



Can Resident Health Advocates boost
public housing residents'
use of a health screening van?

Who did this study?

The study was done by the Partners in Health and Housing Prevention Research Center (PRC). This is a four-way partnership for health research among Boston's public housing residents—in particular, among residents of the city's family housing developments. Like other PRCs around the country, this one is funded by a government agency, the US Centers for Disease Control and Prevention. The four partners are:

- the Boston University School of Public Health,
- the Boston Public Health Commission,
- the Boston Housing Authority, and
- the Community Committee for Health Promotion.

The Community Committee for Health Promotion is made up mostly of people who live in the Boston Housing Authority's family developments. It also includes some community leaders and people from key agencies. The committee takes an active role in every stage of the research process—from planning the studies to writing up the results.

What is a Resident Health Advocate?

Every year since 2001, the Partners in Health and Housing PRC has trained a group of public housing residents to work as Resident Health Advocates. Resident Health Advocates are also called RHAs. They are community health workers in the family housing developments of the Boston Housing Authority—right where they live.

In their training, RHAs learn basic information about some health problems that affect a lot of public housing residents. For example, high blood pressure, high cholesterol, diabetes, and

poor dental health are common problems among public housing residents.

RHAs-in-training also learn where residents can find health care in their own neighborhoods. For example, they learn where nearby community health centers are located, and they learn about the programs and services that these centers offer.

After RHAs complete their training, they do an eight-month paid internship. Each RHA works in her or his own housing development. During this internship, the RHAs give their fellow residents basic information about common health problems. RHAs also guide residents to nearby health care. The RHAs benefit, too: their training and internship experiences can help them get jobs in health care, or get more advanced training.

Why did we do this study?

We already know that high blood pressure, high cholesterol, diabetes, and dental disease are serious health problems. We also know that these conditions are more common in public housing residents than they are in other US residents.

Often people live with these health problems for a long time. If people get the right care, they can feel better, do more, and live longer. But, for example, if a woman doesn't know that she has high blood pressure, she won't get the care she needs.

That's why it's a good idea to check a whole group of people to see if they have an important health problem. This is called screening. Once you identify the people who have high blood pressure or high cholesterol, you can help them get the care they need. And of course, the more people you screen, the more people you can help.

There is a catch: screening can help people only if the people actually come to get screened—and this is where the Resident Health Advocates fit in. It seemed natural that RHAs could help get more public housing residents into health screening programs.

Still, before the Partners in Health and Housing PRC could recommend this approach to health professionals in other cities, we had to find out for sure if it would work. And that's what this study did: it tested the idea that more residents will get health screening if an RHA is active in their housing development.

How exactly did we do this study?

The study took place during two summers, and it was set up like this. In the summer of 2007, a health screening van visited each of four housing developments three times. The van's staff screened adult residents for high blood pressure, high cholesterol, high diabetes risk, and dental disease.

The van is run by the Boston Public Health Commission. The Commission followed its usual procedures for letting residents know that the van was coming. At all four developments, the development manager was given flyers to let residents know about the screening van's visits, and the manager distributed these in the usual way. The flyers described the screening van and its schedule, in English and Spanish.

But at two of the developments, something extra was added. In these developments, a bilingual RHA asked another resident to help her, and the two of them worked hard to motivate residents to use the screening van. They repeatedly distributed the flyers all around the development, going door to door. RHAs talked to residents one-on-one about the

screening van, answered their questions, and even helped them to the van on screening day.

The researchers also found a way to be fair to people in the two developments that did not get the "something extra" in 2007. These developments did receive the extra service the next year. In the summer of 2008, when the health screening van made its visits, an RHA and another resident worked hard to encourage people to use the van—just as they had in other developments in 2007.

At the end of the second summer, the PRC researchers counted up the number of residents who had been screened. First they counted those who had been screened in 2007 in the developments where no RHA was present. Then they counted up those who had been screened in a development where an RHA was helping and encouraging residents (in either 2007 or 2008).

Finally, the researchers did some arithmetic so they could answer this question: Did a higher percentage of a development's residents get screened when there was an RHA present who went the extra mile?

What did we learn?

In the housing developments where no RHA was working, 3.4 percent of adults were screened. In other words, between 3 and 4 out of every 100 adults were screened. But in the housing developments where the RHAs were working, 5.8 percent of adults were screened—almost 6 out of every 100 adults. Many of the people who screened positive for high blood pressure, high cholesterol, or high diabetes risk did not know about their condition, and had not been taking a prescription medication for it.

Does this difference matter?

The difference between 3.4 percent and 5.8 percent may not seem very big. Still, this difference was “statistically significant.” To a researcher, this means that it probably didn’t happen just by chance. In other words, the effect of the

Resident Health Advocates on screening rates was real, even though it wasn’t big.

And taking a broader view, this difference could have a real-world impact. Of all the residents who were screened during the study, about two-thirds turned out to have at least one of these health problems: high blood pressure (hypertension), too much cholesterol, high diabetes risk, or dental disease (see table). This suggests that even a modest increase

in the rate of screening among public housing residents nationwide would benefit a large number of people.

Screening diagnosis	Percent who had a positive screening result
stage 1 or 2 hypertension	29.5
borderline or high cholesterol	23.5
high diabetes risk	66.3
need for follow-up dental care	52.6

Looking ahead

These results emphasize the value of both Resident Health Advocates and van-based screening services for public housing residents. We hope that both will be used more widely to help this underserved population get screening for chronic diseases.

But of course, screening alone isn’t enough. The results of this study also remind us how important it is to link screening to follow-up medical care for important chronic diseases. And more broadly, these results highlight the importance of linking public housing residents into primary care.

This is a reader-friendly summary of a published research article:
Rorie J, Smith A, Evans T, Horsburgh CR, Brooks DR, Goodman R, et al. Using resident health advocates to improve public health screening and follow-up among public housing residents, Boston, 2007-2008. *Prev Chronic Dis* 2011;8(1).
http://www.cdc.gov/pcd/issues/2011/jan/09_0103.htm. Accessed January 25, 2011.