



Collection of Promising Practices on Health Center and Housing Partnerships



National Center for Health in Public Housing

DISCLAIMER

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Introduction

The National Center for Health in Public Housing (NCHPH) has compiled a set of promising practices on how to improve the health of public housing residents through thoughtful and intentional partnerships between health centers and housing agencies. These strategies were identified through various webinars and learning collaboratives conducted by NCHPH on improving access to care, behavioral health, and addressing the COVID-19 pandemic.

The purpose of the document is to provide health center staff with easy access to promising practices. The promising practices will also be available online through a promising practices portal. Each promising practice will be tagged with key terms to make them easily searchable and accessible.

Promising Practices Definition

Promising practices were chosen based on the following definition identified and created by the [Health Center Resource Clearinghouse](#) and the [Health Resources and Services Administration \(HRSA\)](#) to provide training and technical assistance to health centers. A promising practice generated at a health center must demonstrate at least three of the following:

- **Impact/Outcomes:** Guidelines and protocols that have been successfully used by at least one organization and with an emerging positive track record of improved clinical or operational outcomes and insights.
- **Satisfaction:** Approach demonstrates effectiveness in increasing overall satisfaction for patients and/or staff.
- **Data Collection Mechanism:** Provide initial data to support the establishment of benchmarks.
- **Reduced Costs:** Have the potential to lower the per capita costs of delivering care or services.
- **Partnerships:** The approach creates innovative, strong partnerships and maximizes efficiency.
- **Operational Feasibility:** Offer strategies that can be easily shared and implemented.

Promising Practices

This publication includes a list of promising practices on the following topics:

- Collaborations with Community Health Workers (CHWs)
- Collaborations on Flu Vaccinations
- Collaborations to Address Smoking
- Collaborations on Health Education and Outreach
- Collaborations to Address COVID-19 Vaccine Confidence and Accessibility
- Collaborations to Address COVID-19
- Collaborations to Improve Access to Care
- Collaborations for Seniors
- Collaborations on Senior Health Initiatives
- Collaborations to Improve Care for Seniors
- Collaborations on Oral Health Care
- Collaborations to Address Community Violence
- Collaborations to Address Lead Exposure
- Collaborations to Address Weatherization

Source of Information

NCHPH has catalogued promising practices on health center and housing partnerships that were identified during T/TA activities. They include collaboration strategies to address COVID-19, vaccination efforts, smoking cessation, and access to health care. See Additional Resources for a list of NCHPH activities related to community collaborations or visit www.nchph.org.



I. Collaborations with Community Health Workers (CHWs)

Collaborations with Community Health Workers (CHWs)

The [CHW Place-based Approach to Health \(CHW PATH\)](#) is a collaboration between the U.S. Department of Health and Human Services (HHS), Office of Minority Health (OMH), and the U.S. Department of Housing and Urban Development (HUD). The goal of CHW PATH is to create CHW job opportunities for residents of public housing and to assess the benefits of embedding CHWs within their own public housing communities to provide peer-to-peer support for health and social needs. CHW PATH is a pilot within the Jobs Plus program and aims to develop novel CHW positions that are informed by existing CHW models/roles (e.g., care coordinator/navigator, health educator, cultural mediator, community organizer, promotores de salud) while tailored for the unique needs and contexts of public housing settings.

The health centers involved in implementation are:

- [AxessPointe Community Health Center \(Akron, Ohio\)](#) - coordinates with the Akron Metropolitan Public Housing Authority to bring services to residents of public housing, including older adults and people with disabilities, with funding from CHW-PATH. Mobile units support the provision of enabling services, with outreach done by CHWs who know the residents, health care providers, and public housing managers. The CHWs are shared by the health center and the local Public Housing Agency (PHA). PHAs are funded by the U.S. Department of Housing and Urban Development to provide housing for low-income individuals.
- [WATTS Healthcare Corporation \(Los Angeles, CA\)](#) - was invited by HUD and the Office of Minority Health (OMH) to develop and implement a Jobs Plus Community Health Worker program in coordination with the Nickerson Gardens housing complex. Also involved in this collaborative was the PHA of the City of Los Angeles (HACLA) and the Interdepartmental Health Equity Collaboration (IHEC).

CHW PATH key partners include:

- U.S. Department of Health and Human Services (HHS)
 - Office of Minority Health (OMH)
- U.S. Department of Housing and Urban Development (HUD)
 - Office of Public and Indian Housing, HUD
 - Office of Field Policy and Management, HUD
- Environmental Protection Agency (EPA)
 - Office of Environmental Justice, EPA
- Housing Authority of Baltimore City (HABC)
- Housing Authority of the City of Los Angeles (HACLA)

Collaborations with Community Health Workers (CHWs)

OMH is supporting CHW PATH with FY19-21 funds and plans to provide additional funding upon receipt of FY20 Congressional appropriations. HUD is leveraging resources and in-kind support from Jobs Plus investments (total of \$13.6M allocated for all sites over 4 years) to support CHW PATH.

For more information on this partnership, go to [Collaborations Toolkit](#), [Community Partnerships to Address the Consequences of the COVID-19 Pandemic Among Residents of Public Housing](#).



II. Collaborations on Flu Vaccinations

Collaborations on Flu Vaccinations

The [Flu Linkages to End Access Disparities \(Flu LEAD\)](#) pilot project is a partnership between HUD, the Health Resources and Services Administration's (HRSA) Bureau of Primary Health Care, and the Ambulatory Team of the COVID-19 Healthcare Resilience Working Group (HRWG). The project's goal, which is no longer active, was to increase influenza vaccination coverage among residents of HUD-assisted communities and improve community health and resilience by fostering partnerships between HUD-assisted communities and local HRSA-funded health centers.

To improve vaccination rates, health center staff provided flu shots through curbside services, door-to-door, mobile units, transportation, and virtual follow ups through telemedicine. They prioritized the elderly and disabled.

Overall, around 30% of the individuals vaccinated in the Flu-LEAD project became patients at the health center. The keys to the success of the program are communication within the health center and with local housing staff and residents using multiple methods of contact and promotion. Health centers also utilized student nurses to administer vaccine as well as CHWs to act as a liaison between the housing agency and residents and patients.

For more information on this partnership, go to [Flu LEAD Webinar Series](#).



III. Collaborations to Address Smoking

Collaborations to Address Smoking

Birmingham, Alabama

Housing Authority:
County Housing Authority

Health Center:
Alabama Regional Medical Services

Alabama Regional Medical Services (ARMS) is a Federal Qualified Health Center that provides primary care for the whole family, including OB/GYN in Birmingham, AL since 1985. There are five medical sites, a dental clinic, and a pharmacy. ARMS also manages a permanent housing choice 48-unit single resident occupancy (SRO) in partnership with the local housing authority.

ARMS collaborated with the housing authority to provide smoking cessation groups and inform tenants in the SRO and participants in substance use disorders' (SUD) housing support group of the availability of smoking cessation services. The participants in the SUD group were seeking housing choice vouchers in housing partners with the county housing authority.

Because smoking and smoking cessation services were discussed during SUD support groups, many clients expressed the desire to stop smoking. A mother of four who had been drug free for six months decided to stop smoking after 16 plus years as a smoker and has been smoke free for three weeks at the close of this report. The mother attended a SUD group during the Tips® Campaign pilot project period where the importance of smoking cessation was highlighted.

For more information, go to [Promoting CDC TIPS® Campaign Materials to Public Housing Residents.](#)

Collaborations to Address Smoking

Lancaster, Pennsylvania

Housing Authority:
Lancaster County Housing Authority

Health Center:
Union Community Care, previously known as Lancaster Health Center

Union Community Care located in Lancaster, PA collaborated with Lancaster County Housing Authority to address the need for smoking cessation services and support for patients living in public housing development sites. Although rates of smoking among adults nationally have declined, they are still high among public housing residents. The goals of the collaboration, which is still an active collaboration, were to increase access to tobacco cessation services among residents of public housing to encourage quit attempts; strengthen collaborations among community health centers, quitlines, and public housing agencies. The purpose was also to promote smoking cessation in public housing communities; and improve systems and clinical workflows to effectively deliver high quality tobacco cessation services in the Lancaster, PA area.

Patients seen at the Union Community Care can schedule an appointment with resources or connect via a warm handoff during a medical or dental appointment.

Accomplishments: Union Community Care has held community education sessions, health fairs, and has been featured on podcasts about this collaboration and service.

Other accomplishments include:

- Staff trainings on smoking cessation best practices
- Free NRT on site for distribution to patients experiencing barriers to accessing NRT
- Wallet cards with the Quitline phone number to teams
- Posters and smoking cessation handouts to teams
- Free NRT in Sample Closets

Lancaster County had the following programs: PA Free Quitline; My Life, My Quit Program; and the Tobacco Dependence Treatment Program at Lancaster General Hospital. The PA Free Quitline provided telephone coaching services and Nicotine Replacement Therapy (NRT). They had specialized materials for patients that spoke a language other

Collaborations to Address Smoking

than English (over 170 languages), deaf/hard of hearing services, youth under 18, pregnant and postpartum tobacco users, racial and ethnic populations, smokeless tobacco users, lesbian, gay, bisexual or transgender individuals, persons with mental and/or behavioral health conditions, and persons with chronic health conditions. The Quitline offered evidence-based, supportive services with monetary incentives to pregnant and postpartum women who use tobacco. Coaching topics included enrollee's history of tobacco use, identification of triggers, setting a quit date, relapse prevention, use of cessation aids/medications and developing a personal quit plan. The Free Nicotine Replacement Therapy (included patch, gum and/or lozenge) – for 4-8 weeks for qualified callers, as available and medically appropriate and was shipped to the enrollee's home, or other preferred location.

The My Life, My Quit Program is a program designed by National Jewish Health with a focus to help young people quit vaping. The program offers services such as coaching and educational assistance to quit smoking online, via text messages or phone calls. The Tobacco Dependence Treatment Program at Lancaster General Hospital offers individual and group counseling by certified tobacco treatment specialists. Programs are provided through the Southeastern Pennsylvania Tobacco Control Project (SEPA TCP), a program of the Health Promotion Council and funded through a grant from the Pennsylvania Department of Health. The program offers group counseling and one-on-one counseling classes and medications: nicotine patch, nicotine gum, and nicotine lozenge. The program is available to all Pennsylvania residents at no cost.

For more information on this partnership, go to [Community Partnerships to Address the Consequences of the COVID-19 Pandemic Among Residents of Public Housing](#).



IV. Collaborations on Health Education and Outreach

Collaborations on Health Education and Outreach

Meridian, Mississippi

Housing Authority:
Meridian Housing Authority

Health Center:
Greater Meridian Health Clinic

The Greater Meridian Health Clinic (GMHC) has partnered with the Meridian Housing Authority (MHA) over the past 25 years to provide direct services to MHA residents. GMHC's mobile unit provides the following patient care:

- Immunizations
- Diabetic Education
- Family Planning (OB/GYN)
- Women's Health
- Social Services
- Dental/Vision
- HIV Testing
- Resident Physicals
- 24-Hour Clinical Coverage
- X-Rays
- COVID-19 Testing
- COVID-19 Vaccinations
- Women's Health
- Health Education

GMHC and MHA engage in joint marketing to improve outreach by collaborating on MHA's newsletter; MHA website updates; and mass emails to employees. They engage in door-to-door flyer distribution by MHA team members, utilize an MHA summer intern to conduct surveys and access Resident Opportunities and Self-Sufficiency (ROSS) Coordinators and Public Housing Self Sufficiency Coordinators to promote health education.

For more information on this partnership, go to [Health Center 101: Building Housing/Health Partnerships](#).



V. Collaborations to Address COVID-19 Vaccine Confidence and Accessibility

Collaborations to Address COVID-19 Vaccine Confidence and Accessibility

Meridian, Mississippi

Housing Authority:
Meridian Housing Authority

Health Center:
Greater Meridian Health Clinic

The Greater Meridian Health Clinic (GMHC) has a long-established partnership with the Meridian Housing Authority (MHA) to provide comprehensive primary care to public housing residents. GMHC and MHA leveraged their networks and relationship to improve vaccine hesitancy for COVID-19. They utilized Resident Advisory Board Support (RAB), public figure endorsements, addressed concerns about vaccination with residents during RAB meetings, and provided vaccine education through ROSS and Public Housing Coordinators. To improve COVID-19 vaccine accessibility, MHA team members set up tents on each site to accommodate residents and coordinated schedules with GMHC's mobile unit to vaccinate residents.

The key to their successful collaboration is establishing resident buy-in. The RAB's President provides positive testimony on GMHC services, RAB's building captains promote COVID-19 vaccination, and MHA's grounds crew assist with mask distribution.

For more information on this partnership, go to [Health Center 101: Building Housing/Health Partnerships](#).



VI. Collaborations to Address COVID-19

Collaborations to Address COVID-19

Miami, Florida

Housing Authority:
Miami Dade Homeless Trust

Health Center:
Camillus Health Concern

Good Shepherd Health Center and the Miami-Dade Homeless Trust collaborated to address COVID-19 testing and vaccination for homeless individuals in Miami-Dade county. The Trust created five full service quarantine and isolation sites, that included meals, telehealth, case management, and security for homeless individuals. The health center provided consultation on quarantine and isolation protocols and ongoing engagement at all sites. There was a total of 4,912 total intakes over the course of the pandemic.

GSHC and Miami Dade Homeless Trust also collaborated on COVID-19 testing and tracing. More than 19,805 Polymerase Chain Reaction (PCR) tests were administered to 1,426 individuals without shelter. They also coordinated with the Florida Division of Emergency Management, Florida Department of Health, State and Federal Sites to administer COVID-19 vaccines.

Partners:

- Miami Dade Homeless Trust
- Miami Dade Department of Health
- Other Homeless Housing Service Providers
- Local Universities
- Other Community Health Centers

The COVID-19 efforts led to other referrals; more than 900 individuals received housing referrals. The enhanced partnership led to the use of Homeless Management Information System (HMIS) to verify disabling conditions. The joint targeted outreach efforts facilitated crisis-housing placements.

Health and Housing partnership successes:

- In April 2020, a patient in their mid-60s with a history of poorly controlled diabetes, congestive heart failure, chronic kidney disease, resistant hypertension, multiple hos-

Collaborations to Address COVID-19

pitalizations, and chronically unsheltered, obtained shelter at Quality Improvement (QI) site, is now in an apartment and receives food assistance. Since April 2020, has only been to the emergency room once. Their diabetes and hypertension is now controlled and continues to receive medical care at the health center.

- A 55-year-old man with a history of alcoholism and chronic homelessness was diagnosed with COVID-19 by the health center outreach team. The patient was high risk for alcohol withdrawal and detox was arranged at local hospital. During hospital stay, the health center team followed up via telehealth. Upon hospital discharge, the health center outreach team assisted in the coordination between the hospital and the Homeless Trust. The patient was transferred to a QI site to complete COVID-19 isolation. The patient is now in a residential drug and alcohol treatment program and continues to be followed by health center staff for primary and behavioral health care.

For more information on this partnership, go to [Health Center 101: Building Housing/Health Partnerships](#).

San Diego, California

Housing Authority:
San Ysidro Housing

Health Center:
San Ysidro Health

The goal of the partnership between San Ysidro Health (SYH) and the housing authority was to expand the health center's reach into low-income housing properties to be able to provide Program of All-Inclusive Care for the Elderly (PACE) services to residents to ensure quality health care. SYH worked with housing sites to add a mobile clinic for on-site COVID-19 testing. SYH also offered vaccination appointments for seniors and arranged transportation and follow up. During phases of vaccine shortage, the partnership helped vulnerable seniors gain access to needed COVID-19 vaccination.

For more information on this partnership, go to [Health Center 101: Building Housing/Health Partnerships](#).



VII. Collaborations to Improve Access to Care

Collaborations to Improve Access to Care

Chicago, Illinois

Housing Authority:
Chicago Housing Authority

Health Center:
TCA Health, Inc.

Illinois issued special funding to community Health Center Programs to help individuals and families enroll into affordable health insurance plans. TCA Health Inc. (TCA), a health center in Chicago, had previously experienced challenges reaching public housing residents in their service area. TCA contacted the Chicago Housing Authority (CHA) to find ways to educate public housing residents about healthcare coverage and services available, particularly those in the Riverdale, Altgeld/Murray community.

TCA Health and CHA collaborated on a grant proposal to improve outreach and enrollment. As part of the grant application, each organization provided a letter of support defining the initiative and outlining the terms of the collaboration. With shared resources, TCA and CHA were able to hire and train two public housing residents to conduct outreach and enrollment activities. TCA worked with CHA's property managers to enroll public housing residents into health insurance when they came in to pay their rent, at CHA laundromats, and at local advisory council meetings and other events hosted by CHA. Together, the organizations were able to maximize opportunities to reach residents and enroll them into affordable health insurance.

One of the greatest impacts of the collaboration was the sustained employment of two public housing residents. Those residents now have a stable source of income and are an essential part of the communication chain between the housing authority, health center, and residents. The original collaboration led to a gradual increase in the number of health-related initiatives in public housing, including a Youth Sports Fitness Program, Adult Fitness Program, Cooking Classes, Community Gardening Projects, Food Accessibility Initiatives, Community Health Education Workshops, and access to mobile health care services.

The collaboration was extremely effective in reaching public housing residents. Through their combined efforts, over 1,000 residents were enrolled into health insurance and

Collaborations to Improve Access to Care

3,000 received one-on-one health education training. Another benefit of the partnership was the ability to collaborate with additional stakeholders to serve the residents. The two organizations planned and formed workgroups with 25 other organizations to identify and address various public housing resident issues. With more partners at the table, TCA and CHA were better positioned to identify key issues and barriers residents face in accessing health and social services, which then informed their programmatic goals. For more information on this partnership, go to [Health and Housing Partnerships report](#).

Gadsden, Alabama

Housing Authority:
Greater Gadsden Housing Authority

Health Center:
Quality of Life Health Centers

The Quality of Life Health Center's (QOLHC) leadership worked with the leadership of the Greater Gadsden Housing Authority (GGHA) to open a primary health care program for public housing residents. GGHA leased facilities to QOLHC and helped identify new residents for outreach purposes. The lease agreement between GGHA and QOLHC outlined the purpose of the relationship, defined the roles and responsibilities of each party, identified the selected services provided in the donated space, and clarified the communication and reporting requirements. Primary care sites were located in two areas designed to service residents of seven housing developments and persons living within a one-mile radius of these developments. The Project called "ProCare" focused on family health care through education and counseling, preventative care, and promotion of healthy living practices.

QOLHC had access to resident contact information provided by GGHA, which helped them to reach residents at point of entry and inform them about available programs and services. Residents received one-on-one health education on site from QOLHC staff that was committed to the health and well-being of residents. The staff was aware of the many barriers patients faced and worked hard to reduce barriers to services.

QOLHC has repositioned their staff in order to better serve the public housing residents.

Collaborations to Improve Access to Care

They have a primary care specialist at the center, as well as an onsite manager that has direct supervision of the services provided at the housing development and who communicates on a regular basis with the housing authority. They also have two outreach employees dedicated to organize events or overseeing outreach in the community and two volunteer Resident Presidents that support all programming. These staff work to improve and expand resident engagement and increase QOLHS presence in the public housing communities. Dedicated staff allocation is a testament to the commitment they have to the residents and is a part of their shared vision.

Whenever possible, they also try to leverage existing community services for their residents rather than seek funding for new programs and services. Their strategy has been to identify organizations that specialize in a specific program, like Big Brothers and Big Sisters, and make space available to them at the housing development site, rather than develop duplicative services.

The QOLHS and GGHA partnership is successful because there is a shared vision, their community presence is consistent, and they are committed to the residents. They conduct a quarterly needs assessment and adapt services and service delivery to residents, changing issues. They meet quarterly to discuss the assessment data, evaluate all of the programs, and consider any suggestions from residents on new programs.

For more information on this partnership, go to [Health and Housing Partnerships report](#).



VIII. Collaborations For Seniors

Collaborations for Seniors

Philadelphia, Pennsylvania

Housing Authority:
Philadelphia Housing Authority

Health Center:
Public Health Management Corporation

The relationship between Public Health Management Corporation (PHMC) and the Philadelphia Housing Authority (PHA) dates back to the 1990's when health centers were first embedded in public housing sites in the City. However, there was a shift in how the organizations work together. PHA went through a significant transition period, resulting in a new president and CEO, entirely new senior administration team, and a renewed desire to strengthen existing relationships and focus more acutely on the resident services.

PHA and PHMC collaborate on three major initiatives: Choice Neighborhoods Planning Grant, Choice Neighborhoods Implementation Grants, and working together to align services across PHA's portfolio of residents.

In one of the Choice Neighborhoods, PHA had to create a relocation plan for 600 families living in public housing, including seniors. PHMC assessed all 96 seniors living in the senior tower, which helped PHA to understand their needs during the relocation process. According to the PHA Director, "that was a tremendous help and a tremendous service to the residents."

PHMC is also one of the strategic partners in the City's other Choice Neighborhoods grant, in a North Central Philly neighborhood, near Temple University. According to PHMC, "MOUs, confidentiality agreements, and information exchange agreements have all helped facilitate the partnership. It provides the freedom and the flexibility to work together." The PHA Director added, "We needed to put those building blocks into place as part of the administrative requirements, in order to have the interaction that we have." Having a legal document that allows the organizations to exchange information freely was particularly important when PHMC conducted a needs assessment of the seniors living in the senior tower.

A number of collaborative efforts illustrate the partnership of PHA and PHMC such as

Collaborations for Seniors

smoking cessation and outreach and enrollment efforts incorporated into public housing sponsored events. The most recent collaborative effort of these two institutions involves the administration of an early childhood education program into a community development initiative. Funding comes from PHA for the first two years with subsequent funding contingent on performance of the program. Benefits from the PHMC and PHA partnership include but are not limited to the improved accessibility to services and programs to improve the health and well-being of residents and employment opportunities in the community.

For more information on this partnership, go to [Health and Housing Partnerships report](#).



IX. Collaborations on Senior Health Initiatives

Collaborations on Senior Health Initiatives

Chicago, Illinois

Health Center:
Alivio Medical Center

Other:
The Resurrection Project, City of Chicago

Casa Maravilla, a 73-unit senior housing building in Chicago, is a great example of a public and private partnership between Alivio Medical Center, The Resurrection Project, and the City of Chicago Department of Family and Support Services Area Agency on Aging. The Resurrection Project is a nonprofit organization that purchased land from Alivio Medical Center to build the senior housing project. Alivio Medical Center allowed the sale of the land with the caveat that affordable units be set aside for seniors. The Resurrection Project agreed and leases out 7,000 square feet of the first floor to the City of Chicago free of cost for a Senior Center, which is managed by Alivio Medical Center.

The senior center has monthly wellness programs. A nurse, registered dietician, and a pharmacist provide health education presentations for the seniors. Seniors and outreach and enrollment staff are housed at the site. The senior center also operates as a Benefits enrollment center to help people with SNAP, Medicare, Medicaid, Medicare Savings Program, Low Income Subsidy, and some local programs. They also work with local school programs to allow students to work or volunteer at the senior center, which is beneficial for both age groups.

The partners routinely evaluate the quality of care delivered to the seniors in the community and strive to improve it where possible. One of the unique characteristics of the community is its diversity. The area is multilingual and multicultural, and the staff of the Senior Center has evolved to reflect those changes. Agencies that serve limited-English speakers must have appropriate staff to provide culturally competent care, beyond just language translation. The staff of Casa Maravilla is not only bilingual, but bicultural.

The partnership continues to grow. On land purchased from Alivio, The Resurrection Project completed construction of a \$15 million Casa Morelos, an environmentally green building with 45 units of affordable rental housing. The complex contains energy efficient appliances, geo-thermal heating systems, semi permeable pavement on the parking areas and a green rooftop.

For more information, go to [Developing Cross-Sector Partnerships](#).

Collaborations on Senior Health Initiatives

Dover, New Jersey

Housing Authority:
Madison Housing Authority

Health Center:
Zufall Health Center

The relationship between Zufall Health Center and Madison Housing Authority (MHA) began in 2012 when MHA received a 3-year Resident Opportunities and Self-Sufficiency (ROSS) Program grant from HUD. The funding was used to assess the needs of residents of conventional public housing and coordinate available resources in the community to meet those needs. The program utilized public and private resources for supportive services and resident empowerment activities. These services enabled participating families to increase earned income, reduce or eliminate the need for welfare assistance, make progress toward achieving economic independence and housing self-sufficiency or, in the case of elderly or disabled residents, help improve living conditions and enable residents to age-in-place. Age-in-place is the ability of older adults to continue living their lives in their homes and communities without having to re-locate to an assisted living facility.

The ROSS service coordinator met with representatives from Zufall Health Center in 2012 to identify services that could be provided to MHA residents. The first program identified was called "Live Your Better Life," a 6-week health education series for seniors. Zufall provided the health education to seniors at the housing site and returned monthly for follow-up services. Fifteen seniors graduated from that program.

The ROSS grant was a key element in getting the partnership started. The funding supported MHA staff to reach out to Zufall and identify programs that would benefit its residents. MHA was able to leverage services provided by the health center to deliver social and community services to residents. Even after funding for the ROSS grant ended, the relationship between the organizations was in place, allowing for continued work on other projects.

For more information on this partnership, go to [Health and Housing Partnerships report](#).



X. Collaborations to Improve Care for Seniors

Collaborations to Improve Care for Seniors

Brooklyn, New York

Housing Agency:
Carroll Gardens Senior Citizen Housing

Health Center:
Community Health Initiatives, Inc.

Community Health Initiatives, Inc. in Brooklyn provides a health education series called the Senior Club. The president of Carroll Gardens Senior Citizen Housing, a 101-unit building for low-income elderly, is also a member of the Board of Directors at Community Health Initiatives, Inc. Under her leadership, the Senior Club has organized regular onsite health education discussions with various specialists and primary care providers. For example, a podiatrist discusses foot care and diabetes, and nurses provide food security screenings.

The Senior Club has been well attended and well received. However, the success of the club has only slightly translated to higher attendance at the local Health Center. This collaboration became a promising practice as improvements were seen on health center attendance by seniors. The CEO of Lifelong Medical Center acknowledged that it can take a long time to develop a rapport with the senior community and even longer to change their behaviors. In addition to engaging with seniors in their homes, he encourages Health Centers that are beginning new senior programs to develop relationships with the discharge staff at local hospitals. Many times, the discharge staff are looking for local services that can benefit their senior patients as they transition from the hospital to their home. He suggests Health Center staff reach out to them, introduce them to the services available at the Health Center, and follow up with them on an ongoing basis to cultivate the relationship.

For more information, go to [Senior Case Study](#) publication.



XI. Collaborations on Oral Health Care

Collaborations on Oral Health Care

Dover, New Jersey

Housing Authority:
Madison Housing Authority

Health Center Program Grantee:
Zufall Health Center

The relationship between Zufall Health Center and Madison Housing Authority (MHA) began in 2012. Following the success of a previous collaboration on health education, Zufall identified other public housing resident health needs, including the need for oral health care. Transportation was an issue for public housing residents, so Zufall delivered dental services through a mobile dental health van. First time patients were given free dental services, which included fluoride treatment, dental exam, X-rays of problem areas, and oral-cancer screening. In order to streamline the administration process, staff from Zufall would pre-register patients prior to the van's arrival, which reduced wait times and allowed providers to see more patients. The goal of the first visit was to encourage patients to access additional dental services at the health center; however, staff noted that many patients preferred the mobile van. As a result, a follow-up visit offering a full dental exam was made available through the dental van for a modified fee of \$20.

The mobile dental van was highly successful in providing needed oral health care to public housing residents at MHA. The flexibility of the van allowed travel to multiple sites, increasing access to all public housing and Housing Voucher (Section 8) residents in the county.

Since MHA completed the conversion of the public housing to Rental Assistance Demonstration (RAD), they are no longer eligible to apply for ROSS funding. However, the collaboration between the organizations has already been established, and there is ongoing communication, therefore joint programs will continue to develop.

For more information on this partnership, go to [Health and Housing Partnerships report](#).



POLICE LINE DO NOT CROSS

XII. Collaborations to Address Community Violence

Collaborations to Address Community Violence

Flint, Michigan

Housing Authority:
Public Housing Commission

Health Center Program Grantee:
Genesee Health System

Genesee Health Systems (GHS) operates in the Flint area in Genesee County, MI. GHS established a partnership with the Public Housing Commission to build a Health Center site directly in an 800-unit public housing development in Flint. Health Center leadership assumed that the proximity and the improved access to primary care services would be viewed positively in the community. However, they found that it took almost a year to gain trust and acceptance from residents.

One of the strategies they used to build a rapport in the community was through fun, family-oriented activities and fairs, giveaways, food, and other games and raffles. They also worked thoroughly to ensure a safe environment at GHS. There is a security guard on site and an armed Genesee County Sheriff patrols all of the health center site locations. The presence of law enforcement provides an added sense of safety to both patients and staff at the health center. According to the Director of Operations, knowing the officer is there helps individuals from acting aggressively and decreases the risk of a violent situation. In addition, all Health Center staff receive crisis intervention training to learn de-escalation techniques. Providing training to everyone, rather than a select few, allows the health center staff to attend to the needs of the patients immediately in the event of an acute crisis. The Director of Business Operations also recommends having a separate room available to move individuals when a conflict erupts. A separate space can create a calming effect but can also prevent a potentially violent episode from spreading to the common waiting areas at the health center and affecting other patients, families, and staff.

GHS uses a holistic approach to deliver mental health, substance use, and primary care services. There are several programs that have helped prevent and address crime and violence, including addressing the substance use problems in the area. Specific programs include a sobriety facility, drug courts, mental health courts, and veterans courts.

For more information, go to [Addressing Violence in Public Housing Communities](#).

Collaborations to Address Community Violence

Gadsden, Alabama

Housing Authority:
Greater Gadsden Housing Authority

Health Center Program Grantee:
Quality of Life Health Centers

The greater Gadsden area was not a safe place to live. Gang violence, drugs, vandalism, prostitution, and gambling were pervasive problems in the community. Many public housing residents claimed they slept in bathtubs or never came outside. When funding to bring a health center to people living in public housing was made available, the Quality of Life Health Center (QOLHC) and the Greater Gadsden Housing Authority (GGHA) saw it as an opportunity to bring change to the community.

After collaborating to add primary care sites in two areas designed to service residents of seven housing developments, QOLHC and GGHA began to see change in the community. The partnership received support from city council, schools, community colleges, National Association for the Advancement of Colored People (NAACP), and the police department. One of the most successful joint programs was the Public Housing Drug Elimination program. GGHA employed nine police officers to improve safety in the community. It was originally funded through a grant from HUD, then later through GGHA's operations budget. Because of that program, there was a real shift in the public housing image and a reduction of the stigma of living in public housing. Residents now have a sense of belonging and importance, particularly among elderly residents.

The partnership expands beyond health to services addressing social determinants of health. Their annual initiatives and events include a Father's Day program, holiday parties, Encouraging Students to Exhibit Excellent Minds (ESTEEM) youth program, Reach Out mentoring program, and many more. Residents receive job training and are linked with multiple community resources.

For more information on this partnership, go to [Health and Housing Partnerships report](#)



XIII: Collaborations to Address Lead Exposure

Collaborations to Address Lead Exposure

San Diego, California

Housing Authority:
San Diego Housing Commission

Health Center Program Grantee:
La Maestra Community Health Centers

The San Diego Housing Commission (SDHC) launched a lead-based paint-testing program to address residents of public housing exposure to lead-based paint. The goal of the program was two-fold, test children for lead exposure and educate the community on healthy homes and lead-related issues. However, when the program launched, SDHC had difficulty getting parents to test their children. There was mistrust among the residents of the housing community. SDHC was eager to find new partners and strategies to increase the testing rate.

SDHC identified La Maestra Community Health Centers (LMCHC) as a key community stakeholder who could help engage residents of public housing to educate them around lead hazards and encourage them to test their children. LMCHC was identified as an essential partner in this initiative in large part because of its “Circle of Care” approach. The Circle of Care encourages a holistic, solution-based approach to providing programs and services and was created because LMCHC believes that complete family wellness requires more than just medical services. Every staff member at LMCHC Community Health Centers from receptionist to physician is trained in the Circle of Care approach and to guide the patient towards treatment, education, training and ultimately, self-sufficiency. The Circle of Care involves a network of integrated services provided at LMCHC in addition to community resources like SDHC. SDHC refers residents to LMCHC, for various services, including blood-lead testing.

SDHC partnered with LMCHC and several key stakeholders to conduct blood test events. Testing was offered on site of the housing complexes by staff at LMCHC. The test rate increased from 3% (prior to LMCHC’s engagement) to 29%. LMCHC led the way to host targeted testing at various community sites around San Diego, such as elementary schools, parks and community centers. Through their family self-sufficiency program, LMCHC had greater access to their target population. This collaboration allowed LMCHC to better understand and address challenges the families who lived in San Diego Housing Commission sites had; whatever they needed to become self-sufficient or im-

Collaborations to Address Lead Exposure

prove their quality of life, including education, job search or job training, or health.

For more information on this partnership, go to [Health and Housing Partnerships report](#)



XIV. Collaborations to Address Weatherization

Collaborations to Address Weatherization

San Diego, California

Housing Authority:
San Diego Housing Commission

Health Center Program Grantee:
La Maestra Community Health Centers

The San Diego Housing Commission (SDHC) and La Maestra Community Health Centers (LMCHC) had established a partnership to address lead hazards within the home. The LMCHC and SDHC partnership eventually expanded to the Metropolitan Area Advisory Committee on Anti-Poverty MAAC Project around weatherization for seniors and low-income families. This collaboration allowed several key stakeholders to conduct blood test events where testing was offered on site of the housing complexes by LMCHC staff and at health center sites. Through this partnership, LMCHC also led the way to host targeted testing at various community sites around San Diego, such as elementary schools, parks, and community centers. Through their family self-sufficiency program, La Maestra had greater access to their target population. Collaborating allowed LMCHC to better understand and address challenges the families who lived in San Diego Housing Commission sites had; whatever they needed to become self-sufficient or improve their quality of life, including education, job search or job training, or health.

LMCHC also partnered with San Diego Gas and Electric in Sempra, specifically on how low-income families living in low-income housing and public housing save or reduce their utility bills. Sempra is an energy and infrastructure company from San Diego, California.

For more information on this partnership, go to [Health and Housing Partnerships report](#).



XV. NCHPH Resources on Community Collaborations

NCHPH Resources on Community Collaborations

Webinars:

[Addressing Inequity Through Health Center Partnerships](#)

In this webinar, participants learned the value of integrating a comprehensive network of programs that connect vulnerable patients to social services to address their needs. Strategies and resources to identify community partners and maintain collaborative relationships were discussed.

[EnVision Centers, PHAs, and FQHCs—Opportunities for Collaboration to Improve Resident Health](#)

In this webinar, background information is provided on the intersection of health centers and public housing agencies in the effort to improve health and wellness of residents. This webinar also focuses on EnVision Centers and how community health centers can collaborate nationally with EnVision Center partners in order to achieve the health and wellness goal of the health and wellness pillar within the EnVision Centers. EnVision Centers are centralized location directed the Department of Health and Human Services that focus on providing support to communities on economic empowerment, educational attainment, health and wellness, character and leadership.

[Outreach and Opportunities for Collaboration to Improve Resident Health: Health Centers, Public Housing Agencies and More](#)

This webinar by NCHPH and South Carolina Primary Health Care Association (SCPH-CA) highlights ways to improve outreach.

[Partnering for the COVID Vaccine: Lessons from the Flu-LEAD Project](#)

The National Nurse-Led Care Consortium, the National Center for Health in Public Housing, and subject matter experts from the U.S. Department of Housing and Urban Development (HUD) hosted a webinar about leveraging health center and housing authority partnerships for COVID vaccine distribution. Speakers discussed lessons learned from the HUD/HRSA Flu-LEAD (Linkages to End Access Disparities) project.

NCHPH Resources on Community Collaborations

Learning Collaboratives:

[Building an Effective Collaborative Care Team to Address Diabetes in Special and Vulnerable Populations: Tailoring Care for Social Context](#)

This session focused on the necessary elements to develop a high functioning patient-centered team for diabetes prevention, management, and treatment in primary care. The session addressed the roles of all members of the team including the critical role of leadership and clinical champions to building an effective collaborative team. This session laid the groundwork for the full series by engaging participants in a discussion of how to tailor diabetes care for social context. The conversation focused on the key elements needed for treating diabetes in the primary care and community setting with an emphasis on team-based approaches to wellness.

[Building Value and Return on Investment in Housing and Health Partnerships](#)

This learning collaborative from NCHPH and National Nurse-Led Care Consortium (NNCC) will guide health center staff through practical steps to help build value and return on investment in their current health center and housing authority partnerships. The learning collaborative consists of four modules that discuss strategies, case studies, and promising practices to increase the impact of partnership activities, ultimately improving the health and social outcomes for residents of public housing. The modules will discuss how to optimize the health center workforce and resources, evaluate existing and developing partnerships, and measure and improve their impact.

[Community Partnerships to Address the Consequences of the COVID-19 Pandemic Among Residents of Public Housing](#)

The COVID-19 pandemic and its associated mitigation strategies are expected to have significant psychosocial, behavioral, socioeconomic, and health impacts, which are exacerbated in populations that experience health disparities and other vulnerable groups. Those experiencing health disparities prior to the COVID-19 pandemic are at increased risk of infection and other COVID-19 related consequences, such as job loss, unpaid leave, and lost wages. Given the urgent need for prevention and mitigation strategies (i.e., physical distancing, wearing face coverings, frequent handwashing, disinfecting surfaces, shelter-in-place, self-isolation upon suspected exposure, leaving home only for essential activities, etc.), there is also a need to leverage and scale existing partnerships, resources and platforms and ongoing mitigation efforts within communities to attenuate adverse outcomes. This learning collaborative explored existing or

NCHPH Resources on Community Collaborations

developing partnership strategies to address the negative health impacts of COVID-19 in vulnerable populations.

[Forging Community Collaborations](#)

During this learning collaborative conference call, NCHPH and PHPC Health Centers discuss the most recent topics regarding public housing and public housing primary care, including Envision Centers, Smoke Free Public Housing, Chronic Disease Management, and Integrated Care, and PHPC trends. PHPC leaders offer new perspectives and solutions to improve the health status of public housing residents.

[Partnerships and Collaborations in PHPC Settings](#)

On this call, PHPC Health Centers discuss the changing face of public housing, strategies to increase access to care in public housing primary care, and current and emerging issues affecting Health Centers located in and/or immediately accessible to public housing developments..

NCHPH Resources on Community Collaborations

Publications:

[Developing Cross-Sector Partnerships](#)

This guide will provide health center staff with tools and strategies to initiate, develop, and sustain community partnerships to better serve older adult residents of public housing. Content was developed through a 4-session learning collaborative (LC) launched by the SDOH Academy with a small cohort of HRSA-funded health centers, Health Center Controlled Networks (HCCN), and Primary Care Associations (PCAs). The focus of these LC(s) was to share learning aimed at transforming care to better meet the socioeconomic circumstances and non-clinical needs of special and vulnerable populations.

[Senior-Focused Health Programs for Public Housing Residents](#)

This report provides Health Centers that are interested in developing new senior programs or enhancing existing ones with concrete examples on how to improve their senior patient interactions, increase access to care, and improve health outcomes for older adult populations.

[Promoting CDC TIPS® Campaign Materials to Public Housing Residents](#)

Around 34% of public housing residents smoke compared to 22% of the general adult population. Given the new smoke-free requirement at all public housing developments, NCHPH anticipates that many public housing residents will attempt to quit smoking and/or seek smoking cessation counseling and services from their local Health Centers. This publication by NCHPH explains the prevalence of smoking in public housing communities.

[Addressing Violence in Public Housing Communities](#)

The purpose of this report is to provide Health Centers located in or immediately accessible to public housing with best practices and examples of violence prevention and intervention programs that can be implemented in their communities. NCHPH conducted background research on violence and crime statistics from the Federal Bureau of Investigation Uniform Crime Reporting Program, interviewed four Health Center staff, and analyzed the interviews to identify overlapping themes, lessons learned, and successful strategies used to address and prevent violence.

NCHPH Resources on Community Collaborations

[Housing and Health: Building Partnerships to Support Public Housing Residents](#)

This publication provides an overview of the PHPC program at HRSA, the public housing program at HUD, and highlights the collaborative efforts of five health and housing partnerships between PHPCs with PHAs in Chicago, IL, Philadelphia, PA, Dover, NJ, Gadsden, AL, and San Diego, CA.