenge their communities faced: chronic diseases, especially diabetes. NeighborCare also increased the hours needed to provide support to all six medical clinics. Currently, the health centers are focused on two parts of



NeighborCare Care Giver

Photo: NeighborCare

the chronic care model: improving system design and working with the communities they serve to improve access to services that help patients improve their health.

### ***Program Description***

The Chronic Care program diligently works to improve the health outcomes of patients living with or at risk for chronic disease. Over the past year, NeighborCare has restructured the program to provide staff support at each of its six health clinics. To this end, NeighborCare created the CHEC position. The CHECs coordinate planned care visits, called diabetes days, at each of the six primary care sites. This is a monthly “one-stop shopping” opportunity for patients with diabetes.

Participants get annual eye exams, lab work and foot checks, and they can check in with the diabetes educator and nutritionist. Other services offered include nutrition education, food demonstrations, distribution of vouchers for fruits and vegetables, referrals to community opportunities for physical activity and shoe fittings for those with Medicaid and Medicare. CHECs also are NeighborCare health centers’ link to their communities. Outside their health centers, NeighborCare co-sponsors community activities, works on coalitions and serves on advisory boards.

### ***Team***

CHECs work closely with care teams. They schedule appointments, contact patients and coordinate the diabetes days. Furthermore, CHECs make sure that teams and patients know about programs that NeighborCare and community organizations offer that can have a positive impact on their chronic condition.

### ***Patient Involvement***

Patient involvement is essential to the work of CHECs. They spend time talking with patients, finding out about their preferences and seeking their feedback. To keep in touch with the pulse of its patient population, NeighborCare attends community meetings regularly. In order to make health care affordable, the centers partner with other community agencies to co-sponsor exercise, nutrition and mindfulness-based stress reduction activities.

### ***Collaborations***

Collaborations are vital to the success of NeighborCare’s work, providing the resources to put on many of the events offered to the target population. Some of NeighborCare’s partners include: Seattle Park and Recreation, senior centers, Seattle King County Public Health, University of Washington Center for Health Promotion, SeaMar Community Health Centers, Solid Ground, Neighborhood House, SoundSteps and Design for Active Living.

### ***Significant Results***

NeighborCare has increased the number of annual retinal screens and foot checks across its clinics. They have successfully worked with patients to improve self-management skills by working with

them on setting and accomplishing goals. They have developed and co-sponsored physical activity and nutrition education activities that positively impact patients' mood and decision-making skills. As a result, best practices have emerged. The first is assuring the high quality of programs by using evidence-based models and practices. The second is working with partners to continually learn about differences so that NeighborCare addresses obstacles based on culture and beliefs.

### ***Lessons Learned***

Scheduling multiple patient-care activities and tying those activities to on-site retinal screens improves NeighborCare patient show-rate. Knowing that doing too much at once can be overwhelming, NeighborCare has been able to strike a manageable balance. Because patients need a variety of options to choose from, working together with other community groups helps NeighborCare offer that variety to patients. They help patients access walking groups, water exercise, arthritis exercise, Tai Chi and stress reduction classes. They assist patients with nutrition by doing shop-arounds and cooking demonstrations and by offering vouchers for fresh produce.

### ***Modifications***

Modifications happen regularly. Each NeighborCare clinic serves a community that is different, and each clinic has a variety of resources. For example, a few clinics have meeting space. In clinics with no meeting space, there is access space through community partnerships with appropriate organizations nearby.

#### 4. ON THE HORIZON

With the current recession and with multiple years of slow wage growth not keeping pace with increases in the cost of living, the ranks of lower-income Americans are swelling dramatically and consistently; thus, demand for PHPC services is rising. This growing need is occurring not only among public housing residents, but also among the uninsured, under-insured and others who have insufficient access to health care because of financial difficulties.

##### Emerging Health Trends of the PHPC Population

The PHPC health centers' chronic care visits have grown significantly in the last three years, reflective of the growing prevalence of these conditions nationwide. According to the American Diabetes Association, between 1994-1995 and 2003-2004 the annual incidence of diabetes increased by 23 percent, while the prevalence increased by 62 percent.<sup>6</sup> Data from the 2005 National Health and Nutrition Examination Survey indicate about 80,700,000 American adults (one in three) have one or more types of cardiovascular disease.<sup>7</sup> The Centers for Disease Control and Prevention predicts that the rates for chronic illness, including behavioral health issues, will continue to increase.

The incident and prevalence rates of chronic disease are higher among the PHPC target population than the general U.S. population. There has been a 34 percent increase in the number of PHPC diabetes visits and a 23 percent increase in the number of hypertension visits within the last three years. These trends outstrip the national averages because public housing and low-income areas are far less conducive to providing access to and incentives for healthy eating, regular exercise and effective stress-management. The severity of these increasing rates is compounded by the related increase in double and even triple diagnoses. Service to such patients places severe pressure on the resources of the PHPC programs.

The increase in behavioral health and depression care visits has also grown. The number of Attention Deficit Hyperactivity Disorder (ADHD)/disruptive-behavior patient visits increased a staggering 256 percent, and the number of PHPC depression visits increased 250 percent over the past three years. There are a myriad of conditions causing this exponential growth in the demand for behavior health care within this population.

For example, floods of new entrants to both public housing and low-income neighborhoods often come from environments drastically different from the ones in which they now find themselves. These include new immigrants, people reentering society after incarceration, victims of the foreclosure crisis and others. This makes the navigation of their new environments more difficult and stressful, and it diminishes their ability to protect their health and manage existing conditions. Placement in these new environments also has a notable negative impact on behavioral health, both among the new entrants and the relatives and friends that accommodate them.

In addition, extended U.S. military deployments place a tremendous amount of mental and emotional stress on the families and loved ones of service members serving their country abroad, causing many behavioral health issues. According to a report published in the *Journal of the American Medical Association*, for every three U.S. soldiers who return from active duty in Iraq, one needs mental health treatment. “Those coming back from Iraq do have a greater need for mental health services,” says Col. Charles Hoge, a study co-author and a psychiatrist with the Walter Reed Army Institute of Research. “And we’re pretty sure that’s due to higher frequency and intensity of combat experiences in Iraq.”<sup>8</sup> These individuals within the target population are turning to PHPC health centers to meet these evolving health needs. All of these concerns figure prominently in the future of PHPC program services.

PHPC programs are constantly creating successful and innovative ways to meet the particular and specific needs of their target populations. However, the intense rise in the incidence and prevalence rates of chronic diseases and behavioral health issues among this low-income and public housing population severely taxes PHPC systems and threatens to overwhelm their capacity to meet their target population’s needs. Overcoming these obstacles will require more than mere nominal increases in funding, but also must include innovative ways to expand PHPC resources.

### PHPC Partnerships and Collaborations

PHPC health centers have an established history of creating strong partnerships with public, government, social, community-based, non-profit and educational institutions to augment primary care and social services provided to patients. An example of successful strategic partnering is the types of alliances created at Hill Health Center – a PHPC health center serving the communities of New Haven and West Haven, Connecticut – to increase the health center’s reach and services to the elderly population. By collaborating with Wellcare Pharmaceuticals, City of New Haven Housing Authority and Bell Care Community Resource Center (a community-based organization), Hill Health Center is able to provide diabetes screenings and medication education to hundreds of seniors as a result of strategic partnerships that provide for more pharmacists and service providers, as well as community space, to deliver health promotion activities in a convenient locale. Strategic partnerships are a significant asset for PHPC health centers particularly taxed with ever-growing

demand and limited resources. In the future, PHPC health centers must continue to leverage the strength of partnerships to expand the provision of truly comprehensive care. Strategic linkages will not only increase access to culturally competent comprehensive care, but will also create a health care system that is located in the communities it serves and that is more reflective of these communities.

To face the current and developing challenges to health care for target populations, it is critical that PHPC health centers have adequate technology that will interface seamlessly with hospital systems and other data reporting systems, as well as basic facility improvements to make PHPC health centers more conducive to ready access, urgent-care systems and capacity for extended hours and increased visits. Even though PHPC health centers provide cost-efficient care, the cost for health care has escalated nationwide and impacts PHPC health centers just as it does the rest of the country. Given these economic realities, it is particularly challenging to meet the resource needs of these health centers so they can continue to deliver effective care.

PHPC health centers can no longer solely rely on traditional and existing funding sources to meet their needs. Accordingly, the approach to securing funding must be met with the same energy and creativity as PHPC's approach to the development of effective care models. PHPC health centers need to focus on diversified funds development. By embracing a broad range of funds development, PHPC health centers can begin to secure the types of resources required for services. Everything from special events to individual donor cultivation should be considered. However, a successful fund development effort must be launched in concert with solid marketing plan. Effective marketing ensures that PHPC health centers and the impressive work performed daily are not their own best keep secret. Further, good marketing creates an atmosphere of PHPC health center awareness among potential funders and benefactors, thus making funding requests easier and funds procurement more likely. Integrating development and marketing, along with continuing to support creative linkages, as core elements to PHPC's operational models will ensure growth and sustainability.

### Ahead for PHPC

As the PHPC program approaches its third decade of health care delivery, it remains steadfast in its mission to provide increased access to comprehensive primary health care services to target populations. The PHPC program has also embraced a broader understanding of its role for all special populations, serving not only more than 6.7 million residents of public housing, but also approximately 3 million migrant workers and 3 million homeless individuals. Public housing and government-assisted housing is the pass-through for many of the special populations as they transition to mainstream housing. The PHPC program – through the direct provision of health promotion, disease prevention, primary health care and social services – enhances the health and well-being necessary for productive livelihoods.

To that end, the PHPC program will continue to employ innovation, expertise, collaboration and an unyielding commitment to serve the country's at-risk populations. In this way, PHPC health centers will enhance their leadership as a health care provider, advocate and voice for shaping health policy. Building on the values that have sustained its health centers, the PHPC program will persist in its mandate to provide care and eliminate health disparities as it creates an environment that leads special populations toward self-sufficiency and wellness.

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## APPENDIX

### Linkages/Partnerships

The following are just a few of the many partnerships that PHPC health centers have with other community organizations.

Local Housing Authorities	Dental Services Providers
Tenant Associations	Hospital Residency Programs
Senior Centers	Local Health Departments
Hospitals	Boys and Girls Clubs
Women's Shelters	Head Start Programs
State Health Departments	Pharmaceutical Manufacturers
Mental Health Services Providers	Primary Care Associations
Substance Abuse Treatment Facilities	The Salvation Army
Universities and Colleges	Primary and Secondary Schools
Homeless Shelters	AIDS Service Organizations
Local School Districts	Local Police Departments
Departments of Parks and Recreation	Local Cultural Arts Centers
Community Development Associations	Councils for Domestic Violence
Faith-Based Service Organizations	Local Recreation Centers

### For More Information about the Featured PHPC Programs

Great Brook Valley Health Center Worcester, Massachusetts <a href="http://www.gbvhc.org">www.gbvhc.org</a>	Quality of Life Health Services, Inc. Gasden, Alabama <a href="http://www.qolhs.org">http://www.qolhs.org</a>
Hudson River Health Care, Inc. Peekskill, New York <a href="http://www.hrhc.org/">http://www.hrhc.org/</a>	South Bronx Health Center for Children and Families Montefiore Medical Center New York, New York <a href="http://www.montekids.org">http://www.montekids.org</a>
La Casa-Quigg Newton Clinic Denver, Colorado <a href="http://www.coloradocoalition.org">http://www.coloradocoalition.org</a>	San Ysidro Health Center San Diego, California <a href="http://www.syhc.org">http://www.syhc.org</a>
NeighborCare Health (Formerly Puget Sound Neighborhood Health Centers) Seattle, Washington <a href="http://www.psnhc.org">http://www.psnhc.org</a>	