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PRIMARY CARE FOR RESIDENTS OF PUBLIC HOUSING:

ACCESS STARTS AT HOME

NATIONAL NURSE-LED CARE CONSORTIUM
a PHMC affiliate

CONTENTS

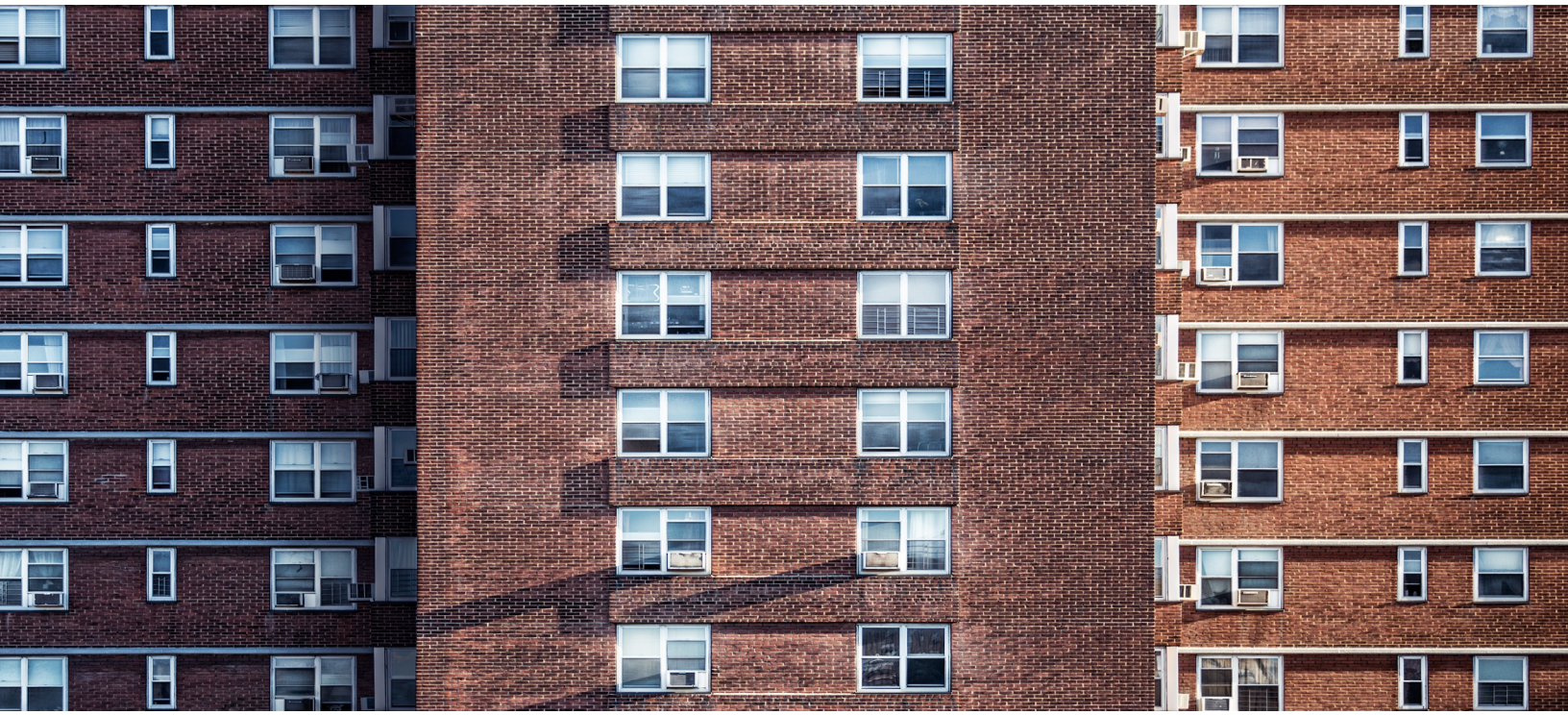
PRIMARY CARE FOR PUBLIC HOUSING RESIDENTS:
ACCESS STARTS AT HOME

EXECUTIVE SUMMARY

Health centers are at the forefront of partnering with residents of public housing to improve health outcomes for communities across the country. As the landscape of public housing evolves in the United States, health centers continue to build on existing models of care to create new solutions to meet the changing needs of residents.

This report details the barriers that inhibit residents of public housing from accessing healthcare, and how federally qualified health centers (FQHCs) are responding to those challenges with innovative programming.

This is a practical resource for health center administrators, federal agency staff, local housing authorities, and other stakeholders interested in increasing access to primary health care to improve health outcomes and equity for residents of public housing.



PUBLIC HOUSING: HISTORY, CONTEXT, AND OVERVIEW

Public housing was initially created as a response to the Great Depression, but has since evolved into a complex system of both public and private funding, regulation, and structure (National Nurse-Led Care Consortium 2019). Traditional public housing, which consists of project-based units owned and operated by housing authorities, is becoming the exception, not the rule, to the public housing landscape (2019). Yet, as described below, the individuals and families residing in traditional public housing are in need of comprehensive, equitable services (like healthcare) to reduce the disparities they experience and, ideally, provide them with opportunities to cultivate financial wellness.

Although the number of traditional public housing units has declined significantly since the 1990's (and relatively few have been replaced with new units), public housing developments are still present in all 50 states, the District of Columbia, and United States territories (such as Puerto Rico) (HUD User, 2019). In 2019, there were an estimated 1,909,223 individuals in the United States living in public housing developments. These individuals reside in 914,549 public housing units, paying an average monthly rent of $348 (2019). Public housing serves as an important safety net resource for the young and old; in 2019, 37% of households had children 17 years of age and younger, while 34% of heads of households living in public housing were aged 62 or older (2019).

Public housing developments are home to diverse people across the country. Nationwide in 2019, 71% of residents of public housing developments were racial or ethnic minorities. The three most common racial/ethnic demographic characteristics[1] of residents were as follows: 43% of residents were non-Hispanic Black; 29% were non-Hispanic White; and 24% of residents identified their ethnicity as Hispanic (of any race). Women make up the majority of heads of household in public housing, with 74% of all households based in public housing headed by women in 2019.

Many residents of public housing have limited financial resources; 75% of households living in public housing have incomes under $20,000 per year. The average household size is 2.1 people with a mean annual income of $15,738, (HUD user, 2019) falling below the 2019 poverty guideline for a household of two ($16,240) (Office of the Assistant Secretary for Planning and Evaluation, n.d.). The proportion of disabled residents will likely continue to increase: 34% of household heads/spouses are age 62 or older. Additionally, 31% of household heads age 61 or younger have a disability, while 24% of all persons living in public housing have a disability.

Residents of public housing share increased risk for chronic health conditions, including cardiovascular disease, diabetes, and asthma.

Source: Adapted by Lauren Taylor from Gibson et al. 2011, Sandel et al. 2018, Maqbool et al. 2015, and Braveman et al. 2011.

1 Note that here and elsewhere in the report, rave/ethnicity data is reported using terms consistent with the original data sources. HUD uses race and ethnicity together (eg, non-Hispanic Black) while HRSA data separate out race and ethnicity (e.g. Black/African American patients may be of any ethnicity and Hispanic/Latino patients may be of any race.

A variety of social determinants of health (SDOH) contribute to these health disparities, such as experiences of poverty, racism, isolation, violence, and crime (National Heart, Lung, and Blood Institute, 2005). Research suggests that housing and health are connected through four pathways: stability, quality and safety, affordability, and neighborhood factors (Taylor, 2018). Residents of public housing often have a history of unstable, unsafe, unhealthy, and/or unaffordable housing. For example, children living in public housing are at an increased risk of developing asthma when compared to children living in private family homes (Hayward, et al., 2015).

Traditionally, public housing has been located in lower income neighborhoods (with 33% of the population under the poverty line compared to the national poverty rate of 11.8%), and in census tracts with a high representation of racial/ethnic minorities (61% on average) (United States Census Bureau, 2019). As a result, residents of public housing live in neighborhoods less accessible to healthy foods, in built environments less conducive to physical activity, with more tobacco retailers, and experience other factors through which racial and economic segregation are known to affect health (Larson, Story, & Nelson, 2009; Dahmann, et al., 2010; Yu, et al., 2010; Williams & Collins, 2001). Additionally, limited resources inhibit accessibility of routine and preventive health care as compared to the general population. Residents experience greater exposure to adverse childhood experiences and trauma that also impacts both physical and behavioral health conditions.

One in three residents of public housing are elderly, necessitating health center services and programs that are responsive to the needs of older adults. HUD administers several programs to support older adults (such as the Section 202 program), yet there is limited availability of low-income units for aging residents (U.S. Department of Housing and Urban Development, n.d.a). The U.S. Census Bureau approximates that by 2030, the 65 and older population will exceed 74 million, which would be roughly a 55 percent increase from 2015 (Uphaus, 2019). As the population of older adults continues to rise, health centers can play a pivotal role in facilitating necessary connections that promote successful independent livability for these individuals, especially for residents of public housing. Research studies illustrate the positive effects that aging in place can have on the overall health of older adults, such as better health outcomes, life satisfaction, and self-esteem when compared to aging in a nursing home (American Association of Retired Persons, 2017).

Overall, existing research on public housing demographics and health issues demonstrates an increased need for patient-centered, affordable, high-quality care. Residents of public housing are racially diverse, low- income, aging, more likely to have or care for someone with a disability, and are exposed to adverse SDOH. By providing behavioral health and other supportive services to care for the whole patient, health centers support management of complex health issues, such as co-occurring diabetes and cardiovascular disease. Additionally, health centers are equipped to ensure residents have access to services by providing mobile health vans and conducting home visits in order to provide full access to routine and preventive care (Stone, et al., 2019).

HEALTH CENTERS SERVING RESIDENTS OF PUBLIC HOUSING: OVERVIEW, DEMOGRAPHICS, AND HEALTH OUTCOMES

OVERVIEW

The Health Resources & Services Administration (HRSA) funds health centers throughout the United States to address health disparities and provide comprehensive primary care to underserved patients. Nearly 30 million people nationwide rely on a HRSA- funded health center for care, including 1 in 3 people living in poverty and 1 in 8 children (Health Resources and Services Administration, Uniform Data System, 2019). Some health centers receive grant support designated for the federal Public Housing Primary Care (PHPC) program, a designation that specifically supports health centers located within public housing developments, or that are immediately accessible to residents of public housing. PHPC funding is linked to a traditional public housing model, and health center eligibility is tied to brick-and-mortar public housing developments, as opposed to voucher programs. The PHPC program supports health services tailored to the special needs of people living in public housing (National Association of Community Health Centers, n.d.). To qualify for PHPC funding, health centers must demonstrate that they serve residents of public housing and that those individuals experience a shortage of services. Health centers must demonstrate that they have consulted with the residents of public housing and the housing authority in their area (via local/regional housing authorities) to be eligible for funding. These health centers must also track and report to HRSA at least one additional Clinical Performance Measure (beyond the usual Uniform Data System data set requirements) that addresses residents' unique health needs. Furthermore, to receive PHPC funding, health centers must have governing boards that include residents of public housing.

The number of health centers funded to provide primary care to residents of public housing has increased in recent years, with 108 grantees receiving PHPC funding as of the 2019 UDS report (HRSA, 2020). An additional 419 HRSA-funded health centers (who do not receive PHPC funding) identify as located in or accessible to residents of public housing and provide care to millions of patients every year. In total, 527 health care organizations report serving patients living in public housing in at least one health center location.

Figure 1. PHPC Grantee Locations

DEFINITIONS AND DATA

The Uniform Data System (UDS) is utilized by all health centers in the United States, including all organizations funded by the PHPC program. Sponsored by the HRSA Bureau of Primary Health Care (BPHC), UDS tracks clinical, operational, and financial data, including patient demographics, clinical indicators, services provided, costs, staffing, and revenues. Drawing from 2013-2019 UDS data sets, the Access Starts at Home report aims to describe primary care resources available to residents of public housing using the best and most recent health center data available. The following sections of this report summarize data for HRSA grantees receiving PHPC funding in 2019.

It is important to note that some of the service-focused UDS data in this report are reported at the organizational level, which limits the ability to focus data analysis on individual health center sites. In the UDS, data from individual health center sites that are in or accessible to public housing and are part of a larger health center network are reported in aggregate across the network. UDS data does not enable focused analysis of health status indicators or service utilization for patients who are residents of public housing. In the case of large health center entities with multiple sites serving diverse populations, UDS data reporting requirements may mask the unique characteristics of the PHPC site. Similarly, when a large health center network operates multiple sites, data related to residents of public housing is aggregated with the grantee's data regarding all patients. When examining PHPC data more closely, these constraints must be kept in mind. Additional information on report methodology and data sources is provided in Appendix 2 (Methodology).

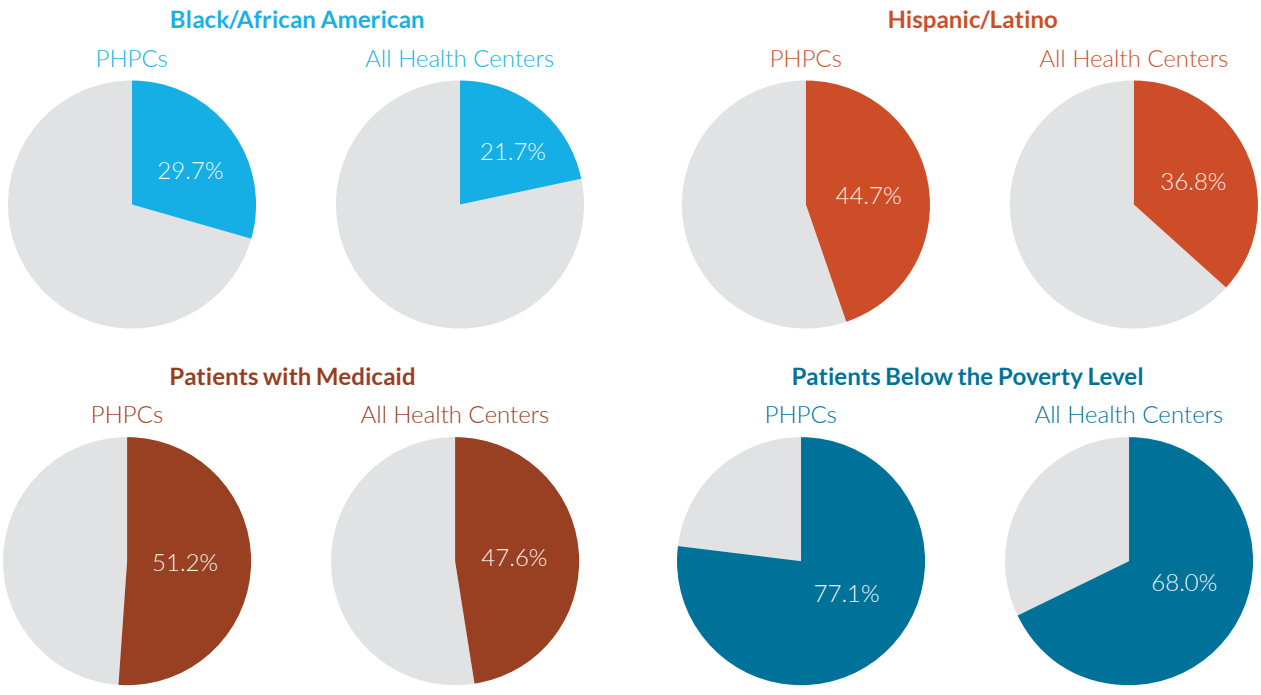
PATIENT CHARACTERISTICS AMONG ALL HEALTH CENTERS SERVING RESIDENTS OF PUBLIC HOUSING

In 2019, the 108 organizations that received PHPC funding to provide primary care services to residents of public housing served more than 3,749,110 patients at all locations and 1,038,325 patients at locations that are accessible to residents of public housing (HRSA, 2020).

Compared to health centers overall, PHPC-funded organizations:

- Served a higher percentage of patients with Medicaid (51.17% of patients as compared to 47.61% of patients among health centers overall);
- Served a lower percentage of patients with private health insurance (14.94% of patients as compared to 18.93% of patients among health centers overall);
- Served a higher percentage of patients with incomes at or below the federal poverty level (77.05% of patients reporting income as compared to % of patients among health centers overall);
- Served a higher percentage of Black/African American patients (29.68% of patients with known race as compared to 21.69% of patients with known race among health centers overall);
- Served a lower percentage of White patients (61.43% of patients with known race as compared to 68.07% of patients with known race among health centers overall);
- Served a higher percentage of Hispanic/Latino patients of any race (44.73% of patients with known ethnicity as compared to 36.84% of patients with known ethnicity at health centers overall); and
- Engaged a higher percentage of patients best served in a language other than English (30.73% of patients as compared to 24.66% of patients among health centers overall) (HRSA, 2019)..

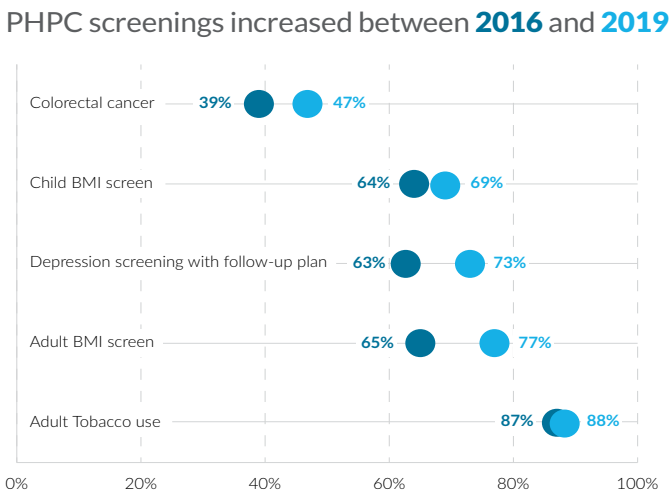
The information highlighted above indicates that PHPC sites continue to treat medically underserved patients at higher rates than the average non-PHPC counterpart.



HEALTH SERVICES AND PATIENT OUTCOMES AMONG HEALTH CENTERS SERVING RESIDENTS OF PUBLIC HOUSING

This section of Access Starts at Home examines 2019 UDS data regarding clinical measures and health outcomes at the 108 PHPC funded health center organizations. Access Starts at Home compares UDS data for this group of health centers with Healthy People 2020 benchmarks and historical UDS data. An initiative of the U.S. Department of Health and Human Services, Healthy People 2020 provides science-based, national health outcome benchmarks to encourage innovation and progress in key areas of patient care (Office of Disease Prevention and Health Promotion, 2014). As described in detail below, health centers serving residents of public housing are making progress to support Healthy People 2020 goals. PHPC organizations have also demonstrated increases in many areas of documented preventive care and counseling since 2015 (see Figures 3 and 4). These increases should be interpreted with caution, since PHPC health center organizations have increased over time. Still, the data suggest that more patients are receiving these screenings as a part of routine care at organizations serving residents of public housing.

Figure 3. Key PHPC health screenings increased between 2016 and 2019



SCREENING

Between 2016 and 2019, PHPC health centers have made progress in increasing the prevalence of key screenings for adults and children. Each of these represents a priority area identified by HRSA.

Colorectal cancer screenings rose. Among PHPC health center organizations, the rate of screening for colorectal cancers in accordance with clinical guidelines increased from 39% in 2016 to 46.6% in 2019 (HRSA, 2020). Increasing colorectal screenings is an important goal, because screening and removing small polyps before they can become cancerous can greatly decrease colon cancer incidence. The Healthy People 2020 benchmark is to reach a colorectal cancer screening rate of 70.5%, so PHPC health center organizations are still working to achieve this goal. Capacity-building activities centered on evidence-based and promising practice interventions, such as patient navigators, have the improved colorectal cancer screening rates among public housing residents and have the potential to continue to increase screening rates.

Child and adult BMI screenings both increased. By 2019, 69% of patients age 3-17 at PHPC health center organizations had at least one BMI screening with counseling on nutrition and physical activity (up from 64%). In 2019, 76.5% of adults age 18 and older had a past-year screening with follow-up plan if BMI was outside of normal parameters, up from 65% in 2016. Healthy People 2020 goals for BMI assessment are on the provider level (48.7% of providers assessing adult BMI and 49.7% assessing child/adolescent BMI), however, the increase in screenings suggests that regular BMI assessments and discussions about nutrition and physical activity are standard practice for many providers at PHPC health centers, likely surpassing the goals. Promising practices from successful BMI screening protocols and processes in PHPC and accessible health centers may help inform areas where surveillance is less impressive, such as colorectal cancer screenings and A1C testing for patients with diabetes.

Depression screenings increased substantially. Past year screening for depression among patients ages 12 and older with a follow-up plan for those positive for depressive symptoms increased from 63% in 2016 to 73% in 2019. Healthy People 2020 goals for adults age 19 and older and adolescents 12-18 focus on increasing screening in each office visit with a provider to 2-3% of visits and are not directly comparable. However, the high annual patient screening rates suggest that many provider encounters at PHPC health center organizations include depression screening.

Adult Tobacco use screenings increased slightly. Rates for adult tobacco use screening and cessation counseling receipt were already very high at PHPC health centers in 2016. The 2019 rate of screening and referral to counseling in PHPC health center organizations (88%) far exceeds the screening target (68.6%) set by Healthy People 2020, and is approaching the 90% cessation treatment goal set by the American Academy of Family Physicians (AAFP). Appropriate assessment and tobacco cessation counseling is especially important for residents of public housing because of recent HUD policy changes mandating all public housing to be smoke-free by July 30, 2019 (HUD, n.d.b). PHPCs are well positioned to provide support to PHAs and other local partners to ensure they can meet the requirements of the rule.

CHRONIC CONDITION MANAGEMENT

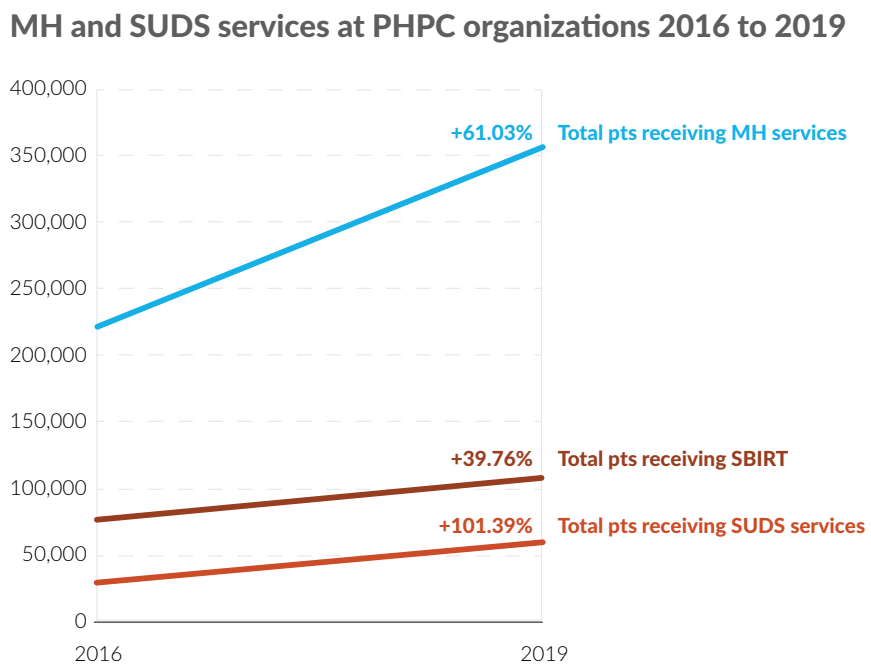
In addition to screenings, PHPC health center organizations play several crucial roles in helping patients to manage chronic conditions through primary care, patient education, and other supportive services. As stated earlier, residents of public housing are likely to live in circumstances and have experiences that make these conditions harder to manage than the average patient. Two examples are Type II diabetes blood sugar control and hypertension control.

Type II Diabetes blood sugar control. By testing a diabetic patient's Hemoglobin A1C levels, clinicians are better able to assess and understand a person's average blood sugar over a period of weeks and months. An A1C level over 9% (commonly denoted as A1C>9) indicates poorly controlled diabetes. Among PHPC grantees, 33.4% of patients with diabetes had A1C>9 or no test in 2019. Unfortunately, far more patients at health centers serving residents of public housing have an A1C >9 than the Healthy People 2020 goal of 16.2%. However, the Healthy People goal does not count untested patients as "uncontrolled" in the same way that UDS indicators do. One effective way to improve the UDS indicator scores could be to ensure that patients with a diabetes diagnosis have their A1C tested annually, even if their primary reason for an appointment is something other than diabetes management. Reducing the proportion of diabetes patients with an A1C>9 (or lacking a recent test) is an important goal, and diabetes is a priority condition for health centers given its high prevalence among underserved populations.

Hypertension under control. Among PHPC grantees, the proportion of patients with hypertension and whose condition was under control was 63.8% in 2019. Adequate control means that the patient's blood pressure had been tested at least once and was never tested to be 140/90 or higher during the past year. This proportion exceeds the Healthy People 2020 goal of 61.2%. However, it is important to note that patients with high but untested blood pressure are not included in this measure, meaning that patients who use the clinic on a less than annual basis are not reflected. Nevertheless, these indicators suggest that PHPC health centers are achieving success in helping patients self-manage their hypertension, and these techniques could be extended to other chronic conditions.

Mental and behavioral health are also a key component to health and one which PHPC health center organizations have recently enhanced services. Overall, mental and behavioral health services at PHPC health centers increased considerably between 2016 and 2019. These increases may be linked to additional funding made available to address the opioid epidemic during that time. This chart depicts the growth of mental health (MH) and substance use disorder (SUD) services provided to patients between 2016 and 2019.

Figure 4: Mental health and substance use disorder service use at PHPCs increased 2016-19.



Patients receiving Screening, Brief Intervention, and Referral to Treatment (SBIRT) (a public health approach to intervening with patients who use substances and may be at risk for substance use disorders) at PHPC health center organizations increased 39.8% from 76,905 in 2016 to 107,480 in 2019. Patients receiving services for SUD at PHPC organizations more than doubled to reach 59,899 patients in 2019, and patients receiving MH services reached 356,289 by 2019, an increase of 61% over the patients served in 2016 The total FTE for all staff in these categories at PHPC health center organizations increased 67% from 1255.12 FTE to 2097.45 FTE on average in 2019. These staff include psychiatrists, psychologists, licensed clinical social workers, other licensed providers (such as psychiatric nurse, family therapists, and psychiatric social workers), and other mental health staff (such as certified recovery specialists or any other provider). The vast majority (99%) of PHPC health center organizations provided mental health and/or substance use disorder services by 2019.

RECOMMENDATIONS

The homes and neighborhoods where public housing residents live, learn, work and play often lack the necessary supports and resources to enable residents to live their healthiest lives. PHPC-funded health centers are uniquely situated at this intersection of health and housing; however, siloed health and housing funding streams, as well as other factors, can make it difficult for health centers to fully address the complex health and social needs of public housing residents. With this context in mind, Access Starts at Home makes the following recommendations:

- Health centers should target programming to improve health outcomes related to diabetes and colorectal cancer screening. Overall, PHPC awardees perform well in relation to Healthy People 2020 benchmarks, especially with regards to preventive and counseling services. However, there are opportunities to target programming related to diabetes and colorectal cancer screening.

- Health centers should work to develop innovative health programs in collaboration with local public housing stakeholders to improve health and service linkages for residents. By fostering coordination and information-sharing with local public housing authorities, PHPC-funded health centers will be better able to fulfill their purpose and ensure that public housing residents' health needs are fully addressed.

- Health centers must coordinate efforts with local housing authorities in order to ensure that health services are truly reaching residents of public housing, in all places where they reside. Given larger trends towards decentralization in public housing, PHPC-funded health centers must partner with housing authorities to assess the impact that relocation of residents may have on health access, and develop strategies to ensure continuity of care.

- Health centers should prioritize interdisciplinary care (including behavioral health integration) to meet the complex needs of residents of public housing. PHPC organizations are poised to offer comprehensive, equitable services that meet the holistic needs of patients and families through team-based models of care that emphasize person-centered interventions.

CONCLUSION

Demographically, residents of public housing face several challenges as compared to the general population. Low income levels, systemic racial discrimination, barriers for people with disabilities, and the increased health complications associated with aging all mean that the average resident of public housing has complex healthcare needs that go well beyond the exam room.

Because the health center model provides patient care regardless of insurance status or ability to pay, health centers are well situated to meet the needs of residents of public housing. Over one hundred community health centers located within or accessible to public housing developments reach these patients with funding from the Public Housing Primary Care program. These health centers see patients with adverse SDOH in a variety of categories: their average patient is more likely to be non-white, insured through Medicaid, best served in a language other than English, and living below the federal poverty line.

Despite treating a higher proportion of medically underserved populations, PHPC health centers have been able to increase testing and screening capacity across several categories in recent years. As models of public housing continue to evolve and change, these health centers will be in need of innovative approaches to continue meeting their patients' complex health and wellness needs.

APPENDICES

APPENDIX 1: ABOUT THE NATIONAL NURSE-LED CARE CONSORTIUM (NNCC)

The National Nurse-Led Care Consortium (NNCC) is a 501(c) 3 non-profit organization that, as part of its mission, has provided technical assistance to health centers since its inception in 1998. NNCC leverages national, regional, and local partners in public health, health care, housing, academia, government, and law to provide free and low-cost training and technical assistance to health centers, including Public Housing Primary Care (PHPC) and other special population grantees, and other health centers looking to ensure long-term sustainability. NNCC provides in-person and web-based trainings as well as one-on-one technical assistance to help all centers become vibrant, long-lasting providers of high quality, cost-effective health care for vulnerable communities.

Since 2008, NNCC has received a National Cooperative Agreement (NCA) from HRSA to provide technical assistance services to health centers serving residents of public housing. Each year, more health centers throughout the nation that serve vulnerable populations, in public housing and beyond, take advantage of the training and technical assistance services offered by NNCC through its NCA. Through individual consultation, national learning opportunities, and peer learning sessions, NNCC staff equip health center providers and community partners with promising practices to meet the needs of residents of public housing and other vulnerable populations. NNCC also provides training and technical assistance to primary care associations and health center controlled networks to improve capacity in addressing the needs of their member health centers.

NNCC continuously updates and expands its extensive web-based Resource Library at https://nurseledcare.org, which provides materials and resources free to all.

APPENDIX 2: REPORT METHODOLOGY AND ACKNOWLEDGMENTS

Methodology

This report primarily uses Health Resources & Services Administration (HRSA) Uniform Data System (UDS) data from 2013-2018 to assess patient populations, outcomes, and quality measures of health center organizations receiving Public Housing Primary Care (PHPC) funding, as well as health centers that do not receive PHPC funding but reported serving residents of public housing in UDS. These data are compared to HRSA Healthy People 2020 goals, which serve as benchmarks for progress toward care-related goals and objectives for the nation. Health outcome, clinical measures, and demographic data are available only at the organizational level through UDS data. Due to the format of available data, this report considers data at the organizational level, but it is important to keep in mind the limitations of this approach.

In addition to HRSA UDS data, the authors also reviewed 2018 data from the U.S. Housing and Urban Development (HUD) public housing dataset to describe the overall demographic characteristics of residents

of public housing. Each year, HUD reports demographic information about individuals receiving housing assistance. As described in this report, HRSA's definition of public housing focuses on serving residents of public housing developments. As a result, this report does not describe the characteristics of individuals receiving Housing Choice vouchers (often referred to as Section 8) or other types of HUD support.

ACKNOWLEDGMENTS

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