Primary Care in Public Housing: Voices of Clinicians

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The Public Housing Primary Care (PHPC) Program, created under the Disadvantaged Minority Health Improvement Act of 1990 and administered by the Department of Health and Human Services' Health Resources and Services Administration (HRSA), enables 40 community health centers across the country to expand their primary care services to residents of public housing. These health centers are located on the premises of public housing, or at locations immediately accessible to residents. Public Housing Primary Care programs utilize partnerships with public housing authorities and resident/tenant organizations to facilitate the delivery of services, including collaboration with state and local managed care systems. Residents are actively involved in the design of services and program governance, and are routinely trained or employed as outreach workers and case managers. The goal of these partnerships is to have increased self-management skills in disease prevention and health promotion.

People living in public housing face complex social, economic, and physical stressors, and general safety concerns, which affect employment and educational opportunities, and contribute to the multiple health challenge. Carlos Manjarrez, a senior researcher at the Urban Institute, has looked at issues of neighborhoods and health outcomes and found that residents of public housing often keep children inside the home instead of taking them to a park for exercise and recreation due to personal safety concerns.[1] Such individual decisions can contribute to a reduction in physical activity and, thus, to obesity and related disease processes. Additionally, limited access to fresh fruit and vegetables, and the proliferation of small stores stocking processed foods, can contribute to poor health behaviors and outcomes.[2]

The majority of the 2 million residents in public housing fall below the federal

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poverty level. Many families in public housing comprise single-heads-of-households and children, and chronic diseases are commonplace among residents. The Association of Clinicians for the Underserved (ACU) has been working with North American Management over the past year on a needs assessment plan for health centers serving residents in public housing. "Place matters with respect to health," commented Urban Institute researcher Carlos Manjarrez at a PHPC strategic planning meeting held by the North American Management in December 2006.[3] The ACU took Manjarrez's notion that health and place are inextricably bound together as a starting point in its work on the public housing health center needs assessment plan.

The links between an impoverished living environment and low socio-economic status have a profound impact on the physical and mental health status of residents of public housing.[4] Medical providers and public housing authorities can benefit from understanding the relationship of both internal and external living environments to the health of their clients.

Just how are place and health connected? One way of imagining the interconnections is this: High quality health services for residents of public housing can have a positive effect on the health of the residents, which ultimately can lead to positive employment outcomes for a resident, which can improve socio-economic status, which ultimately can further improve health.

Clinicians serving residents of public housing understand the disparities in health conditions disfavoring their communities. The high rates of asthma, cancer, lead poisoning, oral health problems, depression, obesity, substance abuse, violence, along with HIV, hypertension and diabetes, are problems to be tackled from a curative and preventive point of view.

Endeavors that incorporate residents' beliefs, cultures, and strengths to decrease disparities are emerging. Some examples of these innovative programs in health centers supported by PHPC funding include:

- At Grace Hill Neighborhood Health Centers, Inc. in St. Louis, Missouri, residents are trained using a National Health Lung and Blood Institute curriculum to provide education and outreach on prevention and treatment of heart disease.
- Pediatric obesity prevention is a focus of the Starting Right program at Montefiore's South Bronx Health Center for Children and Families, where clinicians engage families in making healthy food choices and getting more physical activity. Recognizing the lack of opportunities for local residents to exercise safely outdoors, the health center participated in the South Bronx Active Living Campaign, a coalition led by Sustainable South Bronx with support from the Robert Wood Johnson Foundation's Active Living by Design Program. One of the campaign's primary projects has been the development of a South Bronx greenway, a network of green spaces connecting pedestrian and bicycle trails, for which more than $30 million has been raised to date. *Active Living* is a public health name for incorporating physical activity into daily life.[5]
- Patients with diabetes can access eye and dental care on a walk-in basis at Whittier Street Health Center in Boston, thus increasing access to these services for patients.

Oral health disparities disfavoring racial and ethnic minority groups and low-income populations are another pressing concern. Family Nurse Practitioner Anna Gard of Abbottsford Family Practice and Counseling, a health center in Philadelphia, discusses the links between poor oral hygiene and other diseases with her patients. She incorporates oral health screening and prevention into exams. "Sometimes it just takes reminding a patient of the importance of good oral hygiene, including brushing teeth twice a day and limiting food that can cause tooth decay," stated Gard at the recent national conference. She went on to say that "often the obvious get overlooked, and if the primary care provider isn't going to talk about prevention, we are missing a great opportunity to prevent tooth decay . . . and a clean mouth improves health esteem, as well." At Kokua Kalihi Valley Comprehensive Family Services in Honolulu, Hawaii, outreach workers on a mobile van are addressing oral health issues in the schools, and patient navigators are incorporating oral health self-management into their educational sessions.

Clinician Voices from Public Housing Primary Care Programs

In the following two sections, we hear directly from ACU-member clinicians working with unique and vulnerable populations at public housing primary care clinics. Dr. Kathie Culhane-Pera from West Side Community Health Services in St. Paul, Minnesota and Dr. Dillard Elmore from the William E. Shands Community Health Center in Peekskill, New York are both Family Practice Physicians. Here, they describe their challenges, solutions, and success in working with diverse populations. Dr. Culhane-Pera describes how her health center overcame the cultural and linguistic barriers to working with the Hmong refugee population of St. Paul, MN who reside in public housing. Dr. Dillard Elmore discusses his personal experiences growing up in public housing and later on, becoming a physician for those who live in public housing.

West Side Community Health Services, St. Paul, Minnesota (by Kathie Culhane-Pera, MD)

The challenges of serving community members at a public housing health center are similar to the challenges that all community clinics or community health centers face. These challenges include low literacy skills, limited access to medical and dental care, strained economic resources, little or no health insurance, limited transportation, and perhaps limited English proficiency.

Systems at Public Housing Primary Care programs that promote positive outcomes include sliding fee scales, transportation support for appointments, and culturally responsive health care. The big advantage that public housing health centers have is their location. Proximity reduces the transportation barrier and facilitates mutual familiarity between residents and clinic staff. It allows an intimacy from sharing space, which can improve relationships and lead to partnerships.

When I first worked with Hmong people at a primary care health center close to public housing in St. Paul, Minnesota in 1983, our clinic staff had no knowledge, understanding, or skills with respect to Hmong language, history, culture, or family decision-making processes. Hmong people were refugees from the Secret War in Laos

after the fall of Vietnam who arrived in the U.S. between 1975 and 1997. As part of their resettlement in Minnesota, many found affordable units in public housing projects in St. Paul. Many current Hmong leaders came from public housing, including Minnesota State Senator Mee Moua, Minnesota State Representative Cy Thao, entertainer and community organizer Tou Ger Xiong, and family physician Kang Xiaaj.

At the beginning, our health center did not have a framework for talking about, let alone providing, culturally competent care. We did not know how to use interpreters or culture brokers, and faced conflicts arising from misunderstandings or different perceptions of health, diseases, and optimal treatments. We made numerous mistakes early on and these mistakes undermined our abilities to create trusting relationships with specific patients and with the community-at-large. Building trust is integral in caring for the underserved, and we were hampered by our lack of cultural knowledge, our attitude that biomedicine was superior to Hmong traditional medicine, and our lack of skills in eliciting and then responding to our patients' knowledge and beliefs.

In St. Paul in the early 1980s, we ran into numerous barriers between providers and Hmong community members. For example:

- A 3-month-old boy with possible meningitis was taken away from an emergency room by his parents to avoid a court-ordered septic work-up, including blood culture, lumbar puncture and IV antibiotics. The police went to his house, but could not find the boy. Years later, the editors of *Healing by Heart* found the parents and interviewed them. They stated that the infant did well, and after the conflict, they always avoided the health care system.
- A 76-year-old woman with diabetes and gangrene in her foot refused an amputation and subsequently died from sepsis.
- A 42-year-old man was dying from hepatocellular carcinoma. He was in anguish about the diagnosis and prognosis and went from provider to provider, emergency room to emergency room, and hospital to hospital around Minneapolis and St. Paul, looking for a different answer, until his death.

While we had sought to protect the best interests of the patients in these instances, our messages clashed with the patients' belief system and ethical values. If we had had bilingual bicultural workers, or formally trained interpreters; if we had had skills to elicit people's beliefs and ethics; or if we had had training in cross-cultural negotiations, we might have provided care that was more compassionate and might have avoided disastrous outcomes.

The cultural divide between the Hmong community and the medical establishment in the 1980s and 1990s is described in the book *The Spirit Catches You and You Fall Down*.[6] While successful in highlighting cross-cultural insensitivities, the book is limited because it focuses on one Hmong patient, her family and pediatricians, and represents one person's understandings of complex issues. The subsequent book, *Healing by Heart*,[7] which I had the opportunity to co-edit, includes commentaries by 36 people, 18 of whom are Hmong, including patients, family members, health care workers, a psychologist, a lawyer, a minister and a shaman. The text explores a range of cases across the life cycle, and presents a range of perspectives on the conflicts between Hmong people and health care providers, including different cultural knowledge, beliefs, attitudes, and ethical

orientations. Moreover, the book provides a framework to improve cross-cultural care (The Healing by Heart Model of Culturally Responsive Care).

Allopathic medicine generally, and community health centers specifically, have made great strides in providing culturally competent care, and in improving health care outcomes. There are multiple frameworks to describe ideal culturally competent care.[8–10] There are federal standards of culturally and linguistically appropriate care.[11,12] Furthermore, now there are expectations that trained interpreters will be available for all interactions, whether in person or over telephone lines. My Minnesota clinic, like others, has trained and hired bilingual bicultural community members as health care professionals and has created positions for trained community health workers. In addition, most importantly, clinics have built connections with communities that have contributed to increased respect and trust, both of which improve health care delivery and health care outcomes. These changes came about because of concerned efforts by patients, professionals, and organizations (national, professional, and local organizations) applying pressure on clinics and hospitals to provide quality care for all patients, academic institutions to teach culturally competent care, states to mandate payment for interpreters, and the federal government to create national standards.

At our two Public Housing Primary Care health centers in St. Paul, McDonough Homes Clinic and Roosevelt Homes Clinics, we have addressed several barriers to health care. By locating health centers within walking distance for public housing residents and on bus lines, the transportation barrier is reduced. By providing sliding fee scales and employing and working with bilingual-bicultural staff, our clients fears of the cost of medical care and having a provider who does not understand them are decreased. Our social workers, outreach health educators, and interpreters all enjoy long-term relationships with individuals and community organizations and create trust and acceptance of the clinic among our patient population.

Our successes are evident in several more recent stories concerning Hmong patients:

- A 32-year-old man with depression and diabetes was uninsured because his employer did not offer any health insurance and he made too much money to qualify for Minnesota's state sponsored insurance. Because of his depression, he was unable to implement lifestyle changes to respond to his diabetes. With individual therapy, group support, medications, and ongoing relationships with the public housing primary care staff and physician, his depression improved, and he implemented diet and exercise changes. Ultimately, he became an outspoken advocate for other Hmong people with diabetes to manage their disease.
- A 68-year-old woman with a 25-pound ovarian tumor had refused an operation for years, but she finally accepted surgical excision after developing a trusting relationship with her family physician. This trusting relationship grew as her Hmong speaking provider spent time to elicit her concerns, and agreed to be present during the operation, in order to ensure that no one purposefully harmed her.
- A 36-year-old woman had recurrent seizures and difficulties with various medications until she developed an ongoing relationship with her social worker, who

helped her obtain disability payments, health insurance, and a personal care attendant. Once her social situation improved, she worked with her primary care physician and home care nurses to ensure that she took all of her medications. Once her seizures were controlled, she was able to begin English language lessons, which improved her self-esteem and decreased her depression.

Public Housing Primary Care centers build on successes, including collaborating with public housing authorities and residents to create community-clinic programs to address the relationship between place and health. The challenges faced by clinicians at PHPC health centers of health disparities among residents can be addressed through systems of care that incorporate resident collaboration in programs.

William E. Shands Community Health Center in Peekskill, New York (by Dillard Elmore, DO)

I grew up in public housing as a child and receive great professional satisfaction from caring for residents of public housing. As a Family Practice Physician, I have opportunities to instruct patients of all ages on healthy lifestyles. Additionally, as a Geriatrician, I can look at how my elderly patients function in their homes. Because residents in public housing form a community, I often hear from a concerned neighbor how a patient is doing, and I am able to visit patients at home during regular office hours. I know first-hand how place relates to health, and I bring my personal background and my professional training directly to residents in public housing.

Growing up I would hear about people who had "sugar" (diabetes), heart attacks, and cirrhosis. I had a profound desire to understand what it met for a person to have one of these afflictions. I remember asking my mother about each ailment. I figured since she worked in our local hospital as a nurse's aide, she would be qualified to answer my questions. What I found was that she had a very vague understanding of these diseases. My mother was not unique in this lack of medical knowledge. In fact, she was likely more educated in health maintenance then most of the people in our community. As a physician, I can now see that this early lack of understanding piqued my interest in medicine. I wanted to understand how words like *sugar*, *cirrhosis*, and *heart attack* led to funerals. I also wanted to be able to explain in detail what it means to have these illnesses, and how to prevent morbidity. I find that I spend a longer time initially explaining a patient's condition to him or her in a way that makes the patient appreciate the importance of early management. My own background has helped me appreciate what our residents know, what they would benefit from knowing, and how to best help them acquire self-management skills.

I have worked with a population of about 200 public housing residents for several years, and have experienced the challenges of caring for the elderly, including those posed by non-compliance, depression, and polypharmacy. Additionally, caregiver responsibilities put a large strain on many family members of geriatric patients. Traditionally, one spouse provides care for another with more acute health concerns. The caregiver may focus on the care of the spouse and ignore his or her own health needs. Additionally, a growing number of geriatric patients are caregivers for grandchildren either full time or part time, helping their working adult children by providing childcare.

Mrs. Smith (not her real name) is a 65-year-old woman with a history of poorly controlled diabetes, hypertension, chronic renal insufficiency, and elevated lipids. She has not been to my office in over 6 months. I see her getting her mail from time to time on my way to my office. I ask her why I have not seen her in such a long time. She informs me that her husband has been in and out of the hospital with heart problems over the last few months. She is waiting for him to get better before seeing me. I ask her who will take care of him if her health takes a turn for the worse because of neglect. She does not have an answer for me; however, when she comes back three weeks later, Mrs. Smith informs me that she has begun to think about her health as well as that of her husband's. In such ways, incidental contact with a patient in his or her place of residence enables the clinician to encourage follow up. If I did not practice in the public housing facility, I would not have this access to the people.

When a patient comes to the office requesting a prescription refill, I direct my staff to check our electronic medical records to see if he or she has been seen recently and, if not, to schedule an appointment for the soonest time available (immediately when possible). A frustrating part of being a clinician is keeping track of patient medications. Some patients have multiple co-morbid conditions that are co-managed by several specialists. This leads to patients who have several physicians writing different prescriptions for them. As a primary care provider, I have to keep track of these medications, and watch out for duplicates or fatal interactions. My patients—young and old—often do not bring their medications to the office even when I ask them to. In my Public Housing Primary Care office, the patient will either go and get their medications or have a family member bring them down. I have another practice outside of the public housing site, though, and from there we have to call the specialist's office or the pharmacy to see what new medications the patient is taking.

For me, place matters with respect to health in a positive way. Since I am located in the building where my patients live, I often have daily contact with them or their family members. My staff and I understand first hand their realities and this has allowed us to develop trusting partnerships with them.

Opportunities for the Future

As the Public Housing Primary Care program and community-based agencies expand and re-engineer their programs to meet the changing needs of the community, they continue to build upon their successful efforts to assist residents in public housing to participate actively in their own health care. At the same time, these projects can serve as a catalyst for other community resources and economic enterprises to better support the health, social and physical needs of their clients. Active Living is one way to create healthy communities for public housing residents to break the cycle of obesity and chronic disease. Community support agriculture (CSA) and farmers' markets, outreach vans, and educators recruited from the community are ways to strengthen the health of communities.

Opportunities exist for partnerships between PHPC health centers and the community at large, including housing authorities, health departments, community-based organizations, churches, schools, recreation projects, national non-profit organizations,

and federal entities. These links among and between services to improve the health and welfare of the community are vital to building healthy communities. Patients who engage in self-management goals often feel empowered to take on other obstacles in their lives. Public Housing Primary Care health centers are a force in helping people to engage in positive health behaviors, which can lead to increased self-sufficiency.

Health is not the only priority for public housing residents; economic self-sufficiency and economic solvency also are paramount. Any new direction for resident programs in public housing should be based on an assessment of the problems resident families face today. Given that the majority of household units have children, there is an opportunity to begin to provide wellness care and prevention of chronic disease to shape and model a healthier future for the children raised in public housing. New initiatives need funding to expand, and best practices must be promoted and replicated. Longitudinal studies are needed to document multiple health hazards and conditions at various levels including individual, housing unit, neighborhood, and metropolitan area.

Lastly, there is a need for new research initiatives to address the causes of health disparities in public housing communities, as well as evaluation of best practices to improve the health status of residents in public housing. Public Housing Primary Care health centers seek to address disenfranchisement through innovative practices, outreach, and partnerships between clinicians, consumers and community.

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Notes

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