APPENDICES

Appendix A – Mapping of Existing Data

Appendix B – Community Health Initiative Ethnography Report

Appendix C – Asset Mapping Interview Guide

Appendix D – The Access Partnership (TAP) Manuscripts

Appendix E – Latino Health Seminar Progress Report

Appendix F – Messaging and Communication Capacity Building Workshop Evaluations

Appendix G – Nuts and Bolts of Program Evaluation Capacity Building Workshop Evaluation

Appendix H – Community-University Collaborating Committee Membership List

Appendix I – Abstracts of 2011 Small Grants Awardees

Appendix J – Review of Small Grants Program

Appendix K – Post-Doctoral Fellow Report
Number of Children Hospitalized for Asthma with Asthma
Baltimore City by Zip Code, 2009 and % Change 2000 to 2009
Percentage of People with Vaccine Preventable Diseases per 10,000 people by Zip Code, Baltimore City, 2000 and 2005

Legend

**Zip Codes**
- East Baltimore Area
- Neighborhoods

**% of people with vaccine preventable disease**

**2000**
- 0.0 - 2.7
- 2.8 - 9.1
- 9.2 - 13.0
- 13.1 - 17.7
- 17.8 - 20.6

**2005**
- 0.0 - 10.4
- 10.5 - 20.7
- 20.8 - 31.1
- 31.2 - 41.4
- 41.5 - 51.8
Percentage of People with Vaccine Preventable Diseases per 10,000 people, by Zip Code, Baltimore City, 2009 and % Change 2000 to 2009

Legend
Zip Codes
East Baltimore Area
Neighborhoods
% of people with vaccine preventable disease 2009
0.0
0.1 - 0.7
0.8 - 1.3
1.4 - 1.9
2.0 - 2.6

Legend
% of People with VCP per 10,000 people
% Change 2000-2009
-3.9 - 0.0
-7.9 - -4.0
-11.9 - -8.0
-15.9 - -12.0
-20.6 - -16.0
Percentage of Births where Mothers Received Early Prenatal Care, Baltimore City 2000 and 2005
Percentage of Mothers Receiving Early Prenatal Care
Baltimore City, 2009 and % Change 2000 to 2009

Legend
- Neighborhoods
- % of births where mothers received early prenatal care 2009
  - 0.0
  - 0.1 - 75.7
  - 75.8 - 84.4
  - 84.5 - 93.1
- Community Statistical Area
- East Baltimore Area

Legend
- Neighborhoods
- % change in % of births where mother received early prenatal care 2000 to 2009
  - 14.2 - 31.1
  - 6.2 - 14.1
  - 0.1 - 6.1
  - -3.8 - 0.0
  - -9.7 - -3.9
- Community_Statistical_Areas
Percentage of Babies Born with Satisfactory Birth Weight by Community Statistical Area, Baltimore City, 2000 and 2005
Percentage of Babies Born with Satisfactory Birth Weight by CSA, Baltimore City, 2009 and % Change 2000 to 2009
Violent Crime Rate by Community Statistical Area
Baltimore City, 2000 and 2005

Legend
- Neighborhoods
- Community Statistical Areas

2000
Violent Crime Rate (# of violent offenses per 1000 people)
- 0.0 - 9.7
- 9.8 - 18.7
- 18.8 - 29.7
- 29.8 - 87.3

2005
Violent Crime Rate (# of violent offenses per 1000 people)
- 0.0 - 9.7
- 9.8 - 19.2
- 19.3 - 29.7
- 29.8 - 87.3
Number of Residences by Community Statistical Area, 2000 and % Change 2000 to 2009
Food Deserts in Baltimore City, 2011
Mid-December Report on the Assets Mapping Project:
The Anthropological Component
December 19th 2011

Background

As of mid-December, Mike Rogers, Aaron Goodfellow (Department of Anthropology), and Eric Rice (Urban Heath Institute) have been conducting the ethnographic research outlined in the Anthropological Work Plan to accompany the Community Health Initiative’s Assets Mapping Project being conducted by Urban Health Institute’s (UHI) East Baltimore Health Initiative. The invitation came in July 22nd, Mike Rogers accepted the work July 22nd, and Aaron Goodfellow on July 25th. A job description was submitted n August 16th. Monitoring began immediately. A formalized, dated, Work Plan was presented to Dr. Robert Blum and Dr. Chris Gibbons on October 16th, acknowledged October 19th, 2011. The work of our component of the project was supported with funds from Jane Guyer (Department of Anthropology), the Provost’s office, and UHI (2 months of Mike’s salary) for a projected 6 months: August 2011 thru end of January 2012.

Summary of activities: Mike, Aaron, Eric

At initial meetings, it had been expected that the whole mapping field project would be completed “by Thanksgiving”, and the report by January 1st 2012, hence the time horizon of 6 months for completion of the ethnographic project. During the past five months, the team has organized and attended bi-weekly informational meetings with Dr. Chris Gibbons of the UHI, and in preparation for the mapping itself, they have:

- Attended four ‘All Partners’ meetings (August 15th, September 22nd, October 6th and October 27th); taken part in the ‘Community Assets Mapping Training’ conducted on August 16th; attended an ‘All Partners’ discussion on UHI’s progress in hiring a “Project Coordinator” (December 6th); and attended a workshop about finalizing the asset mapping instrument (December 13th).
- Conducted six interviews with participants in the ‘All Partners’ meetings and the ‘Asset Mapping Project’. The interviews document the various participants’ reflections on the development and planned methods and implementation of the instruments to be used in the ‘Asset Mapping’ project. Included are community members, JHMI faculty, JHSPH staff, and a post-doctoral research fellow associated with the Urban Health institute. (Notes on these interviews to follow.)
- Collected attendance data for the ‘All Partners’ meetings for the 2011 calendar year. (The group possesses attendance records for August, September, and October 2011, and has requested the materials to document attendance at previous meetings. The requested materials were not yet available at the end of November.)
• Begun assembling an archive of the various documents and instruments circulated during the 'All Partners’ meetings, the asset mapping training held on August 16th, and the discussion of the asset-mapping instrument on December 13. The trainings were conducted and led by Jody Kretzmann of the Asset-Based Community Development (ABCD) Institute of Northwestern University, and Terri Sullivan of the Search Institute. A timeline of events, both at and between meetings, is provided as an electronic appendix due to size (see file “Mid-Term Community Health Initiative Timeline). Special attention has been given to the various versions of the evolving asset mapping instrument that have been distributed and discussed.
• Secured permission from Carley Benham, the director of the Homewood IRB to proceed with the collection of data outside of IRB review.

The team is now charting the aspirations and temporal horizons being developed for the mapping project’s completion.

Some preliminary findings and suggestions (as of December 19th, 2011):

Overall, the pace of advance has been slower and more deliberate than anticipated. The actual mapping is now projected toward three future dates:
  The hiring of the coordinator (December 2011 – January 2012)
  The hiring and training of the dyads (late January 2012)
  The field study (beginning February 2012)

Findings on participation (so far):

1.) Attendance: records for the four All Partners Meetings through October 27th and the asset mapping training on August 16th show that JHU affiliates comprise the largest group of participants. (See Appendix A: Attendance, page 5.)

  Suggestion: Since the group has been meeting for more than a year’s time, it is important to complete the record for the duration of the initiative.

2.) Decision-making: Some important decisions are made outside the formal setting and working hours of the ‘All Partners’ meetings. Examples include the development and refinement of the various instruments to be utilized for data collection, the managerial and administrative structures overseeing the hiring of fieldworkers, and the timeline for the eventual completion of the ‘Asset Mapping’ phase of the larger UHI project. That is: the formal structure of hiring, division of labor, responsibility, etc.

  Suggestion: Develop knowledge of the various networks involved in making decisions and meeting plans between the ‘All Partners’ meetings, and define what decisions can be made by meeting participants. It would be invaluable to have a record of such consultations to identify what roles the various partners have played, and when, over the life of the project – including a timeline of the decisions made and their effects.
3.) Interviews: Preliminary interviews – especially with 3 of the 6 participants - confirm a generalized suspicion that Johns Hopkins does not hold the best interests of those living in its surrounding communities as a priority. While they note that the quality and contents of the conversation taking place in the ‘All Partners’ meetings is markedly different and improved from their past encounters with the institution, they do not feel confident that the tone and style of engagement defining the ‘All Partners’ meetings extends beyond the meetings themselves.

Suggestion: Investigate the types of experiences people draw on when formulating their opinions of the Johns Hopkins medical establishment to understand the types of encounters being referenced when people describe the character of the institution and its neighborly comportment. The team would like to know how and where the hospital and its staff – at various levels, including lower-level employees - fit into wider discussions about life in East Baltimore.

4.) Development of the ‘Asset Mapping’ Instrument: The development of the asset mapping instrument has been difficult to follow solely on the basis of attending the public ‘All Partners’ meetings. While each successive revision bears a resemblance to the previous version and contains evidence of responsiveness to concerns expressed in the meetings, it is also evident that much reorganization and restructuring of the instrument takes place in forums outside the ‘All Partners’ meetings (Documented by interview data).

Drafts of the instrument were distributed September 22, October 6, and December 13 (See Appendix B: Instrument Drafts). The September 22 version contains questions generated during a pedagogical “sticky wall” exercise conducted during the August 16 ‘Assets Mapping’ workshop. The October 6 document shows substantial revisions, some of which bear an immediate relation to discussions recorded on September 22nd (for example, a reorganization to include “prompts” with some questions), and some not (such as the substantive revision and reorganization of the instrument’s structure, style, wording and progression). From participation in the group activities conducted during the public meetings, it remains unclear where such substantive changes originate. The instrument distributed on December 13 shows similar evidence of changes that well exceed those suggested during the October 6 meeting.

Suggestion: Have researchers attend the ‘Methods Group’ meetings so as to remain abreast of discussions that result in revisions to the instrument. It will be important to have a record of the consultations that alter the instrument so we might identify the various partners, such as local residents, leaders and UHI staff that have taken an active role in constructing the ‘Asset Mapping’ project. This seems crucial since the instrument distributed on December 13th will be undergoing substantial revisions following its discussion at that meeting.

Overall Plan for the Next Phase
The team plans to continue collecting data as the ‘Asset Mapping’ project works towards completion. Aaron, Mike, and Eric will:

- Continue attending the ‘All Partners’ meetings, interviewing participants and attending to the development of the various instruments to be deployed for data collection.
- Work with the ‘Managerial Committee’ charged with hiring the project manager who will oversee the hiring and training of the fieldwork ‘dyads’ and coordinate future data collection.
- Work with the ‘Methods Committee’ towards the necessary IRB clearances and refine the various research tools to be deployed.
- Continue to collect and archive the materials circulated among the ‘All Partners’.
- Transcribe all previously recorded materials, and continue observing the activities associated with the ‘Asset Mapping’ project.

At this point in mid-December 2011, it now appears that data collection will not begin until early February, 2012, which most likely places the completion of the asset mapping phase in late April, 2012. The holiday season makes it difficult to hold the meetings necessary to complete the tasks associated with developing the instrument and hiring a manager who will then coordinate the hiring and training of the dyads to be sent into the field. As a result, it is unlikely that any significant movement towards the project’s completion will take place before funding for the ethnographic component runs out. During this down time, the team will conduct interviews with the staff of the Urban Health Institute who are associated with the project. When substantive activities resume, the team will observe the recruitment process and training of the dyads, monitoring the content, regularity and ongoing adjustments in the feedback loops central to the management of the project. It is our goal to collect and compile participants’ reflections on the various stages of development and implementation of the ‘Asset Mapping’ project.

**Notes Going Forward**

1.) Project coordinators might revise the attendance taking procedures so as to document with greater detail the affiliations of those taking part in the ‘All Partners’ meetings.

2.) Email chains associated with the planning and structuring of the ‘All Partners’ meeting might be archived and made available to attendees.

3.) Discussions might be held as to what constitutes a community and what constitutes an asset. Each are locally variant and it would seem crucial to establishing the plurality of meanings associated with each term.
Appendix A: Attendance

CHI Participants: All Partners Meetings
8/15/2011 - 10/27/2011

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Appendix B: Asset Mapping Instrument Drafts

1. September 22, 2011:

Asset Mapping Interview Questions
All Partners Meeting August 16, 2011

Community Pride
- What would you miss if you left?
- What makes 21202 special?
- What is great in E. Baltimore?
- What is awesome about your community?
- What makes you smile in the community?
- What is your favorite thing about living here?
- What types of activities do you enjoy participating in?
- Why do you live here?
- How long have you lived here?
- How old is your home?
- What does Baltimore owe you?
- If you have options, and are content, why stay?

Dreams?
- What is your community vision?
- What do you want for E. Baltimore?
- What do you want to see happen in this community?
- How are we to develop as a neighborhood?
- What has been your lifelong dream in making your community better?
- What would benefit your community most?
- What issues do you care about most?
- What happen when all is said and done?
- Recreating a sense of community.
- Can music bring community together?
- Do you love fresh food?
- How can we better help re-entry population?
- Feeling about vacant properties?
- What is your feeling about property taxes?
- Interest in green space development?
- What - who - when can the rebuilding of Midde-East cease and begin to grow? Fair housing - parks for kids - less crime - vacant homes.
- Do you think teaching true Black American History will help?
Motivations & Passions?
- How do you spend your free time?
- What do you do with your free time?
- Where do you spend your time?
- What is important to you?
- What do you do for fun?
- What is your passion?
- What motivates you?
- If you could do one thing with the support of your neighbors, what would it be?
- What makes a healthy community?
- What makes a healthy community?
- What makes communities healthy?
- Describe a healthy neighborhood.
- What does community mean to you?
- What do you consider a great school?
- How can you improve your block?
- Do other people’s children matter?
- Need for job training.
- I care about what will happen to my children (ALL children) as a whole.

Resources?
- What groups are doing good work in the community?
- What organizations do you believe in?
- Can you tell me about 3 resources in this community that help others?
- What place around here would really make you sad if it went away?
- Where does your child play?
- Where do you go to relax?
- How do you feel about healthcare services?
- Do you have access to healthcare?
- What other health resources can be found other than J.H.H.?
- Where do you buy groceries?
- What are positive youth opportunities?
- What can the youth do?
- Developing and harvesting the gifts of the youths.
- What’s great about your school?
- What’s great about being outdoors?
- What’s great about the businesses?
- What’s great about the churches?
- What are your neighborhood assets?
- What resources do you think we need in the community?
• How can developers support our community?
• How does our community help our schools and reduce truancy?
• Viable shelter for the homeless and the abused.

What are your skills?
• Name your top three talents.
• What are your best skills?
• What can you do?
• What do your neighbors value about you?
• What have you done lately for your community?
• How are you involved in the community?
• How do you envision your role in the community?
• Harvesting the gifts.
• Do the community defines who URI (?)

Relationships?
• Who do you respect?
• Who do you care about?
• How can we work together?
• Who helps Hopkins identify volunteer opps in the community?

Miscellaneous
How does change happen?
Asset Mapping Interview Questions – DRAFT – October 4, 2011

Note to Interviewers: Each question is followed by possible “prompts,” or follow up questions. If the interviewee has a hard time coming up with a response to the first question, these prompts are different ways of asking the question that might help.

COMMUNITY VISION
First, I’d like to hear about what you think a great neighborhood might look like.
1. What makes a neighborhood a great place to live?
   a. What would you like to see happen or change that would make your neighborhood a better place? (What is your dream for making the community better? What could neighbors do that would benefit this community?)
   b. What would it take to make that happen?
2. What makes a neighborhood a healthy place to live?
   a. What would you like to see happen that would make your neighborhood a healthier place?
   b. What would it take to make that happen?

COMMUNITY STRENGTHS
Now, I’d like to talk to you about what you think is great about your neighborhood in East Baltimore.
1. What do you love about living in your neighborhood? (What about the community would you miss if you left? What about your community makes you happy?)

2. Who do you care about in the community? (Who do you spend time with? Who is there for you when you need help? Who would you miss if he or she left?)

3. Who in your community do you feel cares about you?
   a. How do these people help you or impact your life?

4. Who are the people that make this neighborhood a great place to live? (Who are the people that everyone looks up to? Who are the people that are the unsung heroes?)
   a. How do these people help you and others and make your lives better?

5. What are some groups in your community that are important to you, make your life better, or help you get important things done?
   a. How have you used or interacted with these groups?
   b. How have these groups helped you?

6. What are some organizations in your community that are important to you, make your life better, or help you get important things done?
   a. How have you used or interacted with these organizations?
   b. How have these organizations helped you?

7. What are some places in your community that are important to you or make your life better?
   a. When and how often do you visit these places?
b. How have these places impacted your life?

PERSONAL STRENGTHS
Now, I'd like to hear a little about yourself and what you bring to your community.

1. How old are you?

2. How long have you lived in East Baltimore?

3. How long have you lived in your neighborhood?

4. What are your skills or talents? (What are you good at doing?)
   a. Which of these skills or talents would you be willing to share if it could help a group of
      neighbors get something done that you all want to get done?

5. Are you involved with any businesses or organizations in your community?
   a. Could this business or organization contribute in some way to help a group of neighbors get
      something done?
Before starting the interview there is need for a detailed introduction where the interview team introduces themselves, who they are, what the project is about, why we are asking the questions that we are and what we will do with them. Attention needs to be paid to time of day and location of where the sessions will be held. There should be a focus on trust and comfort.

It is also imperative that prior to undertaking the data collection in a neighborhood there is an extensive information campaign at the community level. We need to assure that community leaders are engaged and have a chance to ask questions and comment on the issues and questions that are most important to them.

[Consideration should be given to some type of fun or useful gift for participants e.g., a shirt with our logo].

[This instrument should be limited to those 18 years of age and older. Consideration should be given for another assessment of younger youth (10-18 years) to tap school and related issues]

[There is a general consensus that recording devices can be used BUT get informed consent on tape; i.e., get permission to tape on tape and always give people the option to turn off the recorder “Your Information is valuable and important, and I don’t want to miss anything. May I record our conversation?”].

Note to Interviewers: Each question is followed by possible “prompts,” or follow up questions. If the interviewee has a hard time coming up with a response to the first question, these prompts are different ways of asking the question that might help.

First, I’d like to hear about what you think a great neighborhood might look like. We’d like to know what you would hope for here in this neighborhood.

1. What makes your neighborhood a great place to live?

2. What would you miss if you moved out of the neighborhood?
   a. Who would you miss? Why?
   b. Who do you like spending time here with?
   c. Who are people who you can depend on to watch your kids or to give you a lift somewhere or just to help out?
d. What places in the neighborhood would you miss? Why?

   i. Prompt: Are there places here where you like hanging out or spending time with friends?

e. What experiences that you have in this neighborhood would miss were you to leave?

   Prompt: Like community meetings or weekly coffee with friends or anything like that?

3. What would you like to see happen or change that would make your neighborhood a better place?

   Prompt: What is your dream for making the community better? What could neighbors do that would benefit this community?

   a. What would it take to make that happen?

4. What makes this neighborhood a healthy place to live?

5. Where in the neighborhood do you like hanging out or spending time?

   a. What about parks or a church or a beauty parlor/barber shop or any places like that?

   b. Where are they?

   c. What do you like about them?

6. Where are there safe places to hang out? Are there things like parks or safe places to hang out, recreation centers and things like that?

   Prompt: Things like parks? Recreation centers? Barber shops? Bible study?

7. Are there neighborhood groups or organizations that you belong to or count on for help?

   a. Which are they?

   Prompt: It might be a sports club, a children’s play group, a parenting class....

   b. How have they been helpful for you? What have they done? Can you give me an example?
8. What about places to get healthy food? Things like that?

9. What changes would you make that would make this neighborhood healthier?
   a. What would it take to make them happen?

10. Who are the community leaders who really care about this neighborhood?
    a. What have they done that lets you know they care?

PERSONAL STRENGTHS AND INTERESTS
Now, I'd like to hear a little about yourself and what you bring to your community.

1. How long have you lived in East Baltimore?

2. How long have you lived in your neighborhood?

3. What do you see as your skills or talents?
   
   Prompt: What are you good at doing or really like doing?
   
   a. Are there others in the neighborhood who like doing this too?
      i. Who are they?
      ii. Do you ever get together to do ______ (activity) together?
      iii. Would you like to get a group together and if so what would you need to?

4. Is there anything you do that makes your neighborhood/block a better place to live?
   a. Is there anything you'd like to do to make it a better place?
5. What kind of work do you do (or have you done) for pay??
   a. Where did you work?
   b. Where did you work?
   c. Are you working now?
      i. If no, why not?

6. What kind of work have you done as a volunteer?
   a. Where did you do it?
   b. Was it with an organization, a group of friends or what?
   c. Are you still working as a volunteer and if not what would it take for to start doing that again?

7. What do you consider your neighborhood?
   Prompt: Where does it start and stop?

8. In what age group are you:
   - under 25
   - between 25 and 40
   - between 40 and 60
   - over 60

9. What do you consider your race/ethnic group?
APPENDIX C

Interview Guide for Phase II (Asset Mapping)
Community Health Initiative: Methods Group
22 February 2012

BUCKET 1: PHYSICAL COMMUNITY ASSETS

1. What do you consider to be your neighborhood? [Show map here and ask person to indicate on the map.]
   a. Is it this block? This set of blocks? Are there boundaries?

2. Tell me about your neighborhood.
   a. How long have you lived around here? Have you lived here all your life or did you leave for awhile? When did you come back? Why did you come back? When did you move here? Why did you move here? Had you ever lived here before that? If you left, why did you leave (e.g., school, job, family)? If you lived here, moved and then returned, what is the same about the neighborhood and what is different? What do you think about those changes?
   b. Do you have family and friends around here? Would you say most of your family and friends live around here? Do you see each other all the time? Where [else] do your friends and family live? Do they ever come see you here? Is it easy for you to go visit them? If your family and friends don’t come to see you in your neighborhood, what keeps them from coming?
   c. How is it for you and your family members to live here?
   d. How is it for seniors or elders who live around here?
   e. How is it for young kids that live here?
   f. How is it for teenagers who live around here?
   g. Do young adults who grew up here stay around?
   h. How safe do you feel around here? Why or why not? Do you feel safe in your house? Why or why not? Do you feel safe on your block during the day? How about after dark? Why or why not? Can you always park near where you live? Do you worry about your car getting stolen or messed up? Do you feel safe coming from the bus?
   i. Is there a lot of noise around here at night? What’s it from?
   j. How do people on your block take care of their houses? How about the street, or areas outside their houses, steps, yard, etc?

3. What do you think about the city services in this neighborhood?
   a. Do you think the city takes good care of this block?
   b. Is the garbage picked up on time?
   c. Do the fire trucks come when they need to and fast?
   d. Do the police come when you call? How do police help people in the neighborhood?
   e. Are there a lot of conflicts between police and the people in the neighborhood or not so much?
Interview Guide for Phase II (Asset Mapping)
Community Health Initiative: Methods Group
22 February 2012

f. What about Hopkins services, specifically?

4. Where do you and your family go to breathe easy or relax?
5. Is there anything else about your neighborhood that you would like to tell us?

BUCKET 2: VOLUNTARY GROUPS (ASSOCIATIONS)

1. Do you or your family go to church? Where?
   a. Where do the people from your congregation mostly live? Do you get to see them outside church? Are there social activities at your church? If you go to church away from here is it hard for you to get to those activities? [IF APPROPRIATE] Does someone from your church help bring you there and home again?

2. Do you or anyone in your family belong to any other groups that meet regularly?
   a. Clubs? Political groups? Neighborhood or community associations?
   b. Does that group meet around here? Where do the people from the group mostly live? Do you get to see them outside church? How did you get involved with this group?
   c. If there is a problem in the neighborhood, are there groups of people who work to solve them? Do you have an example of when this happened in your neighborhood?

BUCKET 3: PAID GROUPS (INSTITUTIONS)

1. Do you know what schools are in the area?
   a. Do your kids or any kids you know go these schools? Tell me about the school. Do you know what middle schools the kids around here usually go to? Tell me about them. Do you know what high schools the kids around here usually go to? Tell me about them.

2. What’s the best place to go to meet people and hang out?
   a. [IF APPROPRIATE] Is there a club or bar or lounge where you hang out around here? Do you know people there? If there’s not, is there some place like this you go elsewhere? Is it hard for you to get there?
   b. [IF APPROPRIATE] Is there a place where you get your hair done or a person you go to? Do you know other people who go there? Is getting your hair cut a time when you can visit? If there’s not a place or person around here do you go elsewhere? Is it hard for you to get there?
APPENDIX C

Interview Guide for Phase II (Asset Mapping)
Community Health Initiative: Methods Group
22 February 2012

c. [IF APPROPRIATE] Is there a place where you get your nails done or a person you go to? Do you know other people who go there? Is getting your nails done a time when you can visit? If there’s not a place or person around here do you go elsewhere? Is it hard for you to get there?

d. [IF APPROPRIATE] Is there a recreational center, gym, or park around here? Is there a place to play basketball or go bowling or play pool around here? Do you ever go? Do you know people there? If there’s not a place like this, do you go elsewhere? Is it hard for you to get there?

e. What’s the nearest movie theatre? Do you go there? Is it easy to get there? Do you like movies, would you go if it was easier?

3. Any good places to eat or buy food in the area?

   a. Is there a restaurant or carry-out place you always go to? Is it any good?

   b. Is there a convenience store around here? Does it have a good selection of the stuff you want to buy? Is it open when you need it to be?

   c. Is there a big grocery store (like a Giant) around here? What’s the closest one you know? Do you go there? Is it easy to get there? Can you get what you want there? Is there anywhere else you buy food?

   d. Is there a place you go (restaurant or grocery store) if you want healthy food? What do you consider healthy food? What kinds of food do you wish were sold here?

4. Any good places to shop nearby or in the area?

   a. What’s the nearest shopping mall? Do you go there? Is it easy to get there? Is there anywhere else you buy clothes and stuff for the house?

   b. Where’s the nearest hardware store? Do you go there? Is it easy to get there? Is there anywhere else you can buy tools and supplies?

   c. Where’s the nearest bank? Is it easy to get there? Is there a check cashing place nearby?

   d. What’s the nearest laundry place? Is it easy to get there? Is there anywhere else you can wash clothes? Are there TVs or pool tables in the laundry so you can pass the time? Are there usually people you know there? Do you plan to do your wash with others in order to visit while it’s going?

   e. [IF APPROPRIATE] Is there a good place or person to get your car fixed near here? If not, is it hard to get to?

5. Where do you go to the doctor?

   a. Where do you get your medical care? Is it easy to get there? How did you learn about this place? Do you know of another place you could go?

   b. Where do you go to the dentist? Is it easy to get there? How did you learn about this dentist? Do you know of another place you could go?
APPENDIX C

Interview Guide for Phase II (Asset Mapping)
Community Health Initiative: Methods Group
22 February 2012

BUCKET 4: ECONOMIC ASSETS

1. How do you and people in your family make a living or earn money?
   a. What are some ways you make or earn extra money? Driving for a church or other organization? Child care? Hacking? Braiding hair? Doing Nails? Day labor?
   b. How did you learn what you needed to know to do these things?
   c. [IF APPROPRIATE] What type of work do you do?
   d. What is your job?
   e. How did you get the skills you need for your job (like on the job training, vocational school, etc)?
   f. Where is it located? Is it easy to get there?
   g. How did you find out about it?
   h. Do you want to be working?
   i. Do you want to be working more hours?
   j. Do you want to be working fewer hours?

2. Tell me about jobs or work you and people in your family have had in the past.
   a. What was it? Where was it located? Was it easy to get there? How did you find out about it?
   b. Do you have degrees or licenses that qualify you for jobs?
   c. What was your favorite job? Why was that?

3. No matter what your job is now or was recently, is there a job you've always wanted to do?
   a. Why is that? How did you learn about that job? What would help you to get that job (e.g. more training, social networks, etc)?

4. Do most of the people who live around here own their houses?
   a. Do you or a family member own this house?
   b. Do most of the people who own businesses around here live around here?
   c. Do most of the people who work around here live around here?

5. Are there people on this block who aren't close friends or family, who you always talk to when you see them?
   a. If someone on this block who wasn’t a close friend or family member had a baby, would you hear about it? How? Would you take an opportunity when you saw him or her to go over and see the baby and ask how things are going?
APPENDIX C

Interview Guide for Phase II (Asset Mapping)
Community Health Initiative: Methods Group
22 February 2012

b. If someone on this block who wasn’t a close friend or family member moved away, would you hear about it? How? Would you take an opportunity when you saw him or her to wish him or her luck?

c. If someone on this block who wasn’t a close friend or family member died, would you hear about it? How? Would you try to express condolences somehow?

d. Do you ever talk to people on this block about other people on this block, just gossiping? Do you think most of the people on this block do this?

e. If a person on this block was doing something that bothered you, are there people who live near here who you could talk to about it or ask for help to do something about it.

BUCKET 5: INDIVIDUAL ASSETS

1. We’ve talked about how you have developed/used your skill set toward gainful employment. I’d like us to talk about any other skills or talents you have (e.g., great organizer, play an instrument)

   a. Do you play an instrument or sing? Are you in a choir or a band? Do you want to be? Could you help with a kid’s choir or band?

   b. Do you sew or quilt? Do you get together with others who do? Have you done quilting projects for church or other organizations? Do you sew or quilt things for craft fairs to raise money? Would you be interested in teaching kids to quilt or sew?

   c. Do you knit, crochet or embroider? Do you get together with others who do? Have you done yarn projects for church or other organizations? Do you do yarn projects for craft fairs to raise money? Would you be interested in teaching kids to work yarn?

   d. Do you do crosswords or other puzzles? Do you ever do them with another person?

   e. Do you work with wood? Do you get together with others who do? Have you done wood projects for church or other organizations? Do you do wood projects for craft fairs to raise money? Would you be interested in teaching kids to work wood?

   f. Do you like to play cards? Do you belong to a group who plays cards regularly? Could you teach kids to play bridge or some other card game?

   g. Do you like to play chess? Do you belong to a group who plays chess regularly? Could you teach kids to play chess? Are there chess tables in the park where people gather to play?

   h. Do you take pictures? Could you teach kids to take pictures?
APPENDIX C

Interview Guide for Phase II (Asset Mapping)
Community Health Initiative: Methods Group
22 February 2012

i. Do you paint? Do you get together with others who do? Have you done painting projects for church or other organizations? Do you do painting projects for craft fairs to raise money? Would you be interested in teaching kids to paint?

j. Do you dance? Where do you dance? Could you teach kids to dance?

2. Do you have any contact with the politicians who represent you on the City Council, the state or the federal government?
   a. Do you think these politicians represent your views? Have they ever sought out your opinion? Do you know how to contact them?

3. Who can you and your family depend on in your neighborhood?
   a. Who can you depend on for a sudden small emergency, like locking the keys in the car?
   b. Who can you depend on for a bigger problem, like needing a place to stay for awhile?
   c. Who are leaders in your neighborhood? Who around here is a good representative for your community?
   d. Who takes care of the kids in your neighborhood? Who and where do kids go to when they are in trouble?
   e. Who takes people places if they need to go somewhere, like to and from church?

BUCKET 6: COMMUNITY STORIES

1. Are there any stories about the people or places around here?
   a. Like legends of someone who died in a particular place, or a place where there’s supposed to be a ghost?

2. Do you know of anything important that might have happened right around here?

BUCKET 7: COMMUNICATION

1. Where do you get your news and information? How does news get around in your neighborhood?
   a. Is there a local newspaper, besides the Sun? Do you get it or read it? Is it good for anything?
   b. Is there a community bulletin board nearby? Do you ever look at it? Is it good for anything?
   c. What is the best or most reliable source of information about your neighborhood?
   d. Where do you get your health information? Is there someone in your neighborhood that you can go to for health information or health advice? Do you know about community health workers?
APPENDIX C

Interview Guide for Phase II (Asset Mapping)
Community Health Initiative: Methods Group
22 February 2012

2. Who in the neighborhood is the first to know? Who in the neighborhood needs to know? Who do you go to for information?

SUMMARY QUESTIONS:

1. What are the three most important things in this community?
2. What is the best kept secret about East Baltimore?
3. How did you feel about this interview?
4. Do you know of anyone else that I should speak to within the area?
5. Do you have any questions about the Community Health Initiative?

NEXT STEPS: come up with an implementation plan to present to the All Partners group
--there are concerns that we will come to them with a FINAL plan, and everyone won’t get to contribute
--there are concerns that we will not get an appropriately representative sample (including ex-offenders, etc).
--solution: come up with RECOMMENDATIONS for implementation, invite people to the methods meetings

Email methods meeting date to Larry: lschugam@baltimorecp.org
APPENDIX D1

Brief Communication

Improving access to care for uninsured patients at an academic medical center:

The Access Partnership

Lauren Block MD
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Tables: 1
Figures: 1
References: 22
Abstract: Uninsured individuals face great challenges in accessing both primary and specialty care. The Access Partnership (TAP) is a novel collaboration between primary and specialty care providers at an urban academic medical center to provide care coordination and facilitate access to specialty services for uninsured patients. We reviewed administrative data and performed phone surveys of the 213 patients who entered the program over a one-year period. Specialty care visit attendance was analyzed from administrative data for these patients. We then surveyed patients by phone (60% response rate). Patient-reported access to care and satisfaction with care were significantly higher after TAP (33% vs. 87%, p<0.001 and 41% vs. 91%, p<0.001, respectively). 89% of referrals were completed within 90 days among TAP patients, a rate similar to studies involving insured patients. TAP enrollment was associated with significantly decreased patient-reported barriers to specialty care as well as improved access to and satisfaction with care.

Key words: Access to care, uninsured, specialty care, academic medical center.
For the 46 million uninsured in the U.S., lack of insurance is a driver of poor health outcomes and delays in accessing care.\textsuperscript{1} Uninsured adults have less access to preventive and acute care, receive poorer quality of care, and have higher mortality rates than adults with insurance.\textsuperscript{2,3,4} The uninsured are more likely to lack a usual source of care, require avoidable hospitalizations, and have higher utilization of the emergency department.\textsuperscript{5} These risks extend to those who lack stable insurance coverage.\textsuperscript{6} Data suggests that 50\% of uninsured adults delay seeking medical care and that 35\% of uninsured adults who need medical care during a given year do not get it.\textsuperscript{7}

A patchwork of programs in the United States offer access to primary care for the uninsured, and access to emergency care is mandated by the Emergency Medical Treatment and Active Labor Act. However, meeting the outpatient diagnostic and specialty care needs of this population remains a challenge and is a source of health care delays and dissatisfaction with care.\textsuperscript{8,9} Surveys of federally qualified community health centers, which provide primary care to 15 million underserved patients annually, reveal that 25\% of primary care visits end with a specialty care or diagnostic referral. These referrals may be out of reach for the uninsured.\textsuperscript{10,11,12} Provision of health insurance to the previously uninsured has been associated with increased utilization of health care services, increased patient satisfaction with care,\textsuperscript{13} and reduction in disease-specific disparities in care.\textsuperscript{14}

Residents of East Baltimore suffer the poor health outcomes associated with poverty and lack of access to care. A 2008 RAND study concluded that access to quality care is lacking for many Baltimore residents, and rates of uninsurance, acute hospitalization, and ED utilization are high.\textsuperscript{15} While uninsured patients may be able to receive reduced cost primary care at several federally qualified health centers
throughout Baltimore, diagnostic tests and specialty care were generally unaffordable with existing programs.

East Baltimore Medical Center (EBMC) is a large multi-specialty primary care practice devoted to serving the surrounding, largely socioeconomically challenged neighborhoods. Each year the practice cares for over 20,000 patients with a large number of uninsured or under-insured. The practice is located near Johns Hopkins School of Medicine but is not a part of the University.

The Access Partnership (TAP) was created in 2009 to bridge the gap between uninsured East Baltimore patients served by EBMC and specialty care available through Hopkins medicine. TAP provides *pro bono* specialty care and provides care coordination to ensure efficient and effective use of this care. Administrative costs and facility fees are funded through Johns Hopkins Health System, and professional fees are provided *pro bono*. The initial pilot was limited to patients residing in two ZIP codes and was then expanded to five ZIP codes near Hopkins-affiliated hospitals.

We sought to evaluate the effectiveness of TAP. Through survey and administrative data we sought to compare the attitudes and utilization behaviors of TAP patients before and after joining TAP. We used the first year of program activity in order to provide timely feedback to program leadership. We hypothesized that access to specialty care and care coordination offered *via* the TAP program would improve health care satisfaction and change utilization patterns.

**Methods**

**Program.** Beginning in May 2009, providers at EBMC referred uninsured and underinsured internal medicine patients from eligible ZIP codes for needed specialty
care. Referrals were evaluated by the TAP medical director for medical necessity and cost effectiveness. The medical director was a senior family physician who worked at the EBMC practice. If approved, a TAP coordinator invited the patient into the program and explained the program to the patient, the importance of each referral, and full cost coverage offered by the program. The coordinator then collected a fee of about $20, scheduled the patient’s appointment, and followed up to remind the patient of the upcoming appointment. Referrals were made to providers and for tests at Johns Hopkins Hospital. The purpose of collecting the TAP fee was to engage patients in taking proactive steps to protect their health and to encourage follow-through with referrals; the fee was waived in cases of significant financial hardship. Previous research has shown that cost-sharing is associated with more responsible health care utilization.\textsuperscript{16} Subsequent visits, diagnostics, and hospitalizations stemming from the referral were covered by the program as well. Primary care providers received feedback on the status of the appointment, to enable them to facilitate needed follow-up.

**Population.** Patients with approved referrals during the first 12 months of the program who paid the TAP enrollment fee were included in this study. Approval for this study and HIPAA waiver were granted by the Johns Hopkins School of Medicine Institutional Review Board.

**Survey.** Patients were mailed an informational letter, and were then contacted by phone to recruit them into the study. Questions were developed with aid of the PSQ-18, a validated short-form patient questionnaire created by the RAND corporation\textsuperscript{17} and feedback from semi-structured interviews with TAP patients. The survey contained 31 questions on patient satisfaction, understanding of care, and access to care as well as utilization of health care services. Questions pertained to the 12 months before TAP
(pre-TAP), and the time period since enrollment in TAP (post-TAP). Questions regarding patient perceptions of satisfaction, access, and understanding contained a Likert scale with rated answers from 1-5, which were then grouped and tallied.

Participants received token support for their participation. Research assistants trained in HIPAA and research ethics as well as survey administration obtained oral consent from patients and then administered the surveys. Eight of the surveys were conducted in Spanish by a bilingual researcher. Consistency between callers was monitored via periodic observation and recording of call details.

**Analysis.** Survey responses were grouped, tallied, and analyzed using 2-tailed t-tests. TAP administrative data was used to examine 90-day follow through rates for TAP referrals. TAP coordinators obtained specialty visit follow-through data via phone calls to patients and providers. These data were compared with show rates for the EBMC clinic and with standards found in the literature. Referral patterns were analyzed by grouping referrals in four categories: diagnostic (such as CT scan and stress test), therapeutic (such as orthopedic surgery and endocrinology), ancillary (includes nutrition, optometry), and pain-related (includes physical therapy, pain management).

**Results**

During the first year of TAP, 336 patients were referred to the program and 213 joined. Ninety-seven patients were not eligible due to not paying the TAP fee, not asking for a waiver, or not responding to correspondence from TAP staff. Twenty-six patients were not eligible due to referrals deemed not medically necessary by the medical director. Of all 213 TAP participants, 134 patients (63%) were reached by phone, and 128 agreed to be surveyed, resulting in a final response rate of 60%. It took an average of 2.3 calls to
reach survey participants and a maximum of seven attempts were made to reach each participant.

**Demographic characteristics and services.** Demographic data were obtained for the 134 survey participants and the 213 TAP patients (Table 1). Fifty-four percent of patients surveyed were female. Mean age was 47 years. The general population of EBMC is 91% African-American, 4% white, and 5% Hispanic/Latino, multi-race, and all other. Survey respondents had on average two referrals each. Most referrals were classified as diagnostic or therapeutic. The departments with the most referrals were radiology, ophthalmology, and cardiology. Those who participated in the surveys were not significantly different from the general TAP patient population in terms of gender, age, or number or type of referrals.

[Production: Please insert Table 1 here]

**Health care home and insurance status.** Eighty-six percent of responding participants reported most frequently obtaining health care at EBMC. At the time of survey, 48% of patients reported being uninsured, 32% were insured with primary care coverage only, and 15% were insured by the state Medicaid program. When asked about the previous year, 69% of survey respondents reported being uninsured at some point. These results point to significant turnover between Medicaid populations and the uninsured. TAP participants had higher rates of uninsured individuals than the general population at EBMC, where 38% of patients are privately insured, 30% are insured by Medicaid, and 7% are uninsured.

**Health care understanding, access, and satisfaction before and after TAP.** Patients were asked to rate their satisfaction with, understanding of, and access to care pre- and post-TAP (Figure 1). Patient reported access to care increased significantly
after TAP. Thirty-three percent of patients reported access to care pre-TAP, and 87% of patients reported access to care post-TAP (p<.001). Patient satisfaction with care increased significantly, with 41% of patients reporting satisfaction with care pre-TAP, and 91% reporting satisfaction with care post-TAP (p<.001). There was a non-significant trend towards more patients reporting increased understanding of the reason for their treatment plan after TAP (p=.11).

**[Production: Please insert Figure 1 here]**

**Specialty care visit rates.** Twenty-one percent of patients reported completing referrals to specialists or diagnostics pre-TAP, compared with 88% post-TAP (p<.001). Patients unable to complete referrals were asked to say why. Pre-TAP, 86% of patients who were unable to complete referrals reported a financial barrier to specialty care. Post-TAP, 18% of patients reported a financial barrier, and 28% of patients reported not understanding the reason for the referral.

**Referral completion rates.** All TAP patients who paid the fee were scheduled for appointments by TAP coordinators. Referral completion rates were calculated using the first 12 months of TAP data as the number of patients who attended a specialty visit within 90 days of referral, compared with the number of patients eligible to complete the referral. The referral completion rate was 89%, comparable with numbers found in the literature (74-90%)\(^{18,19,20}\) for insured patients and significantly higher than the primary care show rate at EBMC (percent of patients who attend scheduled appointments), which per administrative data is about 60%. Patient-reported satisfaction with care was associated with follow-through with any referral (t=2.4; p=.02).
Referral types. Patient referral types (therapeutic, diagnostic, ancillary, and pain) were tallied and analyzed for the first 12 months of TAP. The majority (52%) of referrals were therapeutic, 32% diagnostic, 6% to ancillary care providers, and 7% pain-related. Since all TAP patients receive referrals, but not all referrals were completed within 90 days, we evaluated whether referral type was associated with referral completion. Ninety-five percent of diagnostic referrals were completed, compared with 88% of pain-related referrals, 85% of therapeutic referrals, and 63% of referrals to ancillary providers. Diagnostic referrals had a higher association with being completed than therapeutic (t=3.66, p<.001) or ancillary referrals (t=3.24, p=.003).

Discussion
Lack of access to care is associated with delayed care and poor health outcomes. Among the objectives for Healthy People 2020 is improved access to health services, with a goal to “reduce the proportion of individuals who are unable to obtain or delay in obtaining necessary medical care.” Novel ideas and programs are needed to provide health care access to the poor, urban uninsured, particularly in the realm of specialty care.

This study describes early results from The Access Partnership, a novel program to improve access to specialty care for uninsured populations in a cost effective way. We found that the TAP program succeeded in achieving specialty care follow-through rates comparable to those reported for insured patients, and improved patient-reported satisfaction and access to care.

We were able to survey 60% of program participants, a rate comparable to that found in studies involving surveys with patients with low socioeconomic status. A high percentage of the patients in our study were uninsured, and 15% of surveyed patients
reported being insured by Medicaid (with attendant coverage of specialty care) by the
time of interview, reflecting high levels of turnover between Medicaid and the uninsured.

Patient-reported outcomes, including satisfaction, access, and understanding,
were high post-TAP and reflect satisfaction with the program. Patient understanding of
care did not increase significantly, possibly because rates were high pre-TAP, or possibly
due to a need for better explanation by providers as to the reasons for referrals.
Twenty-eight percent of patients who reported being unable to attend a referral post-
TAP cited not understanding the reason for referral as a barrier. This is an area for program improvement.

Follow-through rates for referrals in the first year of TAP were quite high, and
may reflect patients following through on referrals they had needed for years, the care
coordination provided by TAP staff, or the TAP fee requirement selecting for patients
interested in attending referrals. We chose to use follow-through rates rather than show
rates for this population because we felt it was most important that a patient followed
through on the referral deemed important by both their provider and the TAP medical
director, not that they made it to an appointment on a prescribed date. While it has
been suggested that many specialty referrals are unnecessary, the requirement for TAP
medical director approval of all referrals selected for necessary and cost-effective referrals.22

We examined referral types for the purpose of evaluating whether follow-through
rates were higher for certain types of referrals due to patients placing higher value on
these specialists or tests. We found that patients were more likely to follow through on
diagnostic and therapeutic referrals than pain-related and ancillary services referrals. We
speculated that this difference might have resulted from a patient perception that
referrals for diagnostic and therapeutic referrals would lead to “answers.” Alternatively, this difference may exist due to improved patient understanding of the reason for these referrals, or differences in ease of scheduling. More thorough explanations of the reasons for referral and more help in scheduling these appointments may be useful to improve attendance rates for ancillary visits.

**Limitations.** Recall bias inherent in self-reported data is a major limitation to our survey data and was the impetus to obtain administrative data on show rates. By choosing to survey those who elected to pay the TAP fee or had the fee waived, we selected for patients who are self-motivated to take care of their own health, which was then associated with referral appointment follow-through. We likely also selected for patients with a high level of health literacy, who understood the reason for referral and thus paid the TAP fee. This work was based on the first year of program data; stronger results may be anticipated over a longer period of time. Future work will address comparison of TAP patients to a similar group of Medicaid patients who received referrals during the same time period. A survey of those patients eligible for TAP who elected not to participate is also underway.

**Implications.** Our evaluation of the first year of operation of the TAP program finds that it achieves its primary goal of improving the ability of underserved patients to complete specialty care referrals, to levels comparable with those found in the literature for insured patients and higher than the primary care show rate at EBMC. Patients reported significantly improved satisfaction with care and access to care after enrollment in the program. Future work will focus on comparison to a group of insured patients of similar socioeconomic backgrounds over a longer time period, in order to investigate further whether or not TAP helps change care utilization patterns. We are also
examining the effect of this program on emergency department utilization and on visits to primary care providers.
Acknowledgments

We would like to acknowledge Dr. Barbara Cook for her leadership; Thomas Heflin, Dena Bushman, and Jordan David for their help with data collection; and the TAP and EBMC staff for their support and advocacy.
References


Table 1: Demographics and services of TAP patients

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<td>Mean number of referrals</td>
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Figure 1: Patient-reported outcomes, pre- and post-TAP

- Understanding: Pre-TAP 85%, Post-TAP 91%, p=0.11
- Access: Pre-TAP 33%, Post-TAP 41%, p<0.001
- Satisfaction: Pre-TAP 87%, Post-TAP 91%, p<0.001
Title: Identifying patient, community and program specific barriers to free specialty care utilization by uninsured patients in East Baltimore

Authors:

Abstract: Uninsured individuals face multiple barriers to accessing specialty care. The Access Partnership (TAP) offers free specialty care and care coordination to qualified uninsured patients at an urban academic medical center for a small program entry fee (waived for financial hardship). In the program’s first year, 104 eligible patients (31%) did not enroll. To understand why, we investigated demographic, referral, personal, and program-specific factors. After adjusting for age, gender and zip code, diagnostic and therapeutic referrals were more likely to be completed than ancillary referrals (OR=8.56, p=0.001; OR 3.53, p=0.03). There was no difference between pain related and ancillary referrals (OR=2.80, p=0.139). Eighteen patients were surveyed and reported program and patient specific barriers. While removing costs is necessary to improve access to specialty care for underserved patients, it is insufficient. Improving communication from program coordinators and enrollment strategies may help to improve utilization of free care programs by the uninsured.

Key words: access to health care, uninsured, specialists, academic medical center
The 50 million uninsured in the United States\(^1\) face poor access to care, quality of care, and health outcomes\(^2\). Inconsistently insured and underinsured patients encounter similar outcomes\(^2\). Most of the health care received by the uninsured is provided by a safety net of providers including federally qualified health centers, community health centers and public and teaching hospitals\(^3\). Specialty care is frequently needed but rarely available to these vulnerable patients\(^4,5\). In addition to a lack of affordable care, uninsured patients frequently report many other barriers to utilizing care\(^6\). Numerous models have been proposed to explain barriers to health care utilization; the behavioral model of health services use developed by Andersen and Aday predominating\(^7-12\). Personal, environmental, and societal factors all play a role in affecting utilization. Even when programs and facilities have provided free care to patients, low level of education, long waiting times and few social ties continue to be reported as barriers\(^13,14\). Lack of access to and utilization of medical care among the uninsured has been associated with decreased use of preventive services, delayed time to diagnosis of illness, inadequate therapeutic care and a greater number of avoidable hospitalizations\(^15\).

In Baltimore City, 14% of adults are uninsured\(^16\). East Baltimore Medical Center (EBMC) is a primary care practice and member organization of Johns Hopkins Health System. This practice fills an important gap by providing primary care services to uninsured and underinsured adults and children. In 2009, The Access Partnership (TAP) was launched by Johns Hopkins Medicine to complement the services provided at EBMC by providing access to specialty care for uninsured patients. Uninsured patients are referred by their primary care provider for specialty care. Referrals are sent to the medical director for approval. Once
approved, the information is sent to program coordinators who contact each patient by phone. If unable to reach the patient after three phone calls, a mailed letter is sent. Patients are asked to pay a $20 fee for entry into the program. The entry fee can be waived upon request for financial hardship. The program then covers the entire cost of the specialty visits and provides care coordination. Over 200 patients paid the entry fee and saw specialists through this program in the first year. These patients reported increased satisfaction with care and increased access to care\textsuperscript{17}. However, 104 eligible patients did not join in the first year of the program. We sought to understand the barriers to utilization of care that prevented these patients from joining the program. Through demographic data, utilization data and surveys, we sought to find ways to improve access to specialty care for this population.

**Methods**

**Population.** Eligible participants were uninsured, internal medicine patients at EBMC, over 18 years of age who lived in one of 5 surrounding zip codes and had a specialty referral approved by the medical director from May 2009 to May 2010. Demographic data and specialty care referral data for eligible patients who joined the program was compared to data for those who did not. Patients eligible for TAP who did not join were contacted for participation in a telephone survey. Approval and HIPAA waiver were granted by the Johns Hopkins School of Medicine Institutional Review Board.

**Survey.** Preliminary, exploratory survey data was sought to understand some of the barriers faced by our patients. Relevant, validated questions were used from the Patient Satisfaction Questionnaire to gauge satisfaction with the process of care through the TAP program\textsuperscript{18}. Additional open ended questions were included on why they chose not to enroll in
the TAP program. Questions were piloted with patients who joined the TAP program and are of a similar demographic. Recruitment letters were mailed to eligible patients to inform them of the study. Surveys were conducted in English via phone by the researcher. Prior to each survey, patients were reminded as to the referral of interest. A token of $10 was given to participants upon completion.

**Analysis.** Program administrative data was used to extract demographic information, specialty referral details, and TAP enrollment status from May 2009 to May 2010. Referrals were categorized as therapeutic, diagnostic, pain related, or ancillary. Therapeutic referrals included those to specialty physicians for interventions. Diagnostic referrals included those for radiologic or other specialty diagnostic tests. Pain related included visits to physical therapists or pain specialists. Ancillary visits included referrals to non-physician allied health professions. Each visit was classified into one of these categories by the researcher based on the reason for each referral and if unclear confirmed by a physician involved in the study.

Stata 11 was used for statistical analysis. Univariate logistic regression analysis was done to see if type of referral, zip code, gender or age were independently associated with increased odds of joining the program. We also adjusted for the clustering effect of more than one referral being made to the same person. Multilevel logistic regression analysis was used to examine the relationship between type of referral and enrollment status after controlling for zip code, gender and age. The Wald test was used to compare differences in the odds ratios of the categorical variables. Open ended survey responses were analyzed using word count analysis where unique words in each response were tallied and synonyms were grouped together\(^{19}\).
Reported barriers faced by the patients were conceptualized as factors specific to the program, factors specific to the patient, or a combination of both. The results of the word count analysis about barriers to the utilization of care were categorized by two of the researchers and verified by a third if there was disagreement. If responses highlighted problems with processes currently in place within the program, those were considered program specific barriers. For example, insufficient follow-up from the program coordinators represented a program-specific problem. If responses highlighted problems that did not fall within the capacity of the program, those were considered patient-specific problems. For example, if a patient would be fired from work for missing a day to attend an additional appointment, that was considered patient-specific. Other responses were categorized as both patient-specific and program- specific if they highlighted a problem not currently within the design of the program but potentially within the capacity of the program. Not being able to find transportation would fall into this category because it is not a formal part of the program for every patient but can be coordinated for patients in need and could potentially be expanded.

Results
In the first year of the program, 737 referrals were made for 333 patients. Of these, 25 patients did not have any referrals approved by the medical director, 204 patients enrolled in the program and completed and followed through with at least one referral. 104 patients did not join TAP and did not complete any referrals. We analyzed whether demographic variables were associated with joining the program. Age and gender were not associated with increased likelihood of joining the program. The odds of joining, after adjusting for age and gender, were 4 to 8 times higher for those who lived in the 21224 zip code compared to those who lived in
21202, 21205 or 21213 (p<0.02). No difference was observed between those living in 21224 and 21231. Table 1 shows the demographic data for the patients who enrolled in TAP compared to those who did not enroll in the program.

We then analyzed whether referral type was associated with referral completion. After adjusting for age, gender and zip code, diagnostic referrals were 8.56 times more likely to be completed than ancillary referrals (p=0.001) and therapeutic referrals were 3.53 times more likely to be completed than ancillary referrals (p=0.03). There was no difference between pain related referrals and ancillary referrals (OR=2.80, p=0.139).

**Survey Results.** Of the 104 eligible patients, 86 were called and 18 surveys were completed with 23 unique responses. The most common reason for not completing a survey was no answer. There were no significant differences in age, gender, zip code, number of referrals or types of referrals between survey participants and survey eligible patients (data not presented).

Patients cited a number of barriers limiting utilization of care that included program specific factors, patient specific factors and a combination of the two. Program-specific barriers included insufficient follow up from the program and unclear eligibility. One patient said “I didn’t hear back from them about the CAT scan.” Another patient said “I didn’t think I was eligible. I was waiting for a medical assistance card to go.” Other survey responders reported patient specific barriers to joining the program. Barriers in this category included work conflicts, forgetting to follow up, too sick to go to additional appointments, no longer
needing services and not wanting services. One patient said “I felt like I was ok and it was just a phase I was going through. I do need to go back though; but I didn't go back.”

Finally, other responders cited a combination of program and patient-specific barriers; barriers not completely within the current design of the program but potentially within the capacity of the program to change. These barriers included financial barriers posed by the entry fee into the program, transportation or mobility issues, not understanding the reason for referral, and choosing outside services. Those citing financial barriers all said that the fee was not too expensive, but they could not come up with the money in the time period they were asked to pay. Figure 1 illustrates the barriers faced and the relative frequency these were reported.

Discussion

The goal of the TAP program is to improve access to specialty care for uninsured patients by reducing financial and logistical barriers to care. Over 300 people were referred to the program in the first year, 104 (31%) of whom did not join the program and utilize the care offered. In order to understand the reasons underlying lack of utilization, we investigated demographic, referral, personal, and program-specific factors. We found that patients living in the 21224 zip code had a higher likelihood of enrollment. This may signify some unmeasured community factors present that support increased healthcare utilization.

We found that diagnostic and therapeutic referrals were more likely to be completed than ancillary and pain-related referrals. Previous research has shown that about 25% of
primary care visits include a referral to see a specialist yet between 20-30% of these referrals go uncompleted. Patients are forgoing care that is indicated by their primary care provider. Most of the research thus far has been in almost entirely insured populations. Among insured adults, specialty to which the patient was referred was not shown to be associated with completion rates. In a low income, insured, pediatric population, surgical specialty referrals were completed more often than medical specialty referrals. Our data comes from a low income, uninsured, adult population and shows that there is a difference in specialty completion rates based on the type of referral received. This may be due to the expectation that diagnostic and therapeutic referrals would provide some desired relief or explanation while the other types would not. The pain and ancillary referrals might also require more time and repeat visits, since a patient may need to go to physical therapy sessions for weeks to achieve the desired result. Ways to improve attendance rates at pain-related or ancillary referrals might include offering those services on site, shortening the wait time to an appointment, or improving communication with patients about the importance of the referral.

Future research is needed to better understand these differences. Patient centered homes may be changing this trend of underutilization of specialty care. Research shows that the patient centered medical home model can have sustained increases specialty care visits with decreased emergency room visits and inpatient admissions. It will be important to ensure that this increased utilization is equal across patients and across specialties. Through surveys of 18 patients, we identified themes within our patient population that have prevented them from utilizing specialty care through the TAP program. These included barriers specific to the program, specific to the patient, and some that were a combination because they were not
within the design of the current program but could be addressed by the program. Based on these survey responses, we identified important aspects of our program that need to be revised, including extending the time window to join the program, implementing payment schedules, increased communication with patients through text messaging and social support networks.

Additional motivational counseling from the program and better advertising of the services offered by the program could also be beneficial.

Previous research on barriers to free care also included personal factors like having to work or watch children, lack of transportation, being too sick or having to prioritize other expenses. Previously reported program factors include long waiting times, history of negative experiences with the health care system and lack of information on affordable options. None of these studies were carried out in patients seeking specialty care services. The barriers faced by uninsured patient populations within programs designed to give free care has little research. The data from our study shows that the uninsured patient population within East Baltimore who had access to the TAP program and needed medical specialty care faced similar logistical concerns with getting to appointments but also cited lack of informational on how to navigate the system as a barrier. Patients who knew less about the referral, why they got the referral, how to follow up or the importance of the referral did not attend.

**Limitations.** Recall bias and non-response bias are major limitations to this survey. Non-responders to the survey were not followed up with in person, but since the demographics of our survey population are not different from the eligible patients, we do not think this greatly
affected our data. Additionally, the small sample size and sampling of only English speaking patients may limit generalizability.

Implications. This evaluation focused on an uninsured population who declined access to a program offering free specialty care and care coordination. We found that certain types of referrals were more likely to be attended, and barriers persisted despite eliminating financial and logistical barriers to care. Improved patient education and follow-up strategies, as well as changes to the services offered by the program can be made to remove these barriers and better serve patients. This research underscores the need for local, state and national programs to look beyond just financial barriers and create programs that address all the barriers patients face in accessing care. While removing costs associated with care is necessary to improve access to specialty care for underserved patients, it is insufficient. As access to care is increased through national changes in health care delivery, it will be important to ensure that all patients are utilizing all of the services they need in order to optimize outpatient medical care. Future work should focus on identifying these patients who are likely not to utilize specialty care services and improve communication and resource coordination to encourage these patients to follow through with their care.
Table 1. Demographic comparison of the patients who did not join the TAP program compared to those patients who did join. Univariate logistic regression was used to determine if gender, age, zip code or referral type was associated with joining the program.

Demographic comparison of Non enrollees and Enrollees in TAP Program

<table>
<thead>
<tr>
<th>Demographic</th>
<th>Non enrollees in TAP</th>
<th>TAP Enrollees</th>
<th>p-value</th>
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</thead>
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<td></td>
<td></td>
<td>0.917</td>
</tr>
<tr>
<td>M</td>
<td>43 41.3%</td>
<td>98 48.0%</td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>61 58.6%</td>
<td>106 52.0%</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
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</tr>
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<td>Mean</td>
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<tr>
<td>Zipcode</td>
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<tr>
<td>21213</td>
<td>41 39.4%</td>
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<tr>
<td>21224</td>
<td>13 12.5%</td>
<td>52 25.5%</td>
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<tr>
<td>21205</td>
<td>26 25.0%</td>
<td>33 16.2%</td>
<td></td>
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<tr>
<td>21202</td>
<td>18 17.3%</td>
<td>24 11.8%</td>
<td></td>
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<td>21231</td>
<td>6 5.8%</td>
<td>15 7.4%</td>
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<td>Referral types</td>
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<td>Therapeutic</td>
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<td>235 50.4%</td>
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<td>Diagnostic</td>
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<td>43 9.2%</td>
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<tr>
<td>Pain</td>
<td>15 10.1%</td>
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<td></td>
</tr>
</tbody>
</table>
Figure 1. Bubble plot showing the degree to which the 23 identified barriers to joining the TAP program were program specific or patient specific. Size of the bubble represents the relative frequency with which each barrier was reported.

Patient reported barriers to joining the TAP program

References


15. Hadley J. Sicker and poorer--the consequences of being uninsured: A review of the research on the relationship between health insurance, medical care use, health, work, and income. Med Care Res Rev. 2003 Jun;60(2 Suppl):3S,75S; discussion 76S-112S.


APPENDIX D3

Does providing access to specialty care to an uninsured population reduce ED utilization?

Abstract word count: Word count:

Tables: 2

Figures: 1

References: 10 (limit 10)

Key words: Access to care, emergency department, underserved populations, program evaluation, uninsured, specialty care, academic medical center

No NIH trial registry number
Abstract

Study hypothesis
The annual number of emergency department (ED) visits increased 23% between 1997 and 2007 nationally. The uninsured and those with chronic medical conditions have been implicated in this increase in utilization. We hypothesized that care coordination and access to specialty services provided by The Access Partnership (TAP) would reduce ED utilization among uninsured patients.

Methods
We conducted a quasi-experimental multiple time series to examine rates of monthly ED utilization and inpatient admission among TAP patients and a comparison group of eligible patients who did not join. Monthly ED utilization and inpatient admission rates for both groups were examined prior to and subsequent to referral to TAP, within a study period 2007-2011, adjusting for socioeconomic factors using multivariate linear regression.

Results
During the first 21 months of the program, 673 patients were referred to TAP and 374 patients joined the program. Rates of ED visits per month increased in both groups, from 0.039 to 0.051 visits per month among TAP patients and 0.057 to 0.083 visits per month among non-TAP patients (p-value of difference=0.15). The number of ED visits per month that did not result in inpatient admission was relatively constant among TAP patients (difference post-pre= 0.006), whereas the rate increased among non-TAP patients (difference=0.023, p=0.05). TAP status was a moderate predictor of ED visits not leading to admission, after controlling for age, gender, and zip code (p=0.045).

Conclusions
There was not a significantly different change in overall ED utilization between program participants and non-participants. However, there was a trend toward lower rate of inpatient admission for TAP patients relative to the comparison group.
Introduction

Background

The annual number of emergency department (ED) visits in the U.S. increased 23% between 1997 and 2007 (1). The uninsured are more likely to lack a usual source of care, require avoidable hospitalizations, and have higher utilization of emergency care (2). Poverty, lack of insurance, and ethnic minority status have been implicated in predicting use of the ED as a usual source of care (3) as well as use of the ED for ambulatory sensitive conditions (4). Though many uninsured patients are able to access primary care through the federal safety net program of federally qualified health centers and other free and low cost clinics, these patients often lack access to specialty care (5). Studies have failed to show that access to primary care alone decreases utilization of the ED (6,7), and in fact, patients with a usual source of care may be driving the recent increase in ED visits (8). Project Access, using a model including provision of free care and care coordination to uninsured individuals lacking a primary care provider, was able to demonstrate a reduction in emergency department utilization (9), leading to the hypothesis that access to primary plus specialty care may contribute to reduction in ED utilization among uninsured patients. We sought to evaluate whether a program that targets uninsured patients with a primary care provider, and offers access to specialty care services as well as care coordination, would decrease ED utilization relative to a comparable group of individuals without access to specialty care.

The Access Partnership (TAP) program (10) is a novel collaboration between primary and specialty care clinicians at Johns Hopkins Hospital and East Baltimore Medical Center (EBMC), a primary care center that serves a low-income population with a high rate of uninsurance. TAP facilitates access to specialty services and care coordination for uninsured patients with a primary care provider at EBMC. Eligible patients pay a small one-time fee ($20) to enter the program and receive specialty care and any needed follow-up free of charge.

We hypothesized that the specialty care and care coordination offered by TAP would improve access to outpatient care and might therefore result in decreased ED utilization among patients who joined the program. We further hypothesized that while rates of inpatient admission might not change significantly, more comprehensive outpatient care might result in fewer ED visits that did not result in admission. We examined administrative data on ED and inpatient hospitalization for patients who enrolled in the program, compared to those referred to the program who did not enroll, to determine whether monthly rate of ED utilization changed relative to enrollment in the program.

Methods

Study Design:

We conducted a quasi-experimental multiple time series study using difference-in-difference estimation to determine the impact of TAP on ED and inpatient hospitalization rates. Approval for this study and HIPAA waiver were granted by the Johns Hopkins School of Medicine Institutional Review Board. We retrospectively examined administrative data on ED utilization and inpatient hospitalization at Johns Hopkins Hospital (JHH) and Bayview Medical Center (BMC) during 48 months from May 2007 through April 2011.
Intervention:

Beginning in May 2009, internal medicine providers at EBMC referred uninsured and underinsured patients from ZIP codes 21205, 21213, 21224, 21202, and 21231 for needed specialty care. Referrals were evaluated by the TAP medical director for medical necessity and cost effectiveness. The medical director was a senior family physician who worked at the EBMC practice. The medical director did not approve referrals that were deemed medically unnecessary or incompletely documented, such as referral of a patient with back pain to have an MRI before conservative management had been tried, or without a musculoskeletal exam documented.

If approved, a TAP coordinator invited the patient into the program and explained the program to the patient, the importance of each referral, and full cost coverage offered by the program. The coordinator then collected a fee of about $20, scheduled the patient’s appointment, and followed up to remind the patient of the upcoming appointment. Referrals were made to providers and for tests at Johns Hopkins Hospital (JHH). TAP-covered services included all specialty care available at JHH, including mental health services. The purpose of collecting the TAP fee was to engage patients in taking proactive steps to protect their health and to encourage follow-through with referrals; the fee was waived in cases of reported significant financial hardship. Subsequent visits, diagnostics, and hospitalizations stemming from the referral were covered by the program as well. Primary care providers received feedback on the status of the appointment, to enable them to facilitate needed follow-up (10).

Participants

The study population included patients referred to TAP during the first 21 months of the program; May 2009 through January 2011. Patients were categorized as TAP patients (the intervention group) if they joined the program by paying the fee or requesting a fee waiver. Patients who received referrals but declined entry into the program, never followed up, or whose referrals were not approved by the medical director were classified as non-TAP patients and served as the comparison group for this study. For the purpose of the study, patients who paid the fee continued to be classified as TAP patients, even if they did not follow through with the referral.

Methods of measurement:

Key outcome measures included rates of ED and inpatient admission per month prior to date of referral to TAP, compared with after date of referral. Patient information and referral follow-through were obtained from administrative records kept by the TAP program. ED and inpatient visits were collected from the hospital’s inpatient records, which are reported to the state. To adjust for the fact that patients were referred to TAP at different time points during the study, we calculated per-month ED visit rates for each patient depending on their time in the program. Time prior to TAP (pre-TAP) was calculated for each patient as the number of months from the start of the study on May 1, 2007 until date of first referral to TAP. For non-TAP patients, time prior to TAP was similarly calculated as the time from study start until the date of the first referral. Time subsequent to TAP (post-TAP) was calculated as the number of months from date of first referral through the end of the study on April 30, 2011. We chose a study start
date two years prior to the TAP program in order to permit sufficient observation of patient ED utilization prior to the program. Monthly rates of emergency department utilization and inpatient admission were calculated for the pre-TAP and post-TAP interval for each patient, and compared for TAP patients and non-TAP patients.

Data analysis:

Data was analyzed using 2-tailed t-tests to determine the difference-in-difference between TAP and non-TAP patients’ ED utilization relative to date of first referral to the program. Difference-in-differences estimation as well as multivariate linear regression using STATA IC 11 (College Station, TX) were used to determine whether TAP status was associated with ED utilization and inpatient admission, after adjusting for baseline characteristics including age, sex, and zip code of residence.

Results:

During the first 21 months of TAP, 673 patients were referred to TAP. 374 patients paid the fee or requested a waiver and joined the program. 299 patients did not enter the program due to a patient or clinical reason, referred to as non-TAP patients in the present paper (i.e. comparison group). Demographic characteristics of TAP and non-TAP patients are compared in table 1. Mean age of TAP patients was 46, and mean age of non-TAP patients was 45. 48% of patients were male among TAP and non-TAP groups. Most patients were from zip code 21213. TAP patients were not significantly different from non-TAP patients with respect to age, gender, or zip code, with the exception of zip code 21224, which was disproportionately represented among TAP patients (30% of TAP patients compared with 22% of non-TAP patients, p=0.01).

Table 1: Demographic characteristics of TAP and non-TAP patients

<table>
<thead>
<tr>
<th></th>
<th>TAP</th>
<th>Non-TAP</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>374</td>
<td>299</td>
<td></td>
</tr>
<tr>
<td>Age (mean)</td>
<td>46</td>
<td>45</td>
<td>0.17</td>
</tr>
<tr>
<td>Gender (% female)</td>
<td>52%</td>
<td>52%</td>
<td>0.92</td>
</tr>
<tr>
<td>Zip code 21202 (%)</td>
<td>16%</td>
<td>13%</td>
<td>0.24</td>
</tr>
<tr>
<td>21205</td>
<td>21%</td>
<td>18%</td>
<td>0.31</td>
</tr>
<tr>
<td>21213</td>
<td>31%</td>
<td>31%</td>
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</tr>
<tr>
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</tr>
<tr>
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<td>22%</td>
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</tr>
<tr>
<td>21231</td>
<td>7%</td>
<td>10%</td>
<td>0.24</td>
</tr>
</tbody>
</table>

50% of TAP patients and 58% of non-TAP patients utilized the ED in the pre-referral period, compared with 29% and 32%, respectively, in the post-TAP study period. As shown in table 2, rates of ED visits per month increased in both groups, from 0.039 to 0.051 visits per month among TAP patients, a 31% increase from baseline, and 0.057 to 0.083 visits per month among non-TAP patients, a 46% increase from baseline. Compared with non-TAP patients, TAP patients had 0.014 fewer visits post-TAP (p=0.16, 95% CI -0.033, 0.006).
Multivariate linear regression was then used to determine whether TAP status was associated with lower rate of ED utilization after controlling for sex, age, and zip code of residence. There was not a significant association between TAP status and ED utilization (95% CI -0.005, 0.035, p=0.13). Difference-in-differences regression yielded a non-significant interaction term of -0.014 (95% CI -0.044-0.01).

Among the subgroup of ED visits that did not result in inpatient admission, the number of visits per month was relatively stable among TAP patients, whereas this rate increased among non-TAP patients. As shown in figure 1, TAP patients had 0.030 non-inpatient visits per month pre-TAP and 0.036 visits per month post-TAP (difference post-pre= 0.006), a 20% increase from baseline, whereas non-TAP patients had 0.044 visits pre-TAP and 0.068 visits per month post-TAP (difference post-pre=0.023), a 55% increase from baseline. Compared with non-TAP patients, TAP patients had 0.017 fewer ED visits leading to admission post-TAP (p=0.05, 95% CI -0.0001-0.035).

In multivariate linear regression, TAP status was a moderate predictor of ED visits not leading to admission, after controlling for age, gender, and zip code (p=0.045, 95% CI 0.0004-0.036). Difference-in-differences regression yielded a non-significant interaction term of -0.017 (95% CI -0.044-0.009).

**Discussion**

Similar to national trends among low-income patients over the past decade (1), rates of ED utilization increased in this sample over the study period. This increase was lower among TAP patients than non-TAP patients, though it did not reach statistical significance. However, for ED visits that did not result in inpatient admissions, we did find moderately (p=0.05) lower rates among TAP patients, relative to the comparison group.

We hypothesized that improved access to outpatient care and care coordination provided through the program would result in lower rates of ED utilization. Our comparison group was similar to TAP patients in terms of demographics and socioeconomics, but did have non-significantly higher baseline levels of ED utilization, and did not enroll in the program due to declining services, lack of approved referrals, or a change in eligibility status, such as receiving health insurance after the date of initial referral.

Prior studies have shown that having usual source of care alone does not reduce ED use among uninsured patients. In a low income population, difficulties getting to clinic visits due to work, childcare, or transportation conflicts as well as low health literacy may contribute to the use of emergency services.

Increased access to care rather than reduced ED utilization was the primary goal of the TAP program. Nevertheless, improved access to outpatient services and care coordination as well as an educational intervention addressing benefits of outpatient care services and obtaining urgent care might be a low-cost way to reduce ED utilization. Future work will focus on understanding reasons for increasing utilization of the ED in this population, as well as developing strategies within primary care to improve access in this population, such as open appointments or weekend hours.

**Limitations**

A limitation to this study is that we only were able to assess ED utilization at two major hospitals: JHH and BMC. Any ED visits at other hospitals were not included in this data. Previous survey data with TAP patients indicated that 82% of patients reported utilizing one of
these two hospitals primarily for ED use (9), leading us to believe that we were capturing the majority of ED utilization through administrative data from these two hospitals. This study focused on emergency care and we did not address primary care utilization, which may have differed between the groups and impacted ED utilization.

Our comparison group may differ from our intervention group in terms of motivation towards obtaining needed healthcare, and indeed these groups had different baseline levels of ED utilization. This may have been due to higher burden of illness, reliance on the ED as the usual source of care, or other barriers to use of primary care services. Although we adjusted for demographic variables, we were unable to adjust for comorbidities. Residual confounding is a major limitation of this study. As with any administrative data, misclassification bias is a potential problem. There may have been crossover if study subjects elected to attend the first TAP visit, and not attend any other visits; for the purpose of our analysis, we analyzed this group as TAP patients.

Another limitation is the short time frame for this study. Stronger results might result from more time in the program in which to have medical needs addressed and to change behaviors.

Judging “appropriateness” of ED visits is difficult and wrought with assumptions (12). Our decision to stratify ED visits into those resulting in admission and those not resulting in admission is based on our hypothesis that the TAP program would result in improved access to outpatient care, thereby avoiding some non-urgent ED visits.

**Conclusion**

Increasing ED utilization is in part driving the increasing cost of healthcare in the U.S. Identifying strategies to decrease reliance on the ED are important, particularly among a population with high levels of utilization. Our evaluation found that TAP patients had somewhat decreased ED use resulting in inpatient admission relative to a comparison group of patients who did not receive the intervention. This change in utilization may be due to improved access to specialty care. Future work will focus on in-depth interviews with heavy users regarding ED utilization as well as comparison of TAP patients to a group of insured patients of similar socioeconomic backgrounds over a longer time period, in order to further investigate whether or not TAP helps change care utilization patterns.

**Acknowledgements**

1. Contributors: We would like to acknowledge Dr. Barbara Cook for her leadership; Dr. Baumgartner for his encouragement, and the TAP and EBMC staff for their support and advocacy.
2. Funders: This study was funded by the Urban Health Institute at Johns Hopkins University.
3. Prior Presentations: None
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<th>Non-TAP</th>
<th>Difference in Difference</th>
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<td>Non-inpatient ED visits per month (mean, SD)</td>
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</table>

*Comparing difference-in-difference between TAP and non-TAP patients
Figure 1: Visits per month among TAP and comparison group, pre- and post-TAP
References

6. Zuckerman S, Shen YC. Characteristics of occasional and frequent emergency department users: Do insurance coverage and access to care matter? Med Care 2004; 42; 176-82.
APPENDIX E

Latino Health Seminar Series

In 2010, Johns Hopkins faculty responded to the needs of the growing Latino population in Baltimore by establishing an organization named H.O.L.A. (Hopkins Organization for Latino Awareness) whose mission is to improving the access and quality of care for Latinos seeking healthcare at Hopkins through scholarship, education, and policy leadership. The organization has 15 active members from Internal Medicine, Pediatrics, Psychiatry, and Obstetrics and Gynecology from the Bayview and East Baltimore campus who meet monthly to set priority tasks that can positively impact patient care and outcomes of Latinos in Baltimore.

As part of the educational mission of HOLA and to improve collaborations between community partners and JHU faculty/students, in the Fall of 2011 HOLA launched the Latino Seminar Series at the School of Public Health with the financial support of the Urban Health Institute. Community and academic members were invited to the seminar series according to their interests and expertise in topics relevant to Latino health. The seminar begins with a brief presentation by a JHU faculty or student on work done in partnership with the Baltimore Latino community. A 45 minute question-answer session follows the initial presentation with particular emphasis on getting feedback from our community partners in order to inform the academic work and research.

The following topics have been discussed at the Latino Seminar Series:

**Fall 2011**

1. Use of Technology to Reduce Obesity among Latino Children (Faculty Preceptor: Darcy Thompson)
2. Reducing Late Diagnosis of HIV among Latinos (Preceptors: Kathleen Page and Suzanne Grieb)
3. Obesity in low-income Latino children: Assessing the feasibility of establishing a prospective birth cohort (Faculty Preceptor: Sarah Polk)
4. Mental Health Issues among Recent Latino Migrants (Preceptors: Donna Batkis and Marcelo Batkis)
5. Future Directions of a Community-Based Participatory Occupational Health Needs Assessment of Latino/a Immigrants in Baltimore (Preceptor: Airín Martínez)
6. Mal de Ojo: UhOh- Traditional Health Beliefs of Latinos (Preceptor: Barbara Cook)

**Upcoming topics**
1. Navigating the healthcare system for elder Latinos (Alicia Arbaje)
2. Domestic violence among Latino populations (Nancy Glass)
3. Providing care to limited English proficiency patients (Cheri Wilson)

Attendance

We are pleased to report that the attendance to the Latino Seminar Series has been steadily increasing since its beginning to standing room only (in a room that seats 30). We are particularly encouraged by the high level of attendance from community partners. Members from the following organizations have consistently attended the seminar:

- Casa de Maryland
- La Esperanza Center
- BCHD
- Spanish-Speaking Health Care Leaders and Service Providers of MD
- BMS Medical Systems
- House of Ruth (Adelante Familia)
- Baltimore Health Care Access

Future directions

The Latino Seminar Series has brought together community leaders and JHU faculty, staff and students interested in Latino health. These interactions have not only informed existing work but have also instigated new collaborations to address priority issues. We would like to secure ongoing support to sustain the Latino Seminar Series and to organize an annual day-long workshop focused on Latino Health. Dr. Page has met with Emma Cervone, Associate Director of the JHU Program for Latin American Programs, to explore the feasibility of a joint symposium with the various JH Schools.
APPENDIX F1

Workshop Title: Messaging and Communications
Date: Thursday, November 10, 2011

For each of the following areas, please indicate your reaction:

**Content**

<table>
<thead>
<tr>
<th></th>
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<th>Good</th>
<th>Needs Improvement</th>
<th>Not Applicable</th>
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</tr>
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<td>Practical to My Needs and Interests</td>
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<td>4 (24)</td>
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<td></td>
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<tr>
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<td>1 (6)</td>
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<td>Useful Visual Aids and Handouts</td>
<td>14 (82)</td>
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**Presentation**

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<tr>
<td>Instructor Covered Useful Material</td>
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<td>2 (12)</td>
<td>1 (6)</td>
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<tr>
<td>Instructor Responded Well to Questions</td>
<td>16 (94)</td>
<td>1 (6)</td>
<td></td>
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**Overall, how would you evaluate this workshop training session?**

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<th></th>
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<th>Good</th>
<th>Fair</th>
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<td></td>
<td>16 (94)</td>
<td>1 (6)</td>
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Evaluation Summary

Participants
- Registered = 18
- Actual attended = 17
- JHU personnel attended = 6
- Completed evaluation = 17

The program evaluation workshop on November 10, 2011 received overall positive reviews. Seventeen people completed evaluations and most of the participants rated the workshop as “excellent” or “good” (94% and 6% respectively).

Content
The content of the workshop was received very well by the participants. The overall ratings were “excellent”, “good” and one “needs improvement.”

Presentation
Participants rated the presentation of the workshop as “excellent”, “good” and one “needs improvement. Participants also verbally commented that they enjoyed the workshop – specifically the facilitators and the details of their presentations.

Comments
Several participants included positive comments about the overall workshop:
- Wonderful space – nice chairs, AV, carpet, etc.
- Content and delivery was excellent

Improvement Suggestions
Format and Content:
- Provide participants with the PowerPoint notes
- Review all of the info in the packet
- Lessen classroom setting so that we can see each other
- Had very limited knowledge on Twitter and blogs prior to the training; knowledge has not increased as a result of the workshop
- Have computers available for each participant to connect each media type
- Material/handouts were great – just a little hard to find when trying to relate to follow the presenter; could be better organized

Other/Logistical:
- More “live” hands-on opportunities to practice skills
- Another day of hands-on cases
- More time to practice interviewing and writing out messages
- Annoying setup re: the tables – people can’t get in and out
Future Ideas/Lessons:
- Obtain the before & after video of our individual presentation
- Critique of my organization’s messaging/online/print/materials. We’d love to have someone review and suggest how to improve.
- Need more time to work one-on-one with the experts
- Needs to be longer than one day; also a follow-up with presentations reviewed and critiqued

Additional Topics
Several participants suggested the following topics for future workshops:
- Training on Advocacy, Testimony and Legislation
- Earning CEUs for classes
- Writing for Journals, Opt Eds and Effective Articles
- Communication Strategies
- Grant Writing
- Impacting Government Strategies
- Media Etiquette for Interviewing and (Interacting with the media)
- Current Events/Topics
- Local Non-Profits
- A follow-up to Messaging and Communications; another outcomes measurement training like UHI offered a couple of years ago; something on bringing middle class and low-income communities together (getting fears, prejudices, and values out into the open).
- Translating science into media that the community can understand and use; how to spice it up without losing integrity of the data
- Grant Writing

Overall Evaluation
In total, the workshop was rated as “excellent” and “good”. Most of the participants arrived on time and were eager to receive the information from the facilitators. The weather was cool and rainy. The participants were very engaging and greatly enjoyed the local media speaker (Sherrie Johnson from WMAR-2) along with their mock interview video recordings. All participants stayed for the full workshop which ended at approximately 4:00pm.
APPENDIX F2

Workshop Title: Messaging and Communications
Date: Friday, March 9, 2012

For each of the following areas, please indicate your reaction:

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<td>Practical to My Needs and Interests</td>
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<td>Well Organized</td>
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<td>Effective Activities</td>
<td>11 (85)</td>
<td>2 (15)</td>
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<td>Useful Visual Aids and Handouts</td>
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<td>1 (8)</td>
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Presentation

<table>
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<td>13 (100)</td>
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<td></td>
</tr>
<tr>
<td>Instructor’s Presentation Style</td>
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<td></td>
<td></td>
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<tr>
<td>Instructor Responded Well to Questions</td>
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Workshop Sessions

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<th>Ratings</th>
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<th>Controlling The Interview</th>
<th>Mock Interviews</th>
<th>Lunch with Sherrie Johnson</th>
<th>Engaging Online</th>
<th>Working with Policymakers</th>
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<tr>
<td>Excellent</td>
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<td>10 (77)</td>
<td>13 (100)</td>
<td>10 (77)</td>
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<td>Good</td>
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<td></td>
<td>1 (8)</td>
<td>1 (8)</td>
</tr>
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</table>
Overall, how would you evaluate this workshop training session?

<table>
<thead>
<tr>
<th>Excellent</th>
<th>Good</th>
<th>Needs Improvement</th>
<th>Not Applicable</th>
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<tr>
<td>12 (92%)</td>
<td>1 (8)%</td>
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</table>

**Evaluation Summary**

**Participants**
- Registered = 16
- Actual attendants = 14
- JHU personnel attended = 4
- Completed evaluations = 13

The program evaluation workshop on March 9, 2012 received overall positive reviews. Thirteen people completed evaluations and most of the participants rated the workshop as “excellent” or “good” (92% and 8% respectively).

**Content**
The content of the workshop was received very well by the participants. The overall rating was “excellent”.

**Presentation**
Participants rated the presentation of the workshop as “excellent” and “good”. Participants also verbally commented that they enjoyed the workshop – specifically the facilitators and the details of their presentations.

**Workshop Sessions and Comments**
The ratings for the workshop sessions varied from “excellent” to “good”. Several participants included comments about the overall workshop:
- **Messaging**
  - “The first half of the day was very helpful, especially ‘controlling the message’.”
  - “The messaging session helped to bring an understanding to the messaging process, as well as framing the message to meet the need of your audience”.
  - “The messaging session was a great reinforcement focusing around a few key points.”

- **Bridging**
  - “I learned how to bridge the question asked, answer the question and get my message across”.
  - “I thought the bridging session was the most useful. We all get into conversations with people daily, but if we can bridge over to what’s important, we could address more issues and concerns”.
• “The bridging session helped make me aware of the importance of staying (focused) on messages and not to be distracted by questions that are not relevant to getting your message out”.
• "Bridging was most useful to me. Often people will try to lead you astray with their questions. It was good to learn how to bring it to full circle”.

• On Camera Practice
  o “It gave me a chance to see my presentation – body language, facial expressions, etc.”
  o “The hands on interviews were great, though a bit hard to watch myself on TV”.
  o “I found the on-camera practice to be most useful because it brought together the messaging and bridging content and the feedback was great”.
  o “I was very nervous, and it gave me a confidence that I did not have prior to this workshop”.

• Online Media
  o “The social media session helped put into perspective their relative value and how to use them effectively”.

• Working with Policymakers
  o “The policymakers session allowed me to make sure that I have all bases covered”.
  o “Working with policymakers was the most useful because it demonstrated all of the skills my peers learned during the workshop”.

Least Helpful Session
• Online media
  o Fairly familiar with the topics covered
  o “I think it’s very important to talk and to share info about social networks, but because they are a part of my everyday life, I felt as though I was already up to date”.
• Messaging
• “All sessions were of benefit”.
• “I enjoyed them all”.

Guest Speaker
The workshop participants had the opportunity to have lunch with Sherrie Johnson, General Assignment reporter and anchor from WMAR-2 News (ABC) in Baltimore, MD. She gave an overview on how to communicate effectively during television interviews. Below is the feedback from participants:
• “She gave an inside view of TV news preparation”.
• “She gave useful information and suggestions”.
• “I appreciated hearing her talk about the schedule of a reporter, the time constraints, the logistics and strategies for ‘pitching’ stones effectively”.
• “Her presentation and mock interviews were very helpful”.
• “She was great and made people feel comfortable during the interview”.
• “She offered a polite, friendly and real approach to the world of TV news”.
• “She gave me an insight on what to expect from a reporter – very informative”.

3
• “Sherry was both informative and helpful. Her insight and help with the broadcast media was great”.
• “It was great to hear about how other media stations run their shop”.
• “Extremely helpful – provided the TV media framework”.
• “She was amazing. I plan to network with her”.

Improvement Suggestions

Format and Content:

• “It’s perfect as is”.
• “Refine policymaker scenario. Perhaps focus on city vs. state policymakers.”
• “I would like to see a live demo of social media”.

Other/Logistical:

• More “live” hands-on opportunities to practice skills
• A little shorter day, but overall it was great
• Portions seemed a bit long, specifically in the afternoon
• Increase the amount of time for the workshop
• "More time”
• “Make it available to more people”

Additional Topics

Several participants suggested the following topics for future workshops:

• Blogging
• Setting up organization social media presence
• Effective strategies for collaborating with community members to bring ‘stories’ to messages about research findings/creating coalitions to advocate to policymakers.
• More messaging tailoring to multiple audiences
• Public speaking
• Social media
• Video role play
• Networking with professionals outside of the field of education
• Grant Writing - Certification

Overall Evaluation

In total, the workshop was rated as “excellent”. Most of the participants arrived on time and were eager to receive the information from the facilitators. The weather was cool and sunny. The participants were very engaging and greatly enjoyed the local media speaker, Sherrie Johnson, along with their mock interview video recordings. All but one participant stayed for the full workshop, which ended at approximately 4:00pm.
APPENDIX G

Workshop Title:  
Nuts and Bolts of Monitoring and Evaluation

Date:  
Friday, April 27, 2012

For each of the following areas, please indicate your reaction:

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<td>Well Organized</td>
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</tr>
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<td>Presented at the Right Level</td>
<td>22 (88)</td>
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<td>Effective Activities</td>
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Please indicate how useful you found each of today’s sessions:

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Overall evaluation of the workshop training session:

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<th>Good</th>
<th>Needs Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>23 (92)</td>
<td>2 (08)</td>
<td></td>
</tr>
</tbody>
</table>

Evaluation Summary

Participants
- Registered = 35
- Actual attendants = 31
- JHU personnel attended = 6
- Completed evaluations = 25

The program evaluation workshop on April 27, 2012 received overall positive reviews. Twenty-five people completed evaluations and most of the participants rated the workshop as “excellent” or “good” (92% and 8% respectively).

Content
The content of the workshop was received very well by the participants. The overall rating was “excellent”.

Presentation
Participants rated the presentation of the workshop as “excellent” and “good”.

Workshop Sessions and Comments
The ratings for the workshop sessions varied from “excellent” to “good”. Several participants included comments about the overall workshop:

Most Useful Session
Several participants included comments about the most useful sessions:
- Describing Programs Through the Evaluation Lens
  - Cleared up my views on how to evaluate and talk about outcomes; the other sessions really expanded well on this intro

- Focus Group
  - Currently conducting focus groups with faith based community and other community groups

- Logic Model
  - Helped with understanding the entire process
  - Helped to organize thoughts
  - I can take it back to my organization and work through it with my team
Helped with evaluating program design, delivery and ability to achieve its goals, objective(s) and outcomes
- It truly helps me break down the steps of my project
- It provided exercise for critically thinking about the program
- I gained clarity of the components, especially output vs. outcome

- Evaluation
  - A difficult topic, yet this was interesting and most informative

- All Sessions were helpful to some participants
  - All of the Modules were wonderful, well arranged and artfully presented.
  - Modules 1 and 4 really explained what and how to make the process manageable and practical.

Least Helpful Session
Several participants included comments about the least helpful sessions:
- Describing Programs Through the Evaluation Lens
  - Very basic, essentially going through the other sections of the workshop, you should be able to describe your program

- Logic Model
  - I already knew a lot of that information (still a necessary component of the workshop)

- Focus Group
  - I understood its value, but have had experience conducting and participating
  - I didn’t feel like I had enough time to review

- Evaluation
  - Experimental design seemed over my head and too scientific
  - Module 4 – flashbacks of stats college classes

- Comparison Design
  – Not really working with this type of data

Improvement Suggestions

Format and Content:
- Start off asking group needs, expectations and types of work/academic environments of the participants
- Use an example of a program at the beginning of the workshop to refer to throughout the day in relation to each module
- Less group work at the end of the day
- Not so many breakout sessions – interrupted the flow of learning and concentration – 3 should be the limit
- Spend more time on the Logic Model
- More visuals and real world examples
• More focused discussions on the Logic Model and evaluations by the instructors  
  
  Include Module of Quantitative Methods

*Other/Logistical:*
• Make it longer (2 days) to allow enough time to fully develop logic models.  
  • Workshop could be a little shorter in time.  
  • Explain the structure of the workshop and give logistics – i.e. schedule, breaks, bathrooms, reimbursement, etc.  
  • Provide written contact info of professor  
  • Decrease the ability for side comments

**Additional Workshop Topics For The Future**
Several participants suggested the following topics for future workshops:
• Recognizing crime as a public health issue  
  • Grant Writing  
  • Board Retreat Development  
  • Finance and Budgeting for Non-profits  
  • Analysis of Qualitative Data  
  • Community Building  
  • How to get other staff involved in evaluation (for a small organization)  
  • Additional evaluation workshops  
  • Data Collection  
  • Facilitation  
  • Finding or Discovering Funding Sources for Community Based Programs  
  • Partnering with various organizations for mutual outcomes  
  • Non-Profits  
  • Working with Urban Youth and their Common Challenges  
  • Leadership Training in an Urban Community  
  • Workforce Empowerment for Transitioning Adults  
  • After School Programming in City Schools  
  • Engaging and Retaining Participants  
  • Evaluation of CBPR  
  • Evaluation Program Creation for startup organizations or programs

**Overall Evaluation**
In total, the workshop was rated as “excellent”. Half of the participants arrived on time and all were eager to receive the information from the Dr. Mmari (Facilitator). The weather was cool and sunny. One participant stated that “Dr. Mmari is very engaging. It was obvious that she is incredibly knowledgeable and passionate.” All but four participants stayed for the full workshop, which ended at approximately 4:00pm. Many participants also verbally commented that they enjoyed the workshop.
2011 Recipients
UHI Small Grants for Research and Program Development

UNDERGRADUATE STUDENT-COMMUNITY GRANTS

Alexandra Hittman, Undergraduate, School of Arts and Sciences
Zizwe Allette, Literacy Instructor, YO! Eastside Center (HEBCAC)

Community Service Farming: Bridging the Food Gap for Baltimore City Youth

Middle East Baltimore, a neighborhood bordering the Johns Hopkins Medical Campus, has been identified as a ‘food desert,’ defined by the CDC as an “area that lack[s] access to affordable fruits, vegetables, whole grains, low-fat milk, and other foods that make up the full range of a healthy diet.” Within this neighborhood lies YO! Baltimore East, a vibrant community center dedicated to serving struggling local youth with opportunities for education, career skills training and life development skills in a safe and nurturing setting designed to keep them off the streets. In an attempt to address the nutritional inadequacies of this area, we have spearheaded a project to provide YO! students with access to freshly grown healthy food in partnership with the Real Food Farm. This provides them with access to fresh food and practical agricultural and nutritional knowledge, while introducing them to the merits of community service and civic engagement. With this grant, we would hope to expand upon this program and start a student-run vegetable garden on a vacant green lot near the Johns Hopkins Eastern campus where YO! students could fully reap the benefits of what they sow.

Cynthia Idada, Undergraduate, School of Arts Sciences
Lelin Chao, Chief Medical Officer, People's Community Health Centers, Inc.

People for People's: Supporting the Health and Well-Being of Baltimore

People’s Community Health Centers, or “People’s,” is a non-profit Baltimore health care system with nine centers scattered throughout the city. In the past few months, volunteers have flooded the Greenmount Avenue center, helping with everything from clerical to clinical work. By taking on more function, the volunteers improve patient satisfaction, productivity, and ultimately, patient care. However, the volunteers are limited by a lack of funds. We have literally no funding sources, making it difficult to support volunteer training or new program implementation. Relying on a sole stethoscope and blood pressure cuff (the personal set of one of our members), we can only train one volunteer at a time in patient assessments. Without any funds to purchase supplies, we can’t begin the patient education initiatives we intend to pursue. We propose that receiving these vital funds would allow us to expand; not only would we be able to more efficiently train members in currently-existing clinic roles, but we would also begin using wait times in the clinic for patient education initiatives. It is our hope that in so doing, we can be a force for improving the health and well-being of Baltimore.
Amazing Grace Community Kitchen
The mission of the Amazing Grace Community Kitchen is to alleviate the strong correlation between low-income status and poor dietary health in East Baltimore through health education and outreach. In partnership with Morgan Blizzard of the Amazing Grace Lutheran Church, the Community Kitchen will impart residents with the knowledge on how to improve health through a healthy diet. By building upon the existing relationship between Amazing Grace and the East Baltimore community, we hope to establish a permanent, sustainable community-based organization aimed at bringing people together and promoting health. With bi-monthly interactive cooking lessons and workshops, guest chiefs will teach local residents how to prepare affordable, easy to make, nutritious meals using locally grown and acquired foods. In addition to improving health, it is our hope that the community kitchen will serve as a venue for lasting friendships among participants by hosting special events such as cook-off parties and theme nights. By following up with participants, we hope to foster accountability and allow for constructive feedback to ensure that members’ health needs are being met. With this initiative, we seek to promote health by teaching and providing the resources for healthy eating in East Baltimore one person at a time.

Juntos (Together) – Latino HIV+ Peer Support Group
In the last ten years, AIDS incidence rate has doubled among Latinos in Baltimore City, who tend to present with late stage disease. The majority of Baltimore Latinos are recent immigrants from Central America whose primary language is Spanish. Foreign-born status has been shown to correlate with lower levels of knowledge of HIV/AIDS and also with shorter time interval from HIV diagnosis to AIDS. In response to this need, programs to provide culturally competent HIV testing and care to Latinos have emerged over the last few years in Baltimore, but there is still a lack of psychosocial support. Peer support groups have been shown to improve health and measures of well being among HIV-positive individuals, but there are currently no existing groups in Baltimore targeted to HIV-positive Latinos. Unfortunately, many HIV-positive Latinos experience significant isolation from the stigma of being ethnic minority migrants and HIV-positive. We propose to develop a sustainable support group that will provide psychosocial support for HIV-positive Latinos, decrease stigma and create a community of peer leaders among HIV-positive Latinos.

GRADUATE STUDENT-COMMUNITY GRANTS

Addressing Food Insecurity in Reservoir Hill, Baltimore, MD
This project aims to address food insecurity in Reservoir Hill, Baltimore, MD – an identified “food desert” -- by applying theory-based best practices grounded in literature to strengthen existing community based food security efforts. Working with three community partners the project will assess the barriers to expanding food access and increasing healthy eating knowledge, attitudes, and practices in Reservoir Hill through a needs assessment. The project will implement three programs to increase food security:
increase healthy food access by working with corner stores in Reservoir Hill to reduce structural and additunal barriers to stocking fresh vegetables, increase residents healthy food awareness, knowledge, and practices through healthy food cooking classes, and supporting Supplemental Nutrition Assistance Program (SNAP) benefits acceptance at Whitelock Community Farm’s farm stand. This project will be a pilot for ongoing programming of the community partners to apply for additional funding to scale-up existing programs.

Anne Hendrick, Graduate Student, School of Education
Elizabeth Obara Piedramartel, Community School Coordinator, Patterson Park Public Charter School

Family Health and Fitness Club
The goal of the Family Health and Fitness Club is to educate parents and their children about making good choices when it comes to raising healthy families. In creating this club, the school can bring families together one day a week for 24 weeks to learn about nutrition, practice wellness, and participate in fitness through fun family activities.
Specific program goals include: Parents/guardians will feel more confident in making healthy lifestyle choices for their families and accessing needed health resources; Participants will increase weekly level of physical activity, as indicated by weekly activity logs; Participants will demonstrate a positive change in targeted health behaviors, as indicated by pre- and post-surveys, food journals and activity logs. The club will empower parents to take charge of their health and fitness as well as becoming leaders in the school community by sharing their experience with others. Not only will this club help to further develop a school community where parents feel welcomed and supported by one another, it will also improve the well-being and academic outcomes of the students that are educated at Patterson Park Public Charter School.

Carmen Kut, Doctoral Student, School of Medicine
Debbie Rock, Executive Director, LIGHT Health and Wellness Comprehensive Services, Inc.

Truth about Medical Imaging – Addressing Distrust and Promoting Diagnostic Imaging within the Baltimore Community
This is a student-initiated project to build and develop awareness about the benefits and risks of diagnostic imaging. From our experiences working with the Baltimore community, we recognize a lack of trust for medical providers and researches conducted at Hopkins, especially among vulnerable groups such as the HIV/AIDS infected/affected population. By establishing an open and regular source of communication, we believe we can enable better trust and more informed medical decisions for this population. We are currently in search of funds for establishing a series of interactive sessions and lunch/dinner discussions for African American HIV/AIDS infected/affected population at LIGHT Health and Wellness. For this initial effort, we plan to focus on medical imaging, which has been rarely addressed and educated about within the community, despite common misconceptions and fears such as radiation risks. LIGHT Health and Wellness works intimately with the HIV/AIDS infected/affected population in the community. Its director, Ms Debbie Rock, is a strong advocate in addressing distrust issues within the community and Hopkins, and previously sat on the JHH Community Research Advisory Board. After this one-year program, we will continue its investment in the project by expanding our programs to other populations in the community, including cancer and heart disease patients.
Claire Sampankanpanich, Medical Student, School of Medicine
Andrew Gaddis, Executive Director, Charm City Clinic

Charm City Clinic: Connecting the Underserved and Uninsured Residents of East Baltimore to Sustainable, Affordable Health Care Services
Charm City Clinic, Inc. is a 501(c)(3) non-profit organization founded and operated by Baltimore medical, undergraduate, and graduate students in collaboration with community leaders in East Baltimore. Our goal is to reduce health inequities by helping East Baltimore residents to obtain and maintain access to high quality health care and other social services. Since March 2010, Charm City Clinic has served approximately 350 individuals by providing free health assistance with applications to medical assistance programs and social services related to health in conjunction with preventive screenings for hypertension and diabetes and neighborhood-based outreach programs. Support from the Urban Health Institute’s 2011 small grants program will enable us to expand our operations in two directions. First, we will launch a small pilot program to train three past clients who live in East Baltimore as neighborhood health outreach workers (HOWs) who will work side-by-side with student volunteers to identify and follow-up with clinic clients in the clinic, their neighborhood, and their homes. Second, we will expand our preventive screenings to include cholesterol, body mass index, and vision. Combined, these two new programs will better equip us to work alongside East Baltimore residents to identify and follow-up with their neighbors in need.

Emeline Mugisha, Graduate Student, School of Public Health
Ashley Rock, Program Director of Clinical Services, JACQUES Initiative

The Pedagogy of Empowerment: Promoting HIV Prevention and Status Awareness among Young Adults in Baltimore City
The HIV/AIDS epidemic has had a pervasive and disproportionate impact on the city of Baltimore and its continued spread is both a public health challenge and crisis. In Baltimore City, it is estimated that someone becomes infected with HIV every eight hours and despite continued efforts, the city continues to see high numbers of HIV infections each year. Although Baltimore City makes up 12.2% of the population in Maryland, it accounts for nearly half of all reported people living with HIV (46.9%) and of annual HIV diagnoses (41.2%) in the state, according to the most recent data. Adults/adolescents aged 13-29 account for 23.8% of new HIV diagnoses. The risk of HIV infection among young adults is particularly high due to their sexual risk behaviors, high rates of and infrequent testing for STDs, and other evidence-based risk factors. The mission of our project is to empower young adults aged 18-24 in Baltimore City as leaders in HIV prevention and health promotion through provision of both HIV education and rapid HIV testing; to equip those who test negative with the information needed to remain HIV-free; and to link those who test positive to the care and support services needed to live well.

Jeffrey Duong, Doctoral Student, School of Public Health
Carol Berman, Director; Founder, Heart’s Place Homeless Shelter

HEaR ME Tweet and Tumblr
This proposal requests funds for a graduate-student community project between Jeffrey Duong at the Johns Hopkins Bloomberg School of Public Health and Heart’s Place Homeless Shelter. More than 3,000 individuals in Baltimore city are homeless. It is widely accepted that misperceptions and stigma towards the homeless are prevalent. For example, between 1999 and 2009, at least 17 homeless individuals have
been the target of hate crimes in Maryland, where 7 resulted in deaths. With funding from the Albert Schweitzer Fellowship, our team comprising students from the Bloomberg School of Public Health and University of Maryland created the HEaR ME project in 2010, which aims to reduce the stigma associated with homelessness. To continue our work, we propose a new project called HEaR ME Tweet and Tumblr. Using a community-based participatory approach, we aim to teach the homeless how to effectively use social networking sites. We also aim to empower homeless individuals to engage in outreach and self-advocacy. By using social networking sites, this project will help inform members of the general community about the realities associated with homelessness. It also provides a way for lawmakers to understand better the experiences of the homeless, which may help inform policy and planning.

Marcus Seldin, Graduate Student, School of Medicine
Jessica Turral, Executive Director, Hand In Hand Baltimore

Discovering Me: Partnering with Young Men Charged as Adults to Create Self-Worth and Positive Self-Image!

Hand in Hand Baltimore (HIH) provides direct intervention services to youth ages 14-17 charged as adults. Through this grant HIH will provide mentoring, mental health, academic skill-building, and employment support to the youth who are detained or released to the community. Due to the fact that youth are charged as adults in Maryland more than in DC and Virginia, and are held in separate incarceration facilities in the Baltimore City Detention Center (BCDC), which lacks mental health services for the youth like those offered in juvenile detention systems, HIH will use the funding in providing services to these juveniles.

Maya Nadison, Doctoral Student, School of Public Health
Adam Rosenberg, Executive director, Baltimore Child Abuse Center

A Sexual-Abuse Awareness Program, Using Puppetry, for Middle-School Students

Child sexual abuse violates fundamental social norms and can be prevented. This proposal aspires to partner with the Baltimore Child Abuse Center (BCAC) to: 1) empower teenage victims by helping them produce a puppet performance about child sexual abuse, which will be presented to a group of peers and non-offending caregivers, and 2) use insights gained from working with this group of teenagers to design and implement a replicable school-based health education program, using puppetry, to promote sexual-abuse awareness in Baltimore City schools. Specifically, this intervention aims to teach children core concepts for resisting the approach of an offender. These concepts include body ownership, appropriate touches, attitudes regarding strangers, secrets that should not be kept, and potential familiarity of the offender1–3. Well executed, such a complementary outreach program could have a long-lasting and far-reaching impact on the welfare of the entire Baltimore community by preventing cases of child sexual abuse. The messages will embrace the guidelines established by the National Children’s Advocacy Center (NCAC). The NCAC models, promotes, and delivers excellence in child-abuse response and prevention through service, education, and leadership.
Expanding MnDS in Biology: A High School Outreach Program

Expanding MnDS in Biology is a science outreach program entering its fourth year. The Biology graduate student group, Mentoring to Inspire Diversity in Science (MnDS) works with the Biology teachers at a local West Baltimore public high school. Each year we visit six 10th grade Baltimore Talent Development High School Biology classes. We visit once a month during the school year bringing exciting, hands-on biology lab exercises to the classroom to expose the students to the forefront of scientific thinking. As scientists, we have access to scientific materials that are difficult if not impossible for a high school teacher to obtain. Our lesson plans are designed to improve the understanding of key concepts, and will ultimately help improve the school’s performance in Maryland state testing (currently only 45% of BTDHS students pass the Biology HSA test). Our lessons are taught in conjunction with ongoing classroom topics, and in the coming year, we aim to integrate more teacher-taught activities and worksheets as both preparation and follow-up to the lab demonstrations that MnDS teaches. We will also bring the students to Johns Hopkins for a visit, not only to see where scientists work, but also to bring post-secondary education into the forefront.

Understanding the Life Priorities and Needs of Women Recovering from Addiction

In response to the Urban Health Institute’s request for project proposals aimed at advancing the health of residents in Baltimore, we propose collaboration with The Light of Truth Center (LTC) to perform a qualitative study that will assess the needs of women recovering from addiction to drugs and alcohol. Addiction to drugs and alcohol continues to be a leading public health problem in the nation and Baltimore city. LTC provides supportive housing, psychosocial services, educational training, and other services to women recovering from addiction to drugs and alcohol. In order to ensure that the needs of their clients are being met, LTC staff aim to understand the needs of their clients and determine gaps in service provision. Based on these goals, we propose a qualitative study conducted by two JHSPH students who will administer in-depth interviews to women at the LTC to elicit insight on these issues. The insight gathered will not only inform future operations, but will also inform the development of follow-up and exit forms that will be used to monitor clients’ progress in the program. The findings from this study will be relevant to other organizations providing similar services and can inform the tailoring of services elsewhere.

Catch: Community Based Adolescent Testing For Chlamydia: Using Lessons Learned to Pilot New Strategies for the Delivery of Reproductive Health Services to Community Supervised Juvenile Justice Youth

Youth detained in juvenile justice facilities in the United States have some of the highest Chlamydia (CT) and gonorrhea (GC) rates in the country, with the highest prevalence among females. The Maryland
Department of Juvenile Services (DJS) has an established CT/GC screening program in its secure detention facilities, but has limited reproductive health services available for community supervised juvenile justice youth (CSJJY). Since July 2010, DJS has worked to expand health services to CSJJY through the CATCh program. CATCh stands for Community-based Adolescent Testing for Chlamydia and provides CT/GC testing, counseling and referral services to CSJJY in Baltimore City, including adolescent girls supervised in the Female Intervention Team (FIT) Unit. Preliminary results from FIT reveal high CT positivity consistent with levels seen in secure detention facilities. The initial evaluation of CATCh also identified several recommendations for improvement, including the need for health care provider rather than case manager driven testing efforts. The key elements of the current project proposal are CT/GC testing by a health care provider via distinct targeted testing efforts, health fairs to promote positive health behaviors and connect youth to local health resources, and an evaluation to determine the acceptability of this model for CSJJY.

Suzanne Grieb, Postdoctoral Fellow, School of Public Health
Joyce Jones, Co-Medical Director, Latino Outreach Program, Baltimore City Health Department

Improving HIV Preventative and Testing Services to Heterosexual-identifying Migrant Latino Men Who Have Sex with Men (MSM)
Latinos in the U.S. are disproportionately affected by HIV, and this has become a growing concern for Baltimore City Latinos as their population and HIV incidence continues to increase. Although the Baltimore City Health Department (BCHD) continues to serve this population through their Latino Outreach Program, they have not been successful in engaging Latino men who have sex with men (MSM) or men who have sex with men and women (MSMW). Previous research has demonstrated the role of stigma based on immigrant status, race/ethnicity, and sexuality in increasing HIV vulnerability among homosexual Latinos. However, many recent immigrant Latino MSM/MSMW do not identify as homosexual, and thus pose additional obstacles to engagement in HIV preventative and testing services. We propose to recruit 25 recent migrant Latino MSM/MSMW in Baltimore through chain-referral sampling to conduct iterative in-depth interviews to better understand their lives and explore how stigma and discrimination impact access to HIV preventive and testing services and to elicit ideas for improving services to this population from this population. Results of this study will be used by the BCHD to improve HIV services for MSM/MSMW in the Latino community. Additional utilization of the findings will be brainstormed with our community coalition.
FACULTY-COMMUNITY GRANTS

Colleen L. Barry, Associate Professor, School of Public Health
Penelope Power, BCARS Program Director, Catholic Charities

Effects of Crisis Response Services on Inpatient and ED Use Among Child and Adolescent Medicaid Enrollees in Baltimore City
Youth experiencing a psychiatric crisis are a high-risk subset of the overall population of children and adolescents with mental illness. In Baltimore, the Baltimore Child and Adolescent Response System (BCARS) serves as the city’s only mental health crisis response program for urban children and their families. To date, few urban crisis response programs for youth have been critically evaluated. In order to evaluate the effectiveness of the BCARS program at reducing high-cost psychiatric emergency department and inpatient hospitalizations, we propose a unique collaboration between Johns Hopkins and Catholic Charities. Through a partnership with the Hilltop Institute at the University of Maryland Baltimore County, we will obtain and analyze Maryland Medicaid claims data for the approximately 1500 BCARS participants between 2004 and 2009 as well as a propensity-score matched comparison group of youth. The aims of the project are to determine the effect of the BCARS intervention on psychiatric inpatient hospitalizations, emergency department visits, and outpatient behavioral health visits among Medicaid beneficiaries ages 0-18. The results will be used by the BCARS program to recruit additional Baltimore area hospitals to refer children to BCARS. In addition, results could enable BCARS to serve as a model urban health program for other cities.

Courtney Keeton, Assistant Professor, School of Medicine
Vanessa Booth, Pastor, Lamb of Life Baptist Church

Behavioral Health Intervention by Paraprofessionals in the Baltimore African American Faith-Based Community
Dr. Keeton and the Division of Child and Adolescent Psychiatry, in partnership with Pastor Dr. Vanessa Booth and Lamb of Life Baptist Church, propose to continue research initiatives associated with a novel parenting intervention designed to reduce mental health disparities and improve the psychological well-being of families in Baltimore’s African American community. In collaboration with local churches, we have developed and collected pilot data on a faith-based, empirically-informed parenting intervention implemented by paraprofessionals in the church setting and designed to reduce risk factors associated with youth behavior problems. Funding is requested to sustain this program of research while preserving our academic-community partnership. The proposed project aims to: (1) Summarize and disseminate pilot data reporting the feasibility, acceptability, and outcome evaluation of the in-church implementation of the Strong Families Project (SFP); (2) Revise the SFP intervention manual for use in a larger trial; (3) Establish procedures to sustain SFP in the community without academic research infrastructure; and (4) Submit a NIH R01 grant to conduct a larger efficacy trial. Achieving these aims is a crucial step toward demonstrating the efficacy of SFP in improving behavioral health outcomes and disseminating the program in order to improve outcomes for Baltimore’s African American youth.

Danielle German, Assistant Scientist, School of Public Health
Colin Flynn, Chief, Center for HIV Surveillance and Epidemiology, Infectious Disease and Environmental Health Administration, Maryland Department of Health and Mental Hygiene
Using Baltimore HIV Behavioral Surveillance Data for New Local HIV Prevention Planning
This project will develop a system for using Baltimore HIV behavioral surveillance data to guide
development of new HIV prevention plans to implement the National HIV/AIDS Strategy (NHAS) in
Baltimore. Addressing HIV/AIDS is a key priority for improving the health of Baltimore residents.
Baltimore is one of 12 metropolitan areas participating in CDC’s Enhanced Comprehensive HIV
Prevention Plan (ECHPP) project, designed to develop and implement local response plans to NHAS to
reduce HIV risk and incidence in jurisdictions most affected by HIV. The proposed project builds on an
existing partnership between Johns Hopkins and the Maryland Department of Health and Mental
Hygiene (DHMH) to implement HIV behavioral surveillance in Baltimore. Collaborative activities will
provide local data on key HIV-related indicators at appropriate levels of analysis to guide the
development of new local HIV prevention plans (ECHPP) to implement the new National HIV/AIDS
Strategy (NHAS), monitor achievement of NHAS/ECHPP goals, and build a foundation for continued local
data utilization. These activities will allow DHMH and local partners to respond to NHAS/ECHPP in
innovative ways that leverage existing resources, benefit the people of Baltimore, and could serve as a
model to be shared with other cities in ECHPP and NHBS.

Keeve Nachman, Assistant Scientist, School of Public Health
Katie Dix, CGRN Coordinator, Community Greening Resource Network (CGRN), Parks and People
Foundation

Understanding Urban Gardeners’ Perceptions of Risk from Soil Contamination: Identifying and Sharing
Resources to Mitigate Contaminant Exposure
Community gardens serve important social, ecological and public health functions in urban
environments. Despite these benefits, urban soils and garden sites are often contaminated with
asbestos, lead, other toxic heavy metals and additional contaminants from past land use, exposing
urban gardeners to potential health risks. To understand current risk information gaps among
community gardeners in Baltimore City, this study will utilize a qualitative methodology comprising of
community gardener surveys and key informant interviews to explore perceptions of risk related to site
contamination among community gardeners. Interviews will also be conducted with members of
gardening support institutions including city government and selected non-profits to understand
organizational resources, educational materials, and perceptions of risk related to soil contamination in
urban gardens. We will also conduct a review of educational materials available to community gardeners
to identify gaps in information and resources regarding site contamination and contaminant mitigation
strategies. This review will result in the production of a resource guide to aid Baltimore City community
urban gardeners in understanding and avoiding soil-based risks from urban gardening. We will then
hold a series of community workshops to disseminate our research findings and communicate
actionable information on mitigating risk and contaminant exposure from urban gardening.

Rachel Johnson Thornton, Assistant Professor, School of Medicine
Laurie Feinberg, Division Chief, Comprehensive Planning, Baltimore City Department of Planning

Reducing Crime through TransForm Baltimore’s Comprehensive Rezoning: The Public Health Case for
Addressing Nonconforming Liquor Stores
A Health Impact Assessment (HIA) of Baltimore’s first comprehensive zoning code rewrite suggests that
rezoning efforts may impact violent injuries and crime by regulating the presence and distribution of
liquor stores in the city. Existing research finds that off-premise alcohol outlets are associated with
crime. The proposed faculty-community partnership analyzes the relationship between liquor stores
and crime in Baltimore with the intention of influencing the rezoning effort addressing nonconforming liquor stores. The specific aims are to assist the Baltimore City Department of Planning and the Law Department in: 1) characterizing the distribution of liquor stores and their relationship to crime in Baltimore, 2) developing an evidence-based policy addressing nonconforming liquor stores through the comprehensive rezoning effort that utilizes public health expertise, and 3) conducting outreach efforts regarding the potential public health benefits of the zoning rewrite. The project will play a critical role in addressing the liquor outlet density reduction goal in Healthy Baltimore 2015. It effectively capitalizes on a rare opportunity to affect changes in the distribution of nonconforming liquor stores through the zoning rewrite. By enhancing collaboration among researchers and the Departments of Law, Planning and Health, this project will serve as a model for future efforts elsewhere.

Roland J. Thorpe, Jr., Assistant Scientist, School of Public Health  
Ryan Petteway, Social Epidemiologist, Baltimore City Health Department

**Baltimore Men’s Health Assessment Project**

Men suffer greatly from gender-based disparities in health outcomes. However much less is known about race differences in men’s health. This proposal outlines the—Baltimore Men’s Health Assessment Project—which seeks to provide an initial assessment of the health profile of men and document race differences in health indicators in Baltimore city, and assist Baltimore City Health Department and other community leaders in identifying target areas of interest in men’s health. The specific aims of the study are to: 1) examine race differences in all-cause and cause-specific mortality by socioeconomic status and by age; 2) examine race differences in men’s health status, health behaviors, and health utilization; and 3) determine if there are race differences among men in costs associated with key health conditions including asthma, type II diabetes, and hypertension. Awareness of differences by race in the health indicators and healthcare cost for men may help to initiate interventions and health promoting strategies to reduce/eliminate race disparities in the men’s health in Baltimore. Findings may also be used to inform program planning and policy development that focuses on men.
<table>
<thead>
<tr>
<th>Project Title</th>
<th>Hopkins Grantee</th>
<th>Community Partner</th>
<th>Progress/Accomplishments</th>
<th>Notes</th>
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| Understanding the Younger Face of Homelessness: Baltimore’s Homeless Youth  | ☐ Vignetta Charles       | ☑ Ross Pologe            | • Project completed  
• Resulted in 2 policy briefs  
• Established background information for 2009 homeless youth count                                                                                           | Unable to reach Vignetta                                                                      |
| Computer Classes for the Homeless                                         | ☐ Jenna Colagiacomi      | ☐ Mary Slicher           | • Unable to reach both grantees                                                                                                                                                                                          |                                                                                           |
| Faith! (Fostering African American Improvement In Total Health) Nutrition Education Program | ☑ LaPrincess Brewer      | ☐ Rev Michael Palmer     | • Project completed  
• Conducted 3 nutrition sessions at a local church  
• Measured improvements in participants nutritional intake  
• Healthier foods now offered at the church – “Faith Pantry”                                             | Unable to reach Rev Michael Palmer                                                            |
| Hopkins4Playgrounds @ Barclay                                            | ☑ Birju Patel            | ☐ Dr. Andre Humphrey     | • Project completed  
• A community space was developed  
• They had difficulty sustaining programming at the space                                                                                                     | Dr. Andre Humphrey’s email no longer working                                                 |
| South Baltimore Community Cancer Profile                                   | ☑ Mary Fox               | ☑ Ryan Petteway          | • Project completed  
• Calculated incidence and prevalence rates for top 10 cancers in South Baltimore  
• Found lung cancer to be more prevalent, but all other cancers lower than the state comparison                                                      | Ryan did most of the work on this project instead of Joshua Sharfstein. Neither could be reached |
| Augmenting The 2009 Census Of Homeless                                     | ☑ Nan Astone             | ☑ Ross Pologue           | • Project completed  
• A count of unaccompanied homeless youth has been institutionalized in the city of Baltimore                                                                                                                        |                                                                                           |
| Medical Student Elective: Healthcare Issues For Homeless Children          | ☑ Kathleen Schwarz       | ☑ Allison Stewart-Hammer | • Project completed  
• Elective for medical students was created, but overall not successful and discontinued  
• 2 non-Hopkins students did have a positive experience                                                                                                      | Unable to reach Allison.                                                                             |

5 interviews with Hopkins grantees  
2 interviews with community partners
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<tr>
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<th>Notes</th>
</tr>
</thead>
</table>
| Self-made Families: Gangs and Latino Youth in East Baltimore                 | 🌋 Precious Ventura                | 🌋 Gina Beaz             | • Project in progress.  
• Precious is still waiting to get IRB approval. She has been working with IRB for almost 2 years.                                                                                                             | • Unable to reach Gina       |
| The Family Employment and Support Program (FESP) Men’s Group                 | ☐ Janet Kerkvliet                 | ☐ Cheryl Harris         | • Project terminated; no activities completed                                                                                                                                                                          |                             |
| Reverse the Trend : Healthy Trendsetters Movement                            | 🌋 Chandra Jackson                 | ☐ Shawn McIntosh        | • Project ongoing  
• They hosted several quarterly Trendsetter events to promote healthy eating and exercise among high school youth and parents  
• They obtained participant pledges to make incremental behavior changes.                                                                                       | • Unable to reach Shawn      |
| Public Education Partnerships                                                | 🌋 Luigi LaPietra                  | ☐ Matthew Werndorfer    | • Project ongoing  
• PEPCorps added 2 new schools to their partnership where Hopkins undergrads provide TAs for Baltimore City public schools.  
• PEPCorps doubled their recruitment and conducted 3 trainings for new TAs.  
• Both partners are much happier with partnership.                                                                                                               | • Unable to reach Matthew    |
| Joy Wellness Center                                                          | ☐ Lakha Mathewkutty               | ☯ Jack VandenHegel      | • Secured funds and purchased materials to start the Joy Wellness Center at Shepherd’s Clinic.  
• Joy Wellness Center is now up and running.                                                                                                                     | • Unable to reach Lakha      |
| From Promise to Pratice : Keys to Successful Implementation Of Street Outreach For Youth Violence Prevention | 🌋 Jennifer Mendell/Whitehill      | ☐ Leon Faruq            | • Project in progress.  
• Jennifer has conducted qualitative research, including focus groups and analysis of field reports, from the Baltimore Cease Fire program. She is in the process of analyzing the data. | • Leon passed away; unable to reach his replacement, Garndel Carter |
| Trajectories Of Mental Health Treatment among African American Men in Impoverished Areas of Baltimore City | 🌋 Anne Sawyer                     | ☯ Deborah Agus          | • Project in progress  
• Anne has conducted a series of 3 interviews with nine males accessing mental health services. She is still analyzing the data.                                                                                     |                             |
<table>
<thead>
<tr>
<th>Project Title</th>
<th>Lead Grantees</th>
<th>Co-Grantees</th>
<th>Project Status</th>
<th>Issues/Contacts</th>
</tr>
</thead>
<tbody>
<tr>
<td>City Scholars: Self-Discovery Through Adventure: Leadership Training For Baltimore Boys</td>
<td>☑ Yetsa Tuakli-Wosornu</td>
<td>☑ Valencia Warnock</td>
<td>• Project completed. &lt;br&gt;• They sent 9 middle school boys and 4 older boys from the Boys of Baraka program to Echo Hills Outdoor School &lt;br&gt;• They also conducted cultural sessions at the Carmelo Anthony Youth Center.</td>
<td></td>
</tr>
<tr>
<td>Data Driven Urban Health Initiatives</td>
<td>☑ Debra Furr-Holden</td>
<td>☑ Jeanette Churchill</td>
<td>• Project completed &lt;br&gt;• Deborah and her graduate student revived the Baltimore Data Collaborative; they created a more efficient and usable data clearinghouse that is self-sustaining. &lt;br&gt;• Using this data, Deborah’s team conducted an exemplar project that showed an interaction between the school environment and the broader social environment on youth violence.</td>
<td>Jeanette and her replacement are no longer working there</td>
</tr>
<tr>
<td>Data Driven Capacity Building for the Baltimore City Fire Department</td>
<td>☑ Andrea Gielen and Wendy Shields</td>
<td>☑ Raymond O’Brocki</td>
<td>• Project completed &lt;br&gt;• Hopkins grantees developed a model plan for utilizing GIS to increase efficiency of Baltimore City Fire Department Home Visiting Program data.</td>
<td></td>
</tr>
<tr>
<td>Improving the Food Environment in Baltimore City Recreation Centers</td>
<td>☑ Megan Rowan</td>
<td>☑ Steve Vassor</td>
<td>• Analysis still in progress. &lt;br&gt;• Their formative research resulted in a Manual of Procedures that provide information on healthy nutrition and food choices for youth in recreation centers. &lt;br&gt;• They were able to get vending machines out of recreation centers. &lt;br&gt;• The Health Commissioner has taken a specific interest in the program.</td>
<td>Megan interviewed in place of Joel &lt;br&gt;Steve is no longer working there, and Megan no longer has a connection to the replacement</td>
</tr>
<tr>
<td>Self-made Families: Gangs and Latino Youth in East Baltimore</td>
<td>☑ Nancy Glass</td>
<td>☑ Terri Wurnser</td>
<td></td>
<td>Nancy is out of the country and difficult to reach &lt;br&gt;Terri’s email is no longer working; unable to contact</td>
</tr>
<tr>
<td>The Family Employment and Support Program (FESP) Men’s Group</td>
<td>☑ Phillip Leaf</td>
<td>☑ Grady Dale Jr.</td>
<td></td>
<td>Unable to contact both grantees</td>
</tr>
</tbody>
</table>

9 interviews with Hopkins grantees 4 interviews with community partners
<table>
<thead>
<tr>
<th>Project Title</th>
<th>Hopkins Grantee</th>
<th>Community Partner</th>
<th>Progress/Accomplishments</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sail-Ability Program at the Downtown Sailing Center</td>
<td>Theresa Marshall</td>
<td>Peter Hegel, Ebony Vaughan</td>
<td>• Project completed.  • They conducted 6 sailing sessions with 8 inner-city youth; each session did not have the same 8 youth.  • For youth who completed all 6 sailing session, there was a sense of personal accomplishment; this was truly a unique experience for these youth.</td>
<td>Theresa met with Ebony prior to the interview. Theresa’s report represents their joint perspective.</td>
</tr>
<tr>
<td>Health Literacy Initiative Days</td>
<td>Eruejerien Okoh, Jeanette Seaman</td>
<td></td>
<td>• Project terminated; no activities completed</td>
<td></td>
</tr>
<tr>
<td>Unrealized Potential: Preparing East Baltimore Youth for Sustainable Careers in Science, Engineering And Medicine</td>
<td>Aaron Chance</td>
<td>Valencia Warnock</td>
<td>• Project in ongoing.  • Hopkins undergrad students from the Center for Social Concern conduct weekly session with elementary school youth at the Carmelo Anthony Youth Center to engage youth in science activities.</td>
<td>Unable to reach Aaron Chance, or anyone from ASEP</td>
</tr>
<tr>
<td>Volunteer Stress and Burnout in ExperienceCorps Baltimore</td>
<td>Vijay Varma, Sylvia McGill</td>
<td></td>
<td>• Project in progress.  • They have conducted 8 focus groups so far and have 3 more to go.  • They have collected preliminary findings on the experience of ExperienceCorps participants.</td>
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<tr>
<td>Acculturation and Migration as a Risk Factor for HIV Among Latinos in Baltimore</td>
<td>Nadine Chen, Kathleen Page</td>
<td></td>
<td>• Project in progress.  • They designed a survey and collected ~350 survey responses to collect and analyze data on the migration history of Latinos in Baltimore and how this may be associated with HIV risk behavior.  • They are still analyzing data.</td>
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</tr>
<tr>
<td>Recovering a Sense of Place: Environment and Community in Treatment (ReSPECT) for Addiction</td>
<td>Joshua Garoon, Peter Bruun</td>
<td></td>
<td>• Project completed, but analysis still in progress.  • They identified 7 artist-researchers who took photographs and conducted ~100 interviews about resident perspectives of addiction treatment and services in the Beverly and Waverly neighborhoods.  • They conducted 2 art exhibits, one of which was attended by 2 city council members.  • Qualitative data is still being analyzed.</td>
<td></td>
</tr>
<tr>
<td>Project Title</td>
<td>PI/Leaders</td>
<td>Status/Progress</td>
<td>Notes</td>
<td></td>
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<tr>
<td>Transitioning to Independence: Assessing the Re-entry Environment for Young Adult Former Prisoners</td>
<td>Eva Moore, Richard Harris</td>
<td>Project in progress; they haven’t drawn down any UHI funds yet.</td>
<td>Richard Harris replaced Rev Horace Smith</td>
<td></td>
</tr>
<tr>
<td>Characterizing the Need For Mental Health Services In Baltimore Youth</td>
<td>Brad Sutton, Susan Tibbels</td>
<td>Project in progress. They have conducted 2 focus groups with parents and teachers of the New Song Academy to assess mental health services available for middle school youth.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improving HIV Preventive Services In Baltimore through Geospatial Analyses</td>
<td>Adam Milam, Rev Debra Hickman</td>
<td>Project not started. Debra Hickman mentioned that she has not heard from Adam Milam since they were awarded funding.</td>
<td>8 interviews with Hopkins grantees</td>
<td></td>
</tr>
<tr>
<td>Neighborhood Characteristics And Stress During Pregnancy: A Community Perspective In Baltimore</td>
<td>Cynthia Minkovitz, Maxine Reed-Vance</td>
<td>Project in progress. They have completed their brainstorming session with community members about environmental stressors during pregnancy. They are just starting the sorting and rating sessions.</td>
<td>Jackie was scheduled to attend the interview but had a last minute medical emergency.</td>
<td></td>
</tr>
<tr>
<td>Finding Our Wings Community Documentary Program</td>
<td>Jacquelyn Duval-Harvey, Kirsten Hollander</td>
<td>Project ongoing. They have continued to offer weekly documentary classes for 8 young African American ladies. They have also helped 4 of these ladies to develop a college plan.</td>
<td>Janice did not respond to emails until 3.29.11.</td>
<td></td>
</tr>
<tr>
<td>Passport to Health: Taking Charge of your Health; Empowering Intimate Partner Violence Survivors to Become their own Health Advocates</td>
<td>Patty Wilson, Janice Miller</td>
<td>Project in progress. They developed health passports for the residents of House of Ruth to store their health information. They conducted three health education classes for an intervention group. They are following a pre-/post-design to evaluate the impact of the health education classes in comparison to a group that did not receive the classes. Evaluation has yet to be completed.</td>
<td>Janice did not respond to emails until 3.29.11.</td>
<td></td>
</tr>
<tr>
<td>Birth Companions Services for New Refugees: Partnering with the International Rescue Committee</td>
<td>Elizabeth Jordan, Erica DelViscio</td>
<td>No information or application from either partner; no materials on file</td>
<td>9 interviews with community partners</td>
<td></td>
</tr>
</tbody>
</table>
Highlights from Hopkins Grantees

**Strengths/What Worked:**

- **Building upon existing relationships.** Most projects had an “in” with the community partner already before they started the project. This existing relationship helped to get the project off the ground.

- **Strengthening Hopkins/community relations.** Many people shared stories of how their UHI project strengthened the relationship between Hopkins and the community or gave the community a better appreciation for Hopkins and public health.

- **Ease of application process.** People appreciated that the application process was not onerous, especially for small amounts of money.

- **Getting support for an idea.** Many people mentioned that the UHI Small Grants Program was helpful for getting funding for a small idea or substudy for which they wouldn’t know where else to go for funding.

- **Providing money upfront.** Students, especially, really appreciated being given the money upfront when it was needed so that they didn’t have to charge and get reimbursed for expenses. However, some grantees also described this as a challenge. Apparently for some grantees it was easy to receive their fund and for others it was an onerous process.

- **Sustainability.** UHI has a really good approach in that encourages building partnerships with the community and using those partnerships to create sustainable programs.

- **Biting off a small piece, especially of something bigger, was a good thing.** My observation is that those projects with a larger funding source that used UHI funds to build in a small substudy generally had an easier time getting their project accomplished. First of all, the relationships were already in place. Second of all, they already had some idea or plan in place, and they just need a little additional money to roll it out. Also, the parent grant helped to carry the work further after UHI money ran out. Other projects that did not have parent funding, but had a smaller, more manageable project also seemed more successful.

**Challenges:**

- **High turnover – both in student population and in community staff.** High staff turnover in the community lead to extra time needed for building new relationships, ongoing training, and assessments. High student turnover lead to ongoing student training to find student replacements. Student turnover also threatened the sustainability of the project because students would come into the community, do their project, and then leave with no one to carry it forward.

- **Sustainability.** Many people talked about wanting to sustain the project but not having the funds to carry it forward. The most common barriers to sustainability
were lack on additional funding resources, and high turnover of student and community partners.

- **Amount of money.** This was both a strength and a challenge. Everyone appreciated having an opportunity to receive a little bit of funding to carry an idea forward, but often it wasn’t enough to do as much as they wanted to do.

- **Receiving money from UHI.** Some grantees had a very difficult time getting money from UHI when they needed it. This red tape made it hard to get things done in the community. People who were funded on their own, without the support of some larger agency infrastructure, had to cover expenses out of pocket. This created issues with personal finances and taxes, and essentially slowed the project down.

- **IRB Logistics.** Some projects experienced long delays with the IRB. While this was a challenge to the momentum of the project, it also created some challenges with the community/partner relationship. In once instance, the IRB has taken about 2 years (and is still not yet approved), and this has generated ongoing questions and some confusion from the community partner about how they were approved for funding but then not approved to do the project.

- **Overambitious projects.** Some people just thought they could do a whole lot more with the money they were given, and quickly found out that this wasn’t the case!

- **Only one project reported difficulty with the community partnership.** In this case, the community partner was not very reliable in coming to the project meetings and didn’t follow-through with the work. *The community partner for this project was unable to be reached for an interview.*

**Suggestions for Improvement:**

- **Improve communication between UHI staff and grantees, especially around receipt of funds.** Grantees wanted more regular communication with UHI about the project, availability of funds, reporting. They wanted clear expectations of reporting requirements. There were several comments about difficulties receiving the UHI funds when they were needed. People wanted more clear direction about this process.

- **Provide technical assistance and support from UHI.** This issue came up primarily with student grantees that had to learn to navigate the system (IRB, budget changes, etc.) There were suggestions to have some form of technical assistance/support through UHI, be it archives of useful links on a website, FAQ from previous grantees, mentoring from prior grantees, more face-to-face meetings and phone calls with UHI staff.

- **More opportunities for UHI funded grantees and community partners to meet.** Some suggested having a “meet and greet” when funding awards are announced. Also a suggestion to have a final “showcase” of projects where all grantees and community partners could attend to learn about each other’s work. One person mentioned that while it could be valuable build bridges and connections among
projects and partners, this would require a serious investment and commitment from UHI along with very skilled facilitation to do this well.

- **Provide a venue for people to share the work they have done.** Some suggestions include: 1) a final “showcase” of projects in an in-person format; 2) a simple reporting system; 3) a glossy booklet or pamphlet that highlights the previous years projects; 4) a website archive of previous projects.

- **Improve sustainability of the projects.** Some ideas included: 1) funding less people and providing more money so that projects could do more with what they were given; 2) have options for getting more funding at the end of the project – this could be in the form of additional UHI funding, or at the very least a resource list of additional funding sources; 3) have a plan for sustainability in the application itself – perhaps a way to better utilize the student population to continue the work that was started through the project;

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**Highlights from Community Partners**

*Strengths*

- **The program is definitely an asset to the community.** There is a lot of appreciation from community partners for the funding and the Hopkins support. More funding for more projects is always appreciated. This sentiment came through in almost every interview.

- **The program allowed community partners to do what they normally wouldn’t have been able to do.** This includes implementing new youth programs, creating a new database system – many examples of how the project helped the community partner do something new.

- **The program brought together the different strengths of the partners.** The community partners recognized that their Hopkins partners had resources and skills that their organization or existing community network just didn’t have (technical skills, training, knowledge, connections, access to funding). Several commented on the benefit of merging the community partner’s strengths (i.e., knowing their community and constituents) with the strengths that the Hopkins partner contributed. One community partner described this project as having the opportunity to work with “world class consultants.”

*Challenges*

- **Sometimes the community and the public health researchers speak a different language.** Although the language was different, after time, they realized that they were saying the same thing. However, it took time and patience to realize that the goals were the same for both entities.
• One project community partner has not heard from their Hopkins partner at all since they were awarded funding.

Suggestions for Improvement

• **Approach the community with sensitivity.** Often academics approach the community with preconceived notions of what is best for the community. UHI can do better to approach the community with a respect for their expertise. People living in the communities know their community best.

• **More opportunities to connect with others working with similar populations.**
OVERALL GOALS for 2011-2013

1. To contribute to research and programming in East Baltimore through current UHI initiatives.
2. To develop an individual research trajectory, with a focus on intimate partner violence (IPV) prevention and intervention.
3. To gain training in community-based research and community development strategies.
4. To write, submit, and publish manuscripts.

During the first 9 months of this post-doctoral research fellowships, I have actively participated in and contributed to the following UHI initiatives:

1. The Community Health Initiative (PI: Chris Gibbons)
   - Participated as an active member of the All Partners group
   - Helped to develop and complete the IRB proposal for the CHI asset mapping project with the Methods Team
   - Helped to draft the data collection tool for asset mapping with the Methods Team
   - Currently working with the Methods Team to finalize asset mapping protocols and procedures

2. The FAITH Project (PI: Bob Blum and Debbie Hickman)
   - Met monthly with FAITH project team members
   - Assisted with the coordination of Advisory Board meetings with pastors and youth pastors
   - Helped finalize the IRB proposal for qualitative/ethnographic data collection
   - Worked with FAITH team to conduct 2 day training of student and parent community data collectors and ongoing phone and in-person training
   - Currently scheduling and coordinating focus groups with youth and parents in churches

3. Rejuvenating Urban Health (Supervisor: Bob Blum)
   - Working with Bob Blum and team of JHSPH faculty to develop a proposal for JHSPH’s vision to address urban health issues in Baltimore under the Capital Campaign.
   - Assisted with drafting an initial proposal
   - Assisted with incorporating feedback from CUCC into proposal
I have worked on the following projects related to IPV prevention and intervention:

1. **Academics and Communities Together To End Violence Against Women (PI: Andrea Gielen and Jessica Burke)**
   - Participated as a member of a team of academics and community advocates coming together to develop research and programming priorities to address IPV using CBPR-based concept mapping methods
   - Currently engaged with this group to move forward with IPV-related research priorities that emerged from concept mapping

2. **Hospital-based domestic violence program CBPR project (Supervisors: Andrea Gielen and Jessica Burke)**
   - Worked with program directors of 6 hospital-based domestic violence programs in Maryland to generate and prioritize research questions
   - Currently moving forward with a collaborative project with DV program directors to determine the effect of hospital-based DV programs on health and health care utilization outcomes of abused women.

3. **The Sex Trade: Abuse, Risk and Health in Baltimore Project (PI: Michelle Decker)**
   - Connected with Michelle Decker to become involved in data collection, data analysis, and manuscript writing for this project
   - Conducted in-depth interviews with sex workers in Baltimore to assess health-related concerns, including experience of violence and HIV risk
   - Currently participating in ongoing coding and data analysis of interview transcripts

I have achieved the following related to writing and publishing manuscripts:

1. Revised and resubmitted first-authored paper on abuse among HIV positive women in primary care to Women’s Health Issues (in review)
2. Revised and resubmitted first-authored paper on the effect of violence, HIV and drug use on depression among abused women to the Journal of Interpersonal Violence (in review)
3. Submitted one of three dissertation papers to the American Journal of Public Health (in review)
4. Currently preparing two dissertation papers for submission to Social Science and Medicine and Violence Against Women
5. Currently collaborating on the preparation of three papers with Andrea Gielen, Jessica Burke, and Karen McDonnell